Patient Registration:

Name: _____ DOB: _____ Driver's Liscense #: _____

Gender: female/male (please circle) or other: _____

Street Address: _____

City, State, and ZIP Code: _____

Primary Phone number: _____ Cell phone number (if not the same as primary) _____

Email: _____ SSN: _____

Marital Status: Married/Single/Divorced/Widowed (please circle)

Employed: yes/no Name of Employer: _____

Emergency Contact Name: _____

Emergency contact phone: _____ (relationship to patient: _____)

Preferred Pharmacy Name and Address: _____

Primary Insurance: _____

Policy ID: _____ Group#: _____

Policy holder name: _____ Policy Holder SSN: _____

Policy holder DOB: _____ Policy holder gender: male/female/other: _____

Secondary Insurance: _____

Policy ID: _____ Group#: _____

Policy holder name: _____ Policy Holder SSN: _____

Policy holder DOB: _____ Policy holder gender: male/female/other: _____

If you are not the insurance Policy Holder, please provide Policy Holder's NAME, GENDER, and DOB:

NAME: _____ DOB: _____ GENDER: male/female/other: _____

PLEASE present **ALL** insurance cards to the receptionist! Thank you!

Authorization for release of medical information

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN BELOW

I _____, hereby voluntarily authorize the disclosure of information from my health record.

Patient Name: _____

Date of Birth: _____

Record Number: _____

Patient's SSN: _____

Information Requested: _____

Purpose of Release: _____

The Information is to be provided to:

Name of Person/Organization/Facility: _____

Address: _____

Phone Number: _____

1. I understand this information will **expire** one year from date signed.
2. I understand that I may **revoke** this authorization at any time by notifying the practice in writing.
3. I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits.
4. I may **inspect or copy** any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a healthcare provider or plan covered by federal privacy regulations, the information described above may be disclosed above may be disclosed and would no longer be protected by these regulations.

Date: _____

Signature of Patient or Patient's Representative: _____

Printed Name of Patient's Representative: _____

Relationship to patient: _____

YOU HAVE THE RIGHT TO RECEIVE THE COPY OF THIS FORM

Under HIPPA with patient's written request, records must be provided within 30 days of a request.
Under House Bill 300 Texas Law with patient's written request, records must be provided within 15 days of a request.

HIPPA Authorization Release of Information

This form does not constitute legal advice and covers only federal, not state laws.

New Albany OB/GYN Clinic P.C.
117 Fairfield Drive
New Albany, MS 38652
Phone: 662-534-0029 Fax: 662-534-0008

Office Financial Policy

Patient Name: Patient DOB:

Basic Policy: Payment is due at the time of service that is provided in our office.

Patients with Insurance: We will submit claims to most insurance carriers on your behalf, if the proper paperwork is provided to us. Co-payments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full.

Non-covered Services: Any care not paid for by your existing insurance coverage will require payment in full at the time of services provided or upon notice of insurance claim denial.

Missed appointments: In fairness to other patients and the doctor, we require at lease 24 hours' notice to cancel appointments.

Collections: Any balance not paid within 90 days will be turned over to a collection agency. If that happens, the patient will incur an additional charge for collection and legal fees.

Returned Check fee: If a check is returned as non-sufficient funds the patient will incur a $25 charge per occurrence. The returned check fee and the amount of the check must be paid in cash.

OB Patients: After confirmation of pregnancy, we will verify your maternity benefits with your insurance carrier. The patient responsibility of the OB package must be paid in full by the completion of 28 weeks of pregnancy (7 months). Self-pay patients will have a payment plan calculated and this must be paid in full by completion of 28th week of pregnancy.

I have read, understood, and agreed to the above financial policy for payment of professional fees. I fully understand that I am ultimately responsible for all charges associated with my account and that if I fail to pay any amount due, I will also be responsible for all collection fees, court cost, attorney fees, and any other charges incurred in the collection of the balance due. I understand that my account with this provider and its associate providers is considered an open account.

Date: _____

Patient/Legal representative signature: _____

Authorization to leave Message and Disclose Healthcare Information

Patient Name: _____ Date of Birth: _____

Which of the following ways of communication are acceptable for NA Ob/Gyn to communicate with you? Please circle all that apply: phone calls/email/text/mailing address

Home or cell number: _____

Email address: _____

Okay to leave a message? Yes/No (please circle)

Authorization to disclose Healthcare Information

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below name(s) of the individual(s) you authorize our office to discuss your care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

Name:	Relationship:
_____	_____
_____	_____
_____	_____

I understand that it is my responsibility to update this list to keep accurate the authorized persons to discuss and use my (the patient's) healthcare information.

Date: _____

Patient/Legal Representative Signature: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patients:

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

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

PRINTED name: _____

Patient/Legal representative signature: _____

Date: _____

HIPPA Acknowledgement of Receipt of the Notice of Privacy Practice 2015
This form does not constitute legal advice and covers only federal, not state law.

FOR OFFICE USE ONLY:

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

- ☐ **Due to an emergency situation, it was not possible to obtain an acknowledgement.**
- ☐ **We were NOT able to communicate with the patient.**
- ☐ **The patient refused to sign.**
- ☐ **Other / Please provide specific details:**

_____

_____

_____

Employee Signature: _____ Date: _____

New Albany OB/GYN Clinic
HIPAA Notice of Privacy Effective Date: May 5, 2003
This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.
If you have any questions about this notice, please contact the office manager at 662-534-0029.
Our Obligations:
We are required by law to:
Maintain the privacy of protected health information about the follow the terms of our notice that is currently in effect.

Give you this notice of our legal duties and privacy practices regarding health information about you. Follow the terms of our notice that is currently in.

How We May Use and Disclose Health Information
Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health information only with your written permission. You may revoke such permission at any time by writing to our practice's office manager privacy officer.
Treatment We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in our medical care and need the information to provide you with medical care.
Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you received. For Example, we may give your health information so that they will pay for your treatment.
Health Care Operations. We may use and disclose Health Information for health care operation purposes. Theses uses and disclosures are necessary make sure all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.
Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and service that may be of interest to you.
Individuals Involved in Your Care of Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.
Research. Under certain circumstances, we may use and disclose Health Information for research. For Example, A Research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, if they do not remove or take a copy of any Health Information.
Special Situations:
As Required by law. We will disclose Health Information when required to do so by international, federal, state, or local law.
To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.
Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services the information is necessary for such functions and services. For example, we may use another

company to perform billing services on our behalf. All our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. Organ and Tissue Donation. If you are an organ donor we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs benefit for work related injuries or illness. Public Health Risks. We may disclose Health information for public health activities. These activities generally include disclosures to prevent or contagious disease, injury, or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spread disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose health information to a health oversight agency for activities authorized by laws. The oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose Health Information in response to a court or administrative order. We may also disclose Health information in response to a subpoena, discovery request, or other lawful process by someone also involved in the dispute but only if efforts have been made to tell you about the request or to obtain an order in protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena , warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime if , under certain vary limited circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises; and 6) in an emergency to report a crime, the location of crime or victims, or identify, description, or location of the person who committed the crime.

Corners, Medical Examiners, and Funeral Directors. We may release Health Information to a corner or medical examiner. This may be necessary examples, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counterintelligence, other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection the President, other authorized persons or foreign heads of state, or conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary: 1) for the intuitions to provide with health care, 2) to protect your health and safety or the health and safety of others, or 3) for the safety and security of the correctional intuitions.

Your Rights:

You must follow rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make a request, in writing, to the office manager/ privacy officer. Right to Amend: If you feel that Health Information, we have is incorrect or incomplete, you ask us to amend the information. You have the right to request

an amendment for as long as the information is kept by or for our office. To request amendment, you must make your request, in writing, to the office manager, privacy officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health operations or for which you provided with written authorization. To request an accounting of disclosures, you must right your request, in writing, to the office manager/privacy officer.

Right to request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose to someone involved in your care the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to office manager/privacy officer. We are not required agree to your request if we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You may have the right to request that we communicate with you about medical matters in a certain way a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make your request, in writing, to the office manager/privacy officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests. Right to a paper copy of the notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any given time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please notify any office personnel.

Changes to this notice

We reserve the right to change this notice and make the new notice apply to Health information we already have as well as any information we received in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page.

Complaints: If you believe our privacy rights have been violated, you may file a complaint with our office or with the Secretary of Department of House and Human Services. To File a complaint with our office, contact the office manager/ privacy office. All complaints must be made in writing. You can be penalized for filing a complaint.

NEW ALBANY OB/GYN Clinic P.C.
Release of Information/Insurance Assignment

Consent for Examination and Treatment

I consent to an examination and treatment by the staff and physician at New Albany Ob/Gyn Clinic, P.L.L.C. This consent will remain in effect from this day forward unless "written" revocation of such is duly presented to the office of New Albany Ob/Gyn Clinic, P.L.L.C., myself or a legally authorized representative. I understand that I have the right to question and/or refuse any proposed treatment.

The following statement agreements allow New Albany Ob/Gyn Clinic, P.L.L.C. to file insurance appropriately for you so that reimbursement can be assured:

Assignment of Insurance Benefits

I hereby authorize direct payment of surgical/medical benefits to the New Albany Ob/Gyn Clinic P.L.L.C by their medical staff in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization to Release Information

I hereby authorize New Albany Ob/Gyn Clinic P.L.L.C to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

A photocopy or computer scanned copy of these assignments shall be valid as the original.

Notice of Receipt of HIPAA Privacy Practices for New Albany Ob/Gyn I hereby certify that I have received a copy of the HIPAA Privacy Practices for New Albany Ob/Gyn Clinic.

Payment Required at The Time of Service

Printed Name: _____ Social Security No.: _____

Patient/Legal representative: _____ Date: _____