Patient Demographics

Name:_____ DOB:_____ SS#:_____

Address:_____
PO Box or Street Address City State Zip Code

Phone Numbers: Home:_____ Cell:_____

Email Address:_____

How would you like for us to contact you? ❑Phone ❑Email

Gender: ❑Male ❑Female Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Primary Language:
❑English ❑Spanish ❑Other:_____

Race: (please check all that apply)
❑White ❑Black or African American ❑Asian
❑American Indian or Alaska Native ❑Native Hawaiian or Other Pacific Islander

Ethnicity:
❑Hispanic or Latino ❑Not Hispanic or Latino

Employer Information

Company Name:_____ Work#:_____

Address:_____
Street Address City State Zip Code

Insurance Information

Primary Insurance

Insured Name:_____

DOB: _____

Secondary Insurance

Insured Name:_____

DOB: _____

Please list any person(s) that may have permission to have access to your information (i.e. pick up films/disk/report) or be used as an emergency contact

Name:_____ Name:_____

Relationship:_____ Relationship:_____

Phone Number:_____ Phone Number:_____

Is your visit today related to an injury or accident? ❑Yes ❑No
(If yes please complete section below)
Injury due to: ❑Work ❑Auto ❑Trauma ❑Slip/Fall
Date of Injury:_____ Time of Injury:_____
Location of Injury: examples (home, skiing, walking, etc.)_____
What part of your body was injured?(be specific)_____
Have you been receiving treatment for this injury? ❑Yes ❑No
If yes, who is the doctor treating you for the injury?_____

Patient Signature X:_____ Date:_____

Patient Name:_____**DOB:**_____ **DOS:**_____

PLEASE READ AND INITIAL THE FOLLOWING:

_____ **CONSENT FOR MEDICAL TREATMENT:** I authorize the above referenced center to furnish the necessary medical procedure that has been ordered by my physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of diagnostic procedures in the above referenced center. I recognize that the physicians who practice at the Center are not employees of the above referenced center, but are independent physicians. The above referenced center may delegate to these independent physicians those services physicians normally provide. Any questions related to my care should be directed to my physician.

_____ **ASSIGNMENT OF BENEFITS:** I hereby authorize payment directly to the above referenced center of any and all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to the Center for charges not covered by this assignment. I also understand that the Center is filing my claim as a courtesy to me and that unless stipulated in a contract with my carrier, I am responsible for payment of this claim.

_____ **AUTHORIZATION FOR RELEASE OF INFORMATION:** I hereby authorize the above referenced center to release any information requested by the insurance company necessary to collect benefits on this claim. Unless noted below, this authorization includes, but is not limited to, the release of information related to drug, alcohol, HIV antibody and/or psychiatric testing. I further authorize any physician or institution that attended this patient previously to furnish medical records or information that may be requested by the above referenced center.

_____ **MEDICARE B SIGNATURE AUTHORIZATION:** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of the Center, any information needed for this claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits to be made to the holder of this assignment on my behalf. I understand that I am responsible for any health deductibles and co-insurance.

_____ **WORKER'S COMPENSATION:** I authorize the above referenced center to furnish written reports of my procedure to any representative, attorney for, or investigator from my Worker's Compensation carrier concerning injuries sustained as a result of accident occurring on _____/_____/_____.

_____ **IF PATIENT IS A MINOR:** I hereby give permission for _____ to be treated at the above referenced center.

_____ **HIPAA NOTICE OF PRIVACY**: I have read the notice of privacy practice of the above referenced center.

_____ **PERSONAL BELONGINGS:** I am personally responsible for my belongings and/or valuables that I have with me in the locker/dressing room or exam room. I will personally make sure I have everything with me before I leave the premises.

_____ **TRICARE/CHAMPUS PATIENTS:** I understand that Tricare is secondary to other insurance plans except for Medicaid and Tricare supplement plans. I agree to provide the above referenced center with all insurance plans that I am currently enrolled so that benefits can be coordinated and the appropriate authorizations can be obtained. I understand that failure to provide correct and accurate information may result in the patient in being responsible for entire balance.

NOTE: I understand that different Payers/Health Plans have different requirements for payment including, but not limited to pre-certification, authorizations, or notifications, timely filing of claims, or that the services be medically necessary as defined by the health plan. I understand that verification of benefits from Patient's Insurance Company is not a guarantee that services are covered or will be paid by the Insurance Company. I also understand that it is MY obligation to know the requirements of my health plan and ensure that they have been fulfilled.

If you did not provide your insurance information today, or if it is not accurate, then you may be obligated to make full payment of all charges. It will be your responsibility to file the claim with your insurance provider. If you provided us insurance information today, you are obligated to pay all co-payments, deductibles, and any non-covered out-of-network/reduced benefits at the time the services are rendered. You have an affirmative duty to make sure that payment and/or correct information for payment is given to the above referenced center for reimbursement of services provided. Be advised there will be a fee of $45 for any returned check.

X_____ _____

Patient/Guardian Signature **Date**

Patient Name: _____

DOB: _____ **DATE:**_____

Current Smoker ❑Yes ❑No

Former Smoker ❑Yes ❑No

Do you use tobacco? ❑Yes ❑No

Are you currently taking any medications? ❑Yes ❑No
If yes, please list the medications:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list any medications that you are allergic to:

_____ _____

_____ _____

_____ _____

NOTICE OF PRIVACY PRACTICES

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.

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how Image South may use and disclose medical information about you to carry out treatment, payment for our health care services and for other health care operations or purposes that are permitted or required by law. It also describes your rights to access and control medical information about you. As a patient of Image South, one of the responsibilities you have entrusted to us is the protection of your personal medical information. **Our physicians and staff take this responsibility very seriously.**

The uses and disclosures listed below may be limited by Alabama Requirements described under Regulatory Requirements.

Uses and Disclosures of Protected Health Information (PHI) for Treatment, Payment and Health Care Operations
The following describes the different ways that we (Image South) may use and disclose your PHI for treatment, payment and health care operations.

For Treatment – We may use PHI about you to provide you with medical treatment or services. For example, we may disclose your PHI to doctors, nurses, or other health care professionals who are involved in taking care of you.

For Payment – We may use and disclose PHI about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may disclose your PHI to your insurance so that they will pay for our services rendered to you.

For Health Care Operations – We may use and disclose your PHI for health care operations. Some of these operations include the use or disclosure of PHI for quality improvement, doctor/employee review activities, compliance, and the training of medical residents and other health care professionals, which includes preceptorships for health care affiliates. For example, we may compare the treatment you received to other similar episodes of care to ensure that Image South continues to provide the highest quality services.

Business Associates
We may disclose PHI to "business associates", who perform services on behalf of our practice. Some examples of our business associates are billing and collection agencies, answering services, and courier service. Whenever an arrangement between our Practice and a business associate involves the use or disclosure of your PHI, we will have a written contract with that business associate that will protect your privacy.

Uses and Disclosures of Protected Health Information (PHI) Based on Your Written Authorization
Other uses and disclosures of PHI not covered by this notice or the laws that apply to our Practice (described below) will be made only with your written permission. If you provide us permission to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, thereafter we will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

Uses and Disclosures That May Be Made With Your Agreement or Opportunity to Object
Unless you object, we may disclose some of your PHI to a family member, other relative, friend, or other persons you identify. We may also notify these people about your location and condition. When you are unable to agree or object, we may still disclose your PHI for these purposes in certain circumstances.

Other Permitted and Required Uses and Disclosure That May Be Made Without Your Authorization
In addition to using and disclosing your PHI for treatment, payment and health care operations, we may use or disclose your PHI without your written authorization in the following situations:

- As required by law: We may use or disclose your PHI when required to do so by applicable law. For example, in certain circumstances, we may disclose PHI to report about an individual that we reasonably believe to be a victim of abuse, neglect, or domestic violence.
- For public health purposes.
- For health oversight activities authorized by law: We may disclose your PHI to the government for oversight activities, such as audits, investigations, inspections, licensure and disciplinary actions, and other activities necessary for monitoring the health care system.
- For Worker's Compensation claims. (These programs provide benefits for work-related injuries or illnesses.)
- To a coroner, medical examiner or funeral director for the purpose of identifying a decedent, determining a cause of death, or as necessary to enable such parties to carry out their duties.
- For cadaveric organ, eye or tissue donations.
- For medical research purposes.
- To prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- For specialized government functions: In certain circumstances, we may use and disclose your PHI if you are a veteran or in the military. We may disclose your PHI to authorized federal officials for intelligence and other national security activities, for the protection of the President or others, and for special investigations. If you are an inmate of a correctional institution or under custody of a law enforcement officer, we may disclose your PHI to the correctional facility or official in certain circumstances.

Communication
We may use and disclose your PHI to contact you (by telephone or mail) and remind you of an appointment, or to inform you of treatment alternatives or other health-related benefits and services that may be of interest to you. We may be required to leave a message on your answering machine, when contacting you by telephone to remind you about an appointment, provide instructions prior to a diagnostic test or procedure, or to discuss payment. We may also use and disclose your PHI to encourage you to purchase or use a product or service through face-to-face communication or by giving you a promotional gift of nominal value.

Your Rights Regarding Medical Information About You

Right to Inspect and Copy You have the right to inspect and copy PHI that may be used to make decisions about your care. To inspect and copy PHI, you must submit your request in writing to our Privacy Officer. You will be notified when your record is ready to inspect or copies are completed. If you request a copy of the information, we will charge you a reasonable fee for the cost of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain circumstances.

Right to Amend If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have a right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing to our Privacy Officer, and it must explain why you are requesting an amendment to your PHI. We may deny your request in certain circumstances. If this request is denied, Image South will send you a written letter supporting reasons for denial.

Right to Request Restrictions You have the right to request a restriction or limitation on the PHI we use or disclose. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to our Privacy Officer. In your request, you must tell us: 1) What information you want to limit; 2) whether you want to limit our use, disclosure or both; and, 3) to whom you want the limits to apply. **Any previous restriction given verbally or written to an Image South employee is no longer valid and must be requested in the above manner.**

Right to request Confidential Communications You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request in writing to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. **Any previous requests given verbally or written to an Image South employee is no longer valid and must be requested in the above manner.**

Right to a Paper Copy of This Notice Even if you agreed to receive this notice electronically, you have a right to request a paper copy by writing our Privacy Officer or by asking for a copy at the reception desk at our Image South facility.

Regulatory Requirements We are required by law to maintain the privacy of your medical information, and we must abide by the terms of this notice. (That is, the version that is currently in effect.) We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for the medical information we already have about you, as well as any information we receive in the future. We will post a copy of the current notice, with the effective date listed in the bottom right hand corner of the last page.

In addition to the privacy protections provided under federal law (which are described in this notice), Alabama law (referred to in this notice as the Alabama Requirements) requires us in certain situations to get your written consent (or, under some statutes or rules, written consent from your attorney, guardian, or upon court order) before we can use or disclose your information.

The Alabama Requirements may apply:

- If you qualify as a patient that suffers from a sexually transmitted disease;
- If you qualify as a patient that receives benefits from the State of Alabama for certain developmental disabilities or mental retardation;
- If you qualify as a patient for whom the Alabama Medicaid program has asked us to serve as a Case Management Service Provider;
- If you qualify as a patient that receives rehabilitation services through the Alabama Medicaid program;
- If you qualify as a patient that receives certain benefits under the Alabama Medicaid's Preventive Health Education program

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us. To file a complaint with Image South, contact our Privacy Officer at the address below. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

If you have any questions about Image South's Notice of Privacy Practices, please contact the Privacy Officer listed below.

Privacy Officer

Manager at Center Location