PREMIER INTERNAL MEDICINE ASSOCIATES, PC

ZIA HASSAN, M.D., FACP 420 LOWELL DRIVE, SUITE 302 HUNTSVILLE, AL 35801 256-265-1910

Welcome to our practice!

Enclosed you will find your new patient packet. Upon arrival to our office on the day of your appointment, the receptionist will ask you for these forms, **please bring them with you completed**. In addition, the receptionist will ask you for your insurance cards and driver's license. We will then register you for the patient portal which allows you 24/7 access to your health record and the ability to request refills, message your provider or request an appointment. The nurse will need you to bring all medications that you are taking, including over the counter medications, and any available medical records from your previous healthcare provider.

We hope the following information is helpful to you and will assist us in meeting your healthcare needs:

PARKING: Parking is available in the parking garage in any assigned patient parking space. There are handicap spaces available.

PATIENT APPOINTMENTS: Patients are encouraged to keep their appointments. We would appreciate you telephoning 24 hours in advance if you must cancel so that we can schedule patients who request to be seen.

PAYMENT OF SERVICE: Our office participates with many managed care contracts, and we comply with the payment policies. It is the patient's responsibility to know their insurance plans. Amounts not covered by the contracts are **DUE AT TIME OF SERVICE**, such as copayments and deductibles. If we do not participate with your plan, or you do not have insurance and you are accepted as a new patient, full payment is expected at the time the service is rendered. At this time we accept cash or check, Discover, MasterCard and Visa.

We hope you find our office staff friendly and helpful. We are here to provide excellent medical services in a cost-effective manner.

Sincerely,

DeLaney Cosola, NRCMA
Office Manager
Premier Internal Medicine Associates, PC

PREMIER INTERNAL MEDICINE ASSOCIATES, P.C.

ZIA HASSAN, M.D., FACP • 420 LOWELL DRIVE, SUITE 302 • HUNTSVILLE, AL 35801 • 256-265-1910

Patient Information

Last Name: _____ ☐ Mr. ☐Mrs. ☐ Miss ☐ Other: _____ Sex: Male _____ Female _____

First Name: _____ Date of Birth: ___/___/___ Age: ____ SSN: _____-____-_____

Middle Name: _____ Preferred Name: _____

Address: _____ City: _____ County: _____ State: ____ Zip: _____

Email Address: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

May we leave a message about appointments and/or normal test results on the phone numbers you provided? Yes ___ No ___

Marital Status: ☐Married ☐Single ☐Separated ☐Divorced ☐Widowed

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Other: _____

Primary Language: ☐English ☐Spanish ☐French ☐Other: _____

Race: ☐ Caucasian ☐ African American ☐Asian ☐Other: _____

Student Status: ☐Not a Student ☐Full ☐Part

Employment Status: ☐Full ☐Part ☐N/A Employer: _____

Pharmacy name: _____ Address: _____ Phone: ( ) _____

Emergency Contact: Name: _____ Relationship: _____ Phone: ( ) _____

Alternate Contact: If you want this Practice to contact you at an alternate address or telephone number, please complete:

Alt. Address: _____ City: _____ State: ____ Zip: _____ Phone: ( ) _____

Referred by: _____ Primary Care Physician: _____

Guarantor/Financially Responsible Person (if different from patient)

Last Name: _____ ☐ Mr. ☐Mrs. ☐ Miss ☐ Other: _____ Sex: Male _____ Female _____

First Name: _____ Date of Birth: ___/___/___ Age: ____ SSN: _____-____-_____

Middle: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Guarantor/Financially Responsible Person's Email Address: _____

Primary Insurance

Insurance Company: _____

Policyholder Name: _____

Member or Policyholder ID#: _____

Policyholder Date of Birth: _____

Insurance Co. Phone #: _____

Group#: _____

Relationship to Patient: _____

Secondary Insurance

Insurance Company: _____

Policyholder Name: _____

Member or Policyholder ID#: _____

Policyholder Date of Birth: _____

Insurance Co. Phone #: _____

Group#: _____

Relationship to Patient: _____

Ongoing Communication Regarding Your Healthcare

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? (Please provide the information below.)

For ongoing communication regarding your healthcare and for your privacy, you must complete this section to authorize this Practice to release and/or discuss your health information with the following people or organizations for the following specific dates of service. Any revocation or modification to your authorization with regard to a family member or other individual must be submitted in writing.

From date of service: _____ To date of service: _____

Name of person	Address	Phone/Fax	Relationship to you
Example: John Doe	*3 Main Street, ABC City, SC 29401*	*843-555-1212*	*Husband*

A separate **Authorization to Release Information Form** must be completed for other releases and disclosures not listed in the section below.

To request restrictions of the use of your information, you must complete a separate Request For Restrictions Form.

Authorization, Assignment of Benefits, and Referral Medical Release

I consent to treatment and allow this Practice and their affiliates to use and release my protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the Premier Internal Medicine, P.C. Notice of information Practices, which a copy has been made available to me

I understand that my medical information including complete medical records, test results, and billing information may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

I allow payment to be made directly to Premier Internal Medicine for all medical or surgical benefits otherwise payable to me under terms of my insurance.

I understand that I am financially responsible for paying all co-payments, co-insurance, deductibles, and non-covered services.

I understand that I will be charged a 25.00 no show fee for missed appointments.

A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep this Practice and my Physician informed of changes to my contact information; a failure to do so may interfere with the ability to contact me concerning my healthcare.

Print Patient's Name: _____

Patient's Signature: _____ Date: ____/____/____

Print Legal Guardian's Name: _____

Legal Guardian's Signature: _____ Date: ____/____/____

Office Use Only:

Revised 01/2014

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Medical History

Patient Name _____ Date of Birth _____

Reason for Visit Today _____

Pharmacy 1) _____ 2) _____

Past Medical History (Please check if you have had any of the following)

High Blood Pressure	☐ yes ☐ no	If yes, year of diagnosis_____
High Cholesterol	☐ yes ☐ no	If yes, year of diagnosis_____
Diabetes	☐ yes ☐ no	If yes, year of diagnosis_____
Bone Density Test	☐ yes ☐ no	If yes, year of test _____ ☐ normal ☐ abnormal
Colonoscopy	☐ yes ☐ no	If yes, year of test _____ ☐ normal ☐ abnormal
Heart Stress Test	☐ yes ☐ no	If yes, year of test_____ ☐ normal ☐ abnormal
Heart Catheterization	☐ yes ☐ no	If yes, year of test _____ ☐ normal ☐ abnormal

FOR MALE PATIENTS ONLY

PSA Test	☐ yes ☐ no	If yes, year of test_____ ☐ normal ☐ abnormal

FOR FEMALE PATIENTS ONLY

Mammogram	☐ yes ☐ no	If yes, year of test _____ ☐ normal ☐ abnormal
Pap smear	☐ yes ☐ no	If yes, year of test _____ ☐ normal ☐ abnormal
Colposcopy	☐ yes ☐ no	If yes, year of test _____ ☐ normal ☐ abnormal

Number of pregnancies_____ Number of births _____

Date of last menstrual period _____ Method of birth control _____

Please list any other medical conditions:

_____

_____

_____

_____

_____

Past Surgical History

Surgery	Date	Surgery	Date
1. _____		4. _____	
2. _____		5. _____	
3. _____		6. _____	

continued

Medical History page 2

Patient Name _____

Family History (Check in the appropriate boxes to identify all illnesses/conditions in your blood relatives)

Relative	Heart Attack	High Blood Pressure	Stroke	Colon Cancer	Breast Cancer	Colon Polyps	Prostate Cancer	Other Illness or Condition	Age if living	Age of death
Father	☐	☐	☐	☐	☐	☐	☐	☐		
Paternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐		
Paternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐		
Mother	☐	☐	☐	☐	☐	☐	☐	☐		
Maternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐		
Maternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐		
Brother	☐	☐	☐	☐	☐	☐	☐	☐		
Sister	☐	☐	☐	☐	☐	☐	☐	☐		

Social History

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation _____

Exercise Type? _____ How long? ____ minutes How often? ____ times per week

	Current Use	Past Use	How often per week	How much per day
Smoking				
Caffeine				
Alcohol				
Drug Use				

Allergies (Please list all allergies)

Reaction: Date:

1. _____
2. _____
3. _____
4. _____

Current Medications

Medication	Reason for taking	Dosage	Times per day	Date Started

continued

Medical History page 3

Patient Name _____

Immunizations

Tetanus	❑ yes ❑ no Date vaccinated_____	Gardasil Series (HPV)	❑ yes ❑ no Date vaccinated _____
Influenza	❑ yes ❑ no Date vaccinated_____	Zoster Vaccine	❑ yes ❑ no Date vaccinated _____
Pneumococcal	❑ yes ❑ no Date vaccinated_____	Varicella	❑ yes ❑ no Date vaccinated _____
Hepatitis A Series	❑ yes ❑ no Date vaccinated_____	Have you had chicken pox?	❑ yes ❑ no Date vaccinated _____
Hepatitis B Series	❑ yes ❑ no Date vaccinated_____		

Review of Systems Please check any of the following that you have experienced in the last 3 weeks

Constitutional
- ❑ Changes in appetite
- ❑ Night sweats
- ❑ Fever
- ❑ Chills
- ❑ Recent weight gain (___lbs)
- ❑ Recent weight loss (___lbs)
- ❑ Fatigue

Skin/Integumentary
- ❑ Change in a wart or mole
- ❑ Rash
- ❑ Sores that won't heal

Eyes
- ❑ Recent changes in vision
- ❑ Double vision
- ❑ Eye pain

Ear, Nose and Throat (ENT)
- ❑ Loss of hearing
- ❑ Seasonal allergies
- ❑ Nasal congestion
- ❑ Snoring
- ❑ Trouble swallowing
- ❑ Cold symptoms
- ❑ Ringing in the ears
- ❑ Sore throat

Respiratory
- ❑ Wheezing
- ❑ Cough

Cardiovascular
- ❑ Fainting
- ❑ Heart rate is fast
- ❑ Calf cramps
- ❑ Varicose veins
- ❑ Difficulty breathing on exertion
- ❑ Irregular heart beat
- ❑ Chest pain
- ❑ Swelling of extremities

Gastrointestinal
- ❑ Black, tarry stool
- ❑ Heartburn
- ❑ Constipation
- ❑ Vomiting
- ❑ Indigestion
- ❑ Bloody stools

Genitourinary
- ❑ Blood in urine
- ❑ Menstrual irregularities
- ❑ Painful intercourse
- ❑ Painful urination
- ❑ Urinating at night

Musculoskeletal
- ❑ Joint pain
- ❑ Muscle pain

Neurological
- ❑ Numbness
- ❑ Headaches

Psychiatric
- ❑ Anxiety
- ❑ Depression
- ❑ Substance abuse

Endocrine
- ❑ Cold intolerance
- ❑ Heat intolerance
- ❑ Excessive urination

Heme/Lymph
- ❑ Easy bruising
- ❑ Enlarged lymph nodes

List all other symptoms you are experiencing that you need to discuss:

_____

_____

_____

We will make every effort to discuss your medical concerns at your visit. However, we may need to schedule an additional appointment to adequately address multiple concerns.

PREMIER INTERNAL MEDICINE ASSOCIATES, P.C.

ZIA HASSAN, M.D., FACP • 420 LOWELL DRIVE, SUITE 302 • HUNTSVILLE, AL 35801 • 256-265-1910

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize _____ to disclose the following information:
(Name of organization releasing information)

_____
(address, phone & fax number if available)

I hereby authorize disclosures of the following information:

_____ Progress Notes
_____ Consults
_____ Laboratory reports
_____ Financial records
_____ Two most recent years
_____ X-ray and imaging reports
_____ Immunization records
_____ Complete (all health information)
_____ Other

I understand that this will include information relating to (check if applicable):
_____ AIDS/HIV (Acquired Immunodeficiency Syndrome of Human Immunodeficiency Virus):
_____ Mental health or psychiatric care
_____ Substance or alcohol abuse treatment

This information is to be disclosed to: Premier Internal Medicine, P.C.
Dr. Zia Hassan, M.D.

for the purpose of _____.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that revocation will not apply to information that has already been released in response to this authorization.

This authorization will expire on the following date, event or condition _____.
If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.

I understand that authorizing the disclosure of my health information is voluntary. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
(Signature of Patient or Legal Representative) (Date)

_____ _____
(If signed by legal representative, relationship to patient.) (Date)

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITY TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on March 26, 2013 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $ .25 for each page and the staff time charged will be $ 0 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of your recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form/format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $ .25 for each page and the staff time charged will be $ 0 per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **HOW TO CONTACT US:**

PREMIER INTERNAL MEDICINE ASSOCIATES, P.C.
420 Lowell Drive, Suite 302
Huntsville, AL 35801
(256) 265-1910

PREMIER INTERNAL MEDICINE ASSOCIATES, P.C.

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HIPAA - HEALTH AND PORTABILITY & ACCOUNTABILITY ACT

Who may receive information regarding your Protected Health Information?

( ) Spouse _____ Date of Birth _____

( ) Children Name(s) and birthdate(s) _____

May we leave a message regarding test results and appointments on your answering machine? Yes ( ) No ( )

Consent to Receive Text Messages or Emails about Appointmen Reminders: Patients in our practice may be contacted via email or text messaging to remind you of an appointment.

_____ I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive appointment reminders. I understand that this request to receive text messages will apply to all future appointment reminders unless I request a change in writing. The cell phone number that I authorize to receive text messages for appointment reminders is _____

The email that I authorize to receive text messages for appointment reminders is: _____

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of Notice of Privacy Practices, which states how we may use and or disclose your health information. Please sign this to acknowledge receipt of the notice. You may refuse to sign this acknowledgement, if you wish.

I hereby acknowledge that I have been presented with a copy of Premier Internal Medicine, P.C.'s Notice of Privacy Practices. I also authorize the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

Name of patient printed: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient but it could not be obtained because:

The patient refused to sign.

Due to an emergency situation it was not possible to obtain an acknowledgement.

We weren't able to communicate with the patient.

Other (Please provide specific details)

_____

_____

_____ _____

Employee Signature Date

Office and Financial Policy

Thank you for choosing Premier Internal Medicine Associates, PC for your health care needs. In an effort to make your transition to our practice as smooth as possible we have the following policies that we request you read & sign. Please feel free to seek clarification on any of our policies.

Premier Internal Medicine Associates Providers:
- **Zia U Hassan, M.D., F.A.C.P.**
- **Ashley Ward, CRNP**
- **Alyson Justice, CRNP**

Patient Identification	All patients must complete our patient information form before seeing the doctor. We must obtain a copy of a valid government issued picture ID and current valid insurance card. Without the requested ID, you may not be seen. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. It is your responsibility to inform us of any address changes immediately.
Cell Phone Use	We ask that cell phones are not in use in the clinical areas.
Referrals and Authorizations	Please allow 5-7 business days for referrals/authorizations to be approved. Most plans do not allow retro-referrals. These are provisions you agreed to when you contracted or signed up with your insurance plan. When providing information to us to initiate a referral we will need providers name, phone number, location, and date of appointment. It is your responsibility to make sure a referral is active before seeing a specialist.
Medications & Prescription Refills	Each patient is asked to bring all medication bottles currently being taken, *including over the counter medication*, with him/her to each visit. All prescription refills require a 24-48 hour notice to our staff to process. We prefer for our patients to call to request refills, or utilize the patient portal for these requests. Pharmacies will auto-fax requests when you do not need the medication or a dosage has been changed. If you call to request a refill but are overdue for a follow-up visit and/or blood work (necessary for monitoring the safety or effectiveness of a medication), the provider may agree to call in enough medication to a local pharmacy to last until we are able to schedule an office visit (two weeks maximum). It is your responsibility to schedule an appointment before you run out of medication. You should schedule your next visit before you leave our office. ***We do not call in new prescriptions without being seen in office, including an antibiotic.*** ***If you are having problems with side effects, or need a change in dosage, please schedule an appointment to discuss problems and explore alternative options.*** ***Prior Authorizations for medications are done as a courtesy to the patient. This may require a trail of the preferred medication on your formulary prior to submission.***

After Hours and Emergency Care	Our providers are on call 24/7 by calling our office at 256-265-1910. Please note that after hour calls are to be charged unless they are considered by the provider to be urgent. The minimum charge is $20. Further charges are at the provider's discretion. Only some insurance companies will pay for this. Please call our office prior to going to the emergency room for non-life threatening emergencies. Emergency rooms are properly staffed for critical situations and not for treatment of cold, flu sprains or chronic conditions. To provide better service to you SAME DAY appointments are now available Monday-Friday for our established patients. After hour and weekend sick appointments can be referred to the Huntsville Hospital Walk-In Clinic located at 700 Airport Road SW Huntsville, AL 35802.
Messages	We encourage patients to contact us through the patient portal for general questions or concerns. We strive to respond the same day. Non-urgent messages will be returned within 48 hours.
Cancellation and Missed Appointments	Appointment times are an important commitment of reserved time for you and the physician/practice. Therefore missed appointments create an interruption for staff members and other patients on the schedule. Our office will attempt to call you **48 hours** prior to your appointment and will leave a message for you to call us back to confirm. It is your responsibility to confirm with our office or if needed to cancel within **24 hours**. **Cancellation of Appointments:** We understand personal matters do occur that may necessitate a cancellation; therefore we ask kindly for at least a **24 hour** advance notification. **No Show to Appointments:** The definition of No Show is when a patient has a scheduled appointment and does not show up as scheduled and without cancellation notification to the office. **New Patients:** • 1st No Show- Office will notify patient by phone call and remind patient of no show policy. • 2nd No Show- Office will notify patient by mailing a final letter indicating termination of services. (Appointment will not be rescheduled) **Established Patients:** • 1st No Show- Office will notify patient by phone call and remind patient of no show policy. • 2nd No Show- Office will notify patient by mailing a letter and policy reminder. • 3rd No Show- Office will notify patient by mailing a final letter indicating termination of services. Termination of services will include a grace period of 30 days for prescription refills. It will be the patient's responsibility to find a new physician and contact his/her insurance carrier for assistance with finding another physician.***All No Show Episodes are subject to a $25.00 fee.**

Late For Appointment	We understand natural unplanned events may cause you to run a little behind. A call in advance would be appreciated; however if you are greater than 15 minutes late when arriving to a scheduled appointment your appointment will be rescheduled.
Insurance & Payment Responsibilities	Payment is expected on the date of service. This includes self-pay patients and your coinsurance and co-payments responsibilities. Failure to do so will result in the rescheduling of your appointment. There will be a $35.00 fee charged for returned checks. Patients with an outstanding balance over 90 days that have not made a payment arrangement will be sent to collection, prevented from scheduling future appointments and discharged from the practice. Your account will then be turned over to a collection agency. Patients with manage care plans with an assigned provider will be responsible for changing their provider to Dr. Zia Hassan. You will not be able to be seen until this is complete and your appointment will be rescheduled. **It is the patient's responsibility for verifying and knowing his/her insurance coverage, deductible, co-payments, etc.**
Forms	A $20.00 form fee will be charged for all forms completed by this office. Please note that some forms will require a face to face visit to be completed. Fees will be paid at time of service. ***We do not complete social security disability forms.**
Medical Records	Copies of medical records are available upon request. A fee of $.25 cents per page will be charged for medical records provided to a patient. There is no fee of sending records to another provider.
Patient Dismissal	We have the right to terminate the patient relationship based on medical non-compliance, threatening or abusive behavior, failure to keep scheduled appointments and failure to pay as described in our dismissal policy.

I have read and understand the office policy and agree to abide by its guidelines:

Patient Signature _____ Date _____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITY TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on March 26, 2013 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $ .25 for each page and the staff time charged will be $ 10 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.