**Notice of Privacy Practices Acknowledgement**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I have a certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third-party payers
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To address any special needs, you may have and to assure your patient information is kept confidential, please answer the following questions:

1. Other than yourself, do you authorize our office to discuss your health information with another family member or spouse?

a. Yes b. No

If yes,

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy & Procedures**

Ahmed Family Practice will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and them, we are not the party to contact. If there is a balance of your claim that is your responsibility, we nor your insurance company pays your claim. If your insurance company does not pay your claim in 45 days, the balance goes automatically to you. Partial and monthly payments will be accepted upon agreement with the office. If your financial agreements or medical necessities are not kept in good faith you will be notified by regular or certified mail that you have 30 days to find alternative medical care. During those 30 days, our physicians will only be able to treat you on an emergency basis.

The office requires you to present a copy of your current insurance card at each visit, we will also need your social security number and picture ID. If your insurance is inactive or delinquent, then payment in full is expected until we can verify your coverage. Copayments and deductibles are due at the time of service. If any questions on billing information, please call 866-949-1215. Our office DOES NOT do the billing in house.

If your account is placed with an outside collection agency, you will be charged the full amount of collection fees, attorney fees, and allowable court cost. Please note that placement with an outside agency may cause us to terminate your care with our office.

**For your convivence we accept cash, money orders, and card.**

**Fees:**

Any paperwork that needs to be filed out will be a charge of $30.00 dollars

**Referral Process:**

Referrals take 1 to 2 weeks to be completed so please plan accordingly.

**Messages:**

All messages will be answered by any staff by the end of the day.

**Medication Request:**

Please plan accordingly when asking for medication requests, they will not be done at the moment when you call. Please be aware if you have not been seen in the last 3 months, you must have an appointment before medications are refilled.

* If you have not met your deductible, then you will be charged for the office visit at the time services are rendered.
  + $100.00- Establish Patient
  + $125.00- New Patient
* If you have a balance with our office, they must be either paid in full if under 100.00, a partial payment is granted for balances over 100.00.
* If you have questions for the billing, we would be more than happy to give you the number to our billing office and reschedule your appointment.
* We at any time **will not** bill patients for Co-pays.
* If for any reason you are late, we would advise giving the office a call. If do not call the office to do so your appointment will be rescheduled.
* We update our paperwork every year to ensure that your information is up to date, this is something that must be done.
* Providers are not able to communicate with a patient unless they are seen, this is in effect to give adequate time to the patients that have scheduled appointments.
* We only provide the flu vaccination when it is in season.
* Providers and staff will answer and refills medications at the end of the day.
* Balances that are 90 days late and have had not been paid will be sent to collections.
* With every patient, we take copies of your ID and Insurance card. This is to decrease any insurance fraud; our system is HIPAA compliant and has protective measures to hold information safety.
* Patients are advised that if you do not have your insurance card, nor a copy that can be sent to our email, we would have to reschedule your appointment.
* Please be advised that anyone under 18 must be present with an adult 21 or older.
* If you do not have an ID with you, we will reschedule your appointment.

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

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Demographic Information**

|  |
| --- |
| Patient Name: |
| Mailing Address: |
| City: State: Zip code: |
| Home Phone: Cell Phone: |
| Date of Birth: Sex: Marital Status: |
| Social Security Number: |
| Employer Name: |
| Employer Address: |
| Email: |
| Select One:  ⃝White ⃝Black ⃝Hispanic ⃝Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Ok to Leave a Message: ⃝**Home ⃝Cell ⃝Brief ⃝Extended** |
| **Emergency Contact Information** |
| Emergency Contact Name: |
| Phone Number: Relationship to Patient: HIPPA: |
| **Pharmacy Information** |
| Pharmacy Name: |
| Pharmacy Number: |
| Pharmacy Address: |
| I attest the above information is correct and have read and understand the policies of Ahmed Family Practice and accept my responsibility as a state in those policies. I hereby authorize the release of information necessary for my insurance company to process my claim. The above information and information given to Ahmed Family Practice is correct to the best of my knowledge. I hereby allow the clinic staff of Ahmed Family Practice to view my medication history from an external source. |
| Patient Signature: |
| Date: |

|  |
| --- |
| Primary Insurance company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Secondary Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Patient History and Physical Form**

Chief Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drug Allergies**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications, Dosages and how are you taking it?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

|  |  |  |
| --- | --- | --- |
|  | Father | Mother |
| Heart Disease |  |  |
| High Blood Pressure |  |  |
| Stroke |  |  |
| Glaucoma |  |  |
| Diabetes |  |  |
| Epilepsy/Convulsions |  |  |
| Bleeding Disorder |  |  |
| Kidney Disease |  |  |
| Thyroid Disease |  |  |
| Mental Illness |  |  |
| Osteoporosis |  |  |

Any Cancers in your family? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospital and Surgeries**

|  |  |
| --- | --- |
| Date | Reason |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Medical History**

|  |  |  |  |
| --- | --- | --- | --- |
| ⃝Headache  ⃝Shortness of Breath  ⃝Heart Palpitations  ⃝Heart Murmur  ⃝Chest Pain  ⃝Dizziness/Fainting  ⃝Peripheral Vascular Disease  ⃝Allergies/Hay Fever  ⃝Asthma/Emphysema  ⃝Bronchitis | ⃝Pneumonia  ⃝Ulcer  ⃝GI Disorder  ⃝Lactose Intolerance  ⃝Gallbladder Disease  ⃝Prostate Disease  ⃝Bowel Irregularity  ⃝Incontinence  ⃝Sexual/Menstrual Dysfunction  ⃝Venereal Disease | ⃝Diabetes  ⃝Hepatitis  ⃝Anemia  ⃝Arthritis  ⃝Osteoporosis  ⃝High Blood Pressure  ⃝Depression  ⃝Gout  ⃝Stroke  ⃝Cancer: \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ⃝Rheumatic Fever  ⃝Glaucoma  ⃝Epilepsy/Convulsions  ⃝Bleeding Disorder  ⃝Kidney Disease  ⃝Thyroid Disease  ⃝Mental Illness  ⃝Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Social History**

Do you Smoke? ⃝ Yes ⃝No How Much do you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you use to smoke? ⃝ Yes ⃝No When did you Stop?

Do you drink alcohol? ⃝ Yes ⃝No How many times per day or week? \_\_\_\_\_\_\_\_\_\_\_

Do you do illegal drug use? ⃝ Yes ⃝No What type of Drugs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a Power of Attorney or DNR (Do not Resuscitate)? ⃝Yes ⃝No ⃝

What type of Work do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise Routine? ⃝None ⃝15-20 Min ⃝30-45 Min ⃝1hr-more

⃝Once per week ⃝2-3 times ⃝4-5 ⃝6 or more

**Females Only:**

When was your last menstrual period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long was it for? \_\_\_\_\_\_

Do you get your period every…? ⃝28 ⃝24 ⃝20 or less

Are you trying to get pregnant? ⃝Yes ⃝No

Have you been pregnant? ⃝Yes ⃝No How many pregnancies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Miscarriages? \_\_\_\_\_\_\_\_\_\_\_\_ Any Abortions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Release of Medical Records

528 Forest Parkway Ste. A Forest Park, GA. 30297

Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last 4 of Social: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request and authorize:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To Release Healthcare information of the patient named above to:

**Name:** Ahmed Family Practice

**Address:** 528 Forest Parkway Ste. A.

**City:** Forest Park **State:** GA. **Zip code:** 30297

This request and authorization apply to:

⃝ Health care information relating to the following treatment, condition or dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

⃝ All Healthcare information

⃝ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et Sep., included herpes simplex, human papillomavirus, wart, genital wart, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma, vanereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and Gonorrhea.

⃝ Yes ⃝No I authorized the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person listed above. I understand that the person listed above will be notified that I must give specific written permission disclosure of these test results to anyone.

⃝Yes ⃝No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person listed above.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_