NORTHSIDE Medical Associates

Dr. Ronald Helms, MD | Dr. Michael Dupre', MD | Dr. Robert Whitmore, MD | Dr. Scott Boyken, MD
Dr. William McClanahan, MD | Dr. Stephen Fortson, MD | Dr. Hunter Russell, MD | Dr. Thomas Perkins, MD
Dr. Lea Clayton, MD | Dr. George Harris, MD | Dr. Drew Smith, MD | Catherine Jennings, CRNP
Kelsie Roulaine, CRNP | Johnathan Windham, CRNP | Joy St. John, CRNP | Frank Crumb, CRNP
Haley White, CRNP | Casey Crumb, CRNP | Celeste Richardson, CRNP | Kimberli Clinkscales, CRNP
Skye Vise, CRNP | Mary Beth Martin, CRNP | Sue Payne, CRNP

PATIENT INFORMATION

Patient Name: Last_____ First: _____ Middle:_____
Address:_____
City: _____ State: _____ Zip Code: _____ Home Phone: _____
Sex: ____ Race: ____ Marital Status: _____ Birthdate: _____ Cell Phone:_____
Retired:____ Employed:____ Full-time student:_____ Part-time student: _____ Disabled Yes:___ No:___
Employer:_____ Phone number: _____
Social Security No. _____ Driver's License No. _____ State: ____
Person Responsible for account: _____ Relationship: _____
Address: _____
City: _____State: ___ Zip:_____ Phone Number: _____
Employer: _____ Phone Number: _____
Social Security: _____ Driver's License: _____ State:_____
Spouse's Name: _____Employer: _____ Phone Number: _____
Person to notify in case of emergency: _____ Phone Number: _____
Relatives or friends that are patients: _____
Drug Allergies: _____

Have you arranged for a living will (Advanced Directives) Yes: __ No: __ Do you have a power of attorney? Yes: __ No: ____

INSURANCE POLICY INFORMATION

Insurance Company (Primary): _____
Policy Holder's Name: _____ Date of Birth: ___/____/___
Employer: _____ Phone number: _____
Contract or Group No.: _____ Relationship to patient: _____
Insurance Company (Secondary)_____
Policy Holder's Name: _____ Date of Birth: ___/____/___
Employer: _____ Phone number: _____
Contract or Group No.: _____ Relationship to patient: _____
Referred by: _____

CONSENT FOR TREATMENT: I consent to necessary treatment, including drugs, medicine, performance of operations and conduct of X-rays, or other studies that may be used by the attending physician, his nurse or staff.

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize NMA companies to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my case, or my employment who is providing payment of my medical bills due to an on-the-job injury.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to NMA companies of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the NMA charges for these services. I understand that I am financially responsible to NMA for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

GUARANTEE OF ACCOUNT: For services furnished by NMA companies, I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption of State of Alabama law and agree to pay, if necessary, all costs of collection,
including attorney's fees.

Signature_____ Date:_____

NORTHSIDE Medical Associates

Date:_____ **Pharmacy: _____**

Name: _____ **DOB: _____**

Past Medical History: PLEASE CIRCLE IF YOU HAVE EVER BEEN DIAGNOSED WITH THE FOLLOWING:

Arthritis Diabetes Heart Disease Stomach Disease Osteoporosis Stroke Respiratory Disorder

Asthma Dizziness Gastric Ulcer Headaches Bowel Disease Renal Disease Thyroid Disorder

Backache Fainting HIV Hepatitis Lupus Parkinson's UTI Bleeding Disorder COPD GOUT

Liver Disease Numbness/Tingling Seizures STD Depression High Blood Pressure

Cancer: Type: _____

Prior Surgery: PLEASE CIRCLE

ENT Surgery Mastectomy Breast Biopsy Heart Bypass Abdominal Colectomy

Aneurysm Repair Prostate Angioplasty Hernia Gastric Bypass Hysterectomy Tubal Ligation

Appendectomy Tonsillectomy Orthopedic Ulcer Neurosurgery Bladder Lithotripsy Gallbladder

Oophorectomy Skin TURP Kidney Thyroid Cataract Cesarean Section Small Bowel Back Carpal

Family History: (IMMEDIATE FAMILY ONLY ex: Mother, Father, Brother, Sister, Maternal Grandparents, Paternal Grandparents) PLEASE CIRCLE

Diabetes Stroke Seizures Cancer (Type) _____ Heart Disease Arthritis Parkinson's COPD

Depression Rheumatoid Arthritis Alzheimer's Liver Disease Lupus Mental Illness

High Blood Pressure Dementia Kidney Disease

Social History: PLEASE CIRCLE

Marital Status: Married Single Divorced Widowed
Number of Children: 1 2 3 4 5 6 7 8+____
Activity Level in the past year: More Less Same
Employment Status: Working Retired Disabled
Ambulatory Status: Independent Cane Walker Wheelchair Bound
Lives with: Family Alone Institution Spouse
Hearing: Normal Hard of Hearing Wears Hearing Aids
Have you fall in the last year: NO YES
Tobacco Use: Never Former Current User Dip chew Vape Packs per Day: _____
Vision: Normal Glasses/Contacts
Illegal Drug Use: YES NO
Alcohol Use: YES NO
Still Driving: YES NO
Transportation Issues: YES NO
Bladder Control: YES NO

Preventative: PLEASE LIST DATE OF SERVICE AND NAME OF DOCTOR

Mammogram: _____ Diabetic Eye Exam: _____

Pap smear:_____ DEXA/Bone Scan: _____

Colonoscopy: _____ Last Eye Exam: _____

PSA: _____ Last Menstrual Cycle: _____

Depression Screening: _____

NORTHSIDE
Medical Associates

Medication List

Patient's Name: _____ DOB_____

Allergies: _____

Medication	Strength	Frequency	Prescribed by

NORTHSIDE Medical Associates

It may be necessary to contact you by phone concerning lab results, test results, and/or other medical reasons; therefore, legally, if we cannot reach you we need your permission to leave results with someone else. Please read and complete the following:

Permission is given to all Physicians and staff to leave our name and number at one of the following locations: Check One: Home: _____ Office: _____ Portal: _____

Permission is given: ____ / not given: _____ (please check one) to the doctors or CRNP's listed above to give my lab results, test results, and/or other medical information to the following: (please list)

Relationship	**Name**	**Phone Number**
Spouse		
Parent		

Other Forms of Contact	**Please enter information below if you wish to be contacted this way**
Answering Machine/Voicemail at Home	
Answering Machine/Voicemail at Work	
Email Address	

** email provided will be used to grant access to Northside Medical's Patient Portal**

https://15135-2.portal.athenahealth.com/

Patient Signature: _____

*****Please note that Dr. Dupre' requires that an adult must accompany all patients under the age of sixteen (16) to receive medical treatment. ****

NORTHSIDE Medical Associates

Dear Patient:

To provide more efficient service with your prescription medications, please provide us with the following information:

Pharmacy: _____

Pharmacy Location:

_____

Pharmacy Telephone Number: _____

Medication Pickup

I, _____ do hereby authorize the following people to pick up a prescription on my behalf from Northside Medical Associates. The individuals listed below will need to present their driver's license to correctly identify themselves prior to prescription being released to them.

Name of Authorized Person	Relationship

must provide a valid I.D. for prescription pick up

I understand that this form will need to be updated every 6 months or sooner in the event the above individuals are no longer allowed to pick up prescriptions on my behalf.

_____ _____ _____

Patient Printed Name Patient Signature Date

NORTHSIDE
Medical Associates

Patient Payment Policy

We would like to thank you for choosing Northside Medical as your healthcare provider. Northside Medical is committed to providing you with the best possible medical care. We are sure you understand that payment for this healthcare is your responsibility. The following information outlines your financial responsibilities related to payment for professional services.

For Our Patients with Medical Insurance Benefits:

We participate in most major health plans. We have contacts with many HMO's, PPO's, Insurance Companies and Government agencies including Medicare and Medicaid. Our business office will submit claims for any services rendered to a patient who is a member of one of these plans and will assist you in any way we reasonably can to help get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance, we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

Please bring your Insurance card with you at the time of your appointment.

If you are insured by a plan we do business with but don't have an insurance card with you, payment in full for each visit is required until we can verify your coverage.

Co-Payments:

Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit. For your convenience we accept cash, checks, debit cards, or the following credit cards: Visa, MasterCard, Discover, and American Express. If you do not have your co-payment your appointment may be rescheduled.

Additionally, you may have coinsurance and/or deductible amounts required by your insurance carrier. These amounts will be collected at check-out. We file your insurance as a courtesy to you, it is important that we have your correct information to properly file each claim. If your insurance does not respond in 45 days we will transfer the balance to you for payment in full.

Waiver of Patient Responsibility:

It is the policy of the practice to treat all patients in an equitable fashion related to account balances. The practice will not waive, fail to collect, or discount co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers.

Non-Covered and Out of Network Services:

Medical services that are considered by your insurance company to be non-covered, out of network, or not medically necessary will be your responsibility.

Coverage Changes:

If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

For Our Patients with No Medical Insurance:

If you do not have group or individual medical insurance, payment for all professional services is expected at the time of your visit. Please note, we do offer discounted fees for patients without health insurance.

Payment Plan:

Please let us know if you are having difficulty paying your account. We may be able to help you by setting up a payment plan based on your financial hardship, call (205) 753-4003 for assistance

NORTHSIDE
Medical Associates

Late Arrivals:

A patient who arrives more than 15 minutes after his/her appointment is considered a late arrival. A late arrival, not considered to be the responsibility of the Practice, will be registered and worked into the schedule as soon as possible. If a patient is more than 30 minutes late, the appointment may be rescheduled.

Appointment No-Shows:

Any patient who fails to arrive for a scheduled appointment without cancelling the appointment at least 24 hours prior to the scheduled time is considered a “no-show”. A no-show patient may be charged $25.00, as set by the Practice, for failure to show. A patient who fails to present themselves two times for scheduled appointments is considered a chronic no-show. A patient who is a no-show four times may be dismissed from the Practice.

Delinquent Balance Appointment:

Patients with a delinquent balance are required to make payment in full for future services. A delinquent account is defined as a patient balance in excess of 60 days if the patient has not made any payments or sought assistance via financial hardship during this time. If such payment is not made, services may be refused.

Nonpayment:

All patient responsible balances that remain delinquent after 90 days, with no response to our requests for payment, may be referred to our collection department. Please be aware that if a balance remains unpaid, you and/or your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, your physician will only be able to treat you on an emergency basis.

Statements:

There will be a monthly statement fee of $8.00 on any unpaid balance over 30 days and a finance charge of 1.5% on any unpaid balance over 60 days. Your prompt payment is appreciated!

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the above policies and consent to treatment.

_____	_____	_____
Patient Printed Name	Patient Signature	Date

NORTHSIDE
Medical Associates

Notice of Privacy Practices

Northside Medical Associates

70 Plaza Drive, Pell City 35125

205-814-9284 Main Line

205-814-9626 Fax Line

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.

WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU IN SEVERAL CIRCUMSTANCES.

1. **Treatment**

We may use and disclose medical information about you to provide healthcare treatment to you. In other words, we may use and disclose medical information about you to provide, coordinate or manage your healthcare and related services. This may include communicating with other healthcare providers regarding your treatment and coordinating and managing your healthcare with others. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

2. Payment

We may use and disclose medical information about you to obtain payment for healthcare services that you received. This means that, within the health department, we may *use* medical information about you to arrange for payment (such as preparing bills and managing accounts). We also may *disclose* medical information about you to others (such as insurers, collection agencies, and consumer reporting agencies). In some instances, we may disclose medical information about you to an insurance plan *before* you receive certain healthcare services because, for example, we may need to know whether the insurance plan will pay for a particular service.

3. Healthcare Operations

We may use and disclose medical information about you in performing a variety of business activities that we call "healthcare operations." These "healthcare operations" activities allow us to, for example, improve the quality of care we provide and reduce healthcare costs. For example, we may use or disclose medical information about you in performing the following activities:

· Reviewing and evaluating the skills, qualifications, and performance of healthcare providers taking care of you.

· Providing training programs for students, trainees, healthcare providers or non-healthcare professionals to help them practice or improve their skills.

· Cooperating with outside organizations that evaluate, certify or license healthcare providers, staff or facilities in a particular

field or specialty.

· Reviewing and improving the quality, efficiency and cost of care that we provide to you and our other patients.

· Improving healthcare and lowering costs for groups of people who have similar health problems and helping manage and coordinate the care for these groups of people.

· Resolving grievances within our organization.

4. Persons Involved in Your Care

We may disclose medical information about you to a relative, close friend or any other person you identify if that person is involved in your care and the information is relevant to your care. If the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances. We may also use or disclose medical information about you to a relative, another person involved in your care or possibly a disaster relief organization (such as the Red Cross) if we need to notify someone about your location or condition.

You may ask us at any time not to disclose medical information about you to persons involved in your care.

We will agree to your request and not disclose the information except in certain limited circumstances (such as emergencies) or if the patient is a minor. If the patient is a minor, we may or may not be able to agree to your request.

5. Required by Law

We will use and disclose medical information about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose medical information. For example, state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.

6. National Priority Uses and Disclosures

When permitted by law, we may use or disclose medical information about you without your permission for various activities that are recognized as "national priorities." In other words, the government has determined that under certain circumstances, it is so important to disclose medical information that it is acceptable to disclose medical information without the individual's permission. We will only disclose medical information about you in the following circumstances when we are permitted to do so by law.

7. Authorizations

Other than the uses and disclosures described, we will not use or disclose medical information about you without the "authorization" – or signed permission – of you or your personal representative. In some instances, we may wish to use or disclose medical information about you and we may contact you to ask you to sign an authorization form. In other instances, you may contact us to ask us to disclose medical information and we will ask you to sign an authorization form.

If you sign a written authorization allowing us to disclose medical information about you, you may later revoke (or cancel) your authorization in writing (except in very limited circumstances related to obtaining insurance coverage). If you would like to revoke your authorization, you may write us a letter revoking

your authorization or fill out an Authorization Revocation Form. If you revoke your authorization, we will follow your instructions except to the extent that we have already relied upon your authorization and taken some action.

YOU HAVE RIGHTS WITH RESPECT

TO MEDICAL INFORMATION ABOUT YOU

1.Right to a Copy of This Notice

You have a right to have a paper copy of our Notice of Privacy Practices at any time. In addition, a copy of this Notice will always be posted in our waiting area.

2. Right of Access to Inspect and Copy

You have the right to inspect (which means see or review) and receive a copy of medical information about you that we maintain in certain groups of records. If we maintain your medical records in an Electronic Health Record (EHR) system, you may obtain an electronic copy of your medical records. You may also instruct us in writing to send an electronic copy of your medical records to a third party. If you would like to inspect or receive a copy of medical information about you, you must provide us with a request in writing. We may be able to provide you with a summary or explanation of the information.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. We will also inform you in writing if you have the right to have our decision reviewed by another person.

If you would like a copy of the medical information about you, we will charge you a fee to cover the costs of the copy. Our fees for electronic copies of your medical records will be limited to the direct labor costs associated with fulfilling your request.

3. Right to Have Medical Information Amended

You have the right to have us amend (which means correct or supplement) medical information about you that we maintain in certain groups of records. If you believe that we have information that is either inaccurate or incomplete, we may amend the

information to indicate the problem and notify others who have copies of the inaccurate or incomplete information. If you would like us to amend information, you must provide us with a request in writing and explain why you would like us to amend the information.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. You will have the opportunity to send us a statement explaining why you disagree with our decision to deny your amendment request and we will share your statement whenever we disclose the information in the future.

4. Right to an Accounting of Disclosures We Have Made

You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. The accounting will not include several types of disclosures, including disclosures for treatment, payment or healthcare operations. If we maintain your medical records in an Electronic Health Record (EHR) system, you may request that include disclosures for treatment, payment or healthcare operations. The accounting will also not include disclosures made prior to April 14, 2003.

If you request an accounting more than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

5. Right to Request Restrictions on Uses and Disclosures

You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and healthcare operations. Under federal law, we must agree to your request and comply with your requested restriction (s) if: except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of healthcare operations (and is not for purposes of carrying out treatment); and, if the medical information pertains solely to a healthcare item or service for which the healthcare provided involved has been paid out-of-pocket in full.

Once we agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

6. Right to Request an Alternative Method of Contact

You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing.

We are required by law to protect the privacy of medical information and provide Notice of our legal duties and privacy practices.

YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies or procedures, you may file a written complaint either with us or with the federal government.

To file a written complaint with the federal government, please use the following contact information:

Office for Civil Rights

U.S. Department of Health and Human Services

200 Independence Avenue, S.W. Room 509F, HHH Building Washington, D.C. 20201

Toll-Free Phone: 1-(877) 696-6775

Website: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

Email: OCRComplaint@hhs.gov

Effective Date: January 2013

NORTHSIDE
Medical Associates

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency prevented us from obtaining acknowledgement

- Other (Please Specify)

_____

_____

_____