



New Patient Packet

PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

____ **Home Telephone** _____
____ O.K. to leave message with detailed Information
____ Leave message with call back number only

____ **Work Telephone** _____
____ O.K. to leave message with detailed information
____ Leave message with call back number only

____ **Written Communication**
____ O.K. to mail to my home address
____ O.K. to mail to my office address
____ O.K. to fax to this number
fax # _____

Other _____

The Privacy Rule (TPO) generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute as adequate records.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

By signing below I acknowledge having read the Patient Record of Disclosure, Patient Financial Policy and Informed Consent to Routine Procedures/Treatments. I have also been afforded a copy of our HIPPA Policy/Privacy Notice.

ACKNOWLEDGE OF FINANCIAL POLICY: I have fully read the Patien's Financial Policy and understand my financial responsibilities under this policy.

AUTHORIZATION FOR TREATMENT: I consent to examination, treatment, and any procedures including emergency treatment deemed necessary and ordered by our physician and I am personally responsible for any charges.

AUTHORIZATION FOR INSURANCE: I authorize release of any information concerning myself or child to my insurance company regarding treatment for services rendered.

AUTHORIZATION FOR INSURANCE BENEFITS: I authorize my insurance company to send payment directly to Northside Urgent Care and Family Medicine LLC for services covered by my insurance plan.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE: I hereby acknowledge that Northside Urgent Care and Family Medicine LLC has provided me a copy of their Privacy Notice.

AUTHORIZATION TO CONTACT ME: I authorize Northside Urgent Care and Family Medicine LLC to contact me by either phone, electronic mail, or mail to provide a reminder appointment, gather demographic or insurance information, or to inform me of services or events offered at the facility.

**READ ALL THE INFORMATION IN THIS PACKET BEFORE SIGNING BELOW
DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS**

SIGNED _____ DATE _____

PRINT _____ WITNESS _____



PATIENT FINANCIAL POLICY

OUR POLICY requires payment at time of service!

If you are a member of an HMO, POS, or PPO plan, who has chosen us as your provider of care, it is your responsibility to:

- Provide us with the information required in filing a claim; the insurance card, patient ID number, employer, date of birth, address, and social security number. The above information is requested on the Patient Registration Form, which is completed during the initial or subsequent visit.
- Pay your deductible, co-payment, or total balance at time of service, if applicable. Failure to do so, can and will result in a \$25.00 surcharge assessed to your account.
- Make sure we have a current referral form on file, if required by your insurance plan.
 - If we do not have a referral on file at the time of your visit, your insurance company may hold you responsible for all charges. You may also be sent back to your Primary Care Physician prior to being treated in order to obtain a referral authorization.

It is your responsibility to:

- Submit a claim to the insurance carrier provided.
- Provide the insurance carrier with the necessary information, to determine the medical and/or surgical care received.

If your insurance carrier has not chosen Northside Urgent Care and Family Medicine as one of their participating providers, we will:

- Require payment at the time of service.
- Assist the patient submitting the proper documentation so that they may file the claim; detailed statement summary, proper ICD-9 and CPT codes.
- We gladly accept cash and all major credit cards; Master Card, Visa, American Express and Discover.
- We will also accept personal checks with proper identification.
 - Please note: a \$25.00 overdraft charge will be added to all returned checks.

Missed Appointments - you may be charged a no-show fee of \$25.00 for each appointment missed.

When your bill remains unpaid a collection agency may be chosen to manage delinquent accounts. If your account is placed with a collection agency, the patient will be assessed a 30% surcharge. The patient is solely responsible for all costs of collections.

Northside Urgent Care and Family Medicine wants to be your chosen provider. If we are not participating with a specific insurance company, we will, from time to time, contact insurance companies and ask for an agreement to provide service.

Thank you for choosing Northside Urgent Care and Family Medicine for your entire healthcare needs!

I have read fully and understand my financial responsibilities under this policy.



INFORMED CONSENT TO ROUTINE PROCEDURES/TREATMENTS

I understand that Physicians rendering services at Northside Urgent Care and Family Medicine are either owners, employees or independent professionals engaged in the private practice of medicine. All of the health-care professionals performing services in this facility are independent contractors and are not Northside Hospital employees. Independent contractors are responsible for their own actions and Northside Hospital shall not be liable for the acts or omissions of any such independent contractors.

- (1) I acknowledge and understand that, during the course of my/my child's care and treatment, it is likely that various types of routine diagnostic and treatment procedures ("Procedures") may be utilized, which are considered necessary techniques for the ordinary care and treatment of my condition(s).
- (2) While these types of Procedures are routinely performed in hospitals and doctors' offices without incident, there are certain risks associated with each of these Procedures.
- (3) The physician or his/her associates or assistants are responsible for providing me with information about the Procedures and for answering all of my questions. It is not possible to enumerate each and every risk for every Procedure utilized in modern health care. However, physicians who practice medicine at Northside Urgent Care and Family Medicine have attempted to identify the most common Procedures, their associated risks and possible alternatives. If I have further questions or concerns regarding these Procedures, I agree to ask my/my child's physician to provide additional information.
- (4) I further acknowledge and understand that my/my child's physician may ask me to provide a separate Informed Consent document to provide additional information.

The Procedures referenced herein may include, but are not limited to, the following:

- (a) **Needle Sticks**, such as shots, injections or intravenous injections (IV's). The risks associated with these types of Procedures include, but are not limited to, nerve damage, causing tingling or burning, infection, swelling, bruising, infiltration (fluid leakage into surrounding tissue), skin sloughing, bleeding, clotting, allergic reactions or paralysis. Alternatives to Needle Sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective or refusal of treatment).
- (b) **Physical test and treatments**, such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, rehabilitation procedures, etc. which may be utilized in conjunction with diagnosis and treatment. The risks associated with these types of Procedures include, but are not



limited to, reactions to the material(s) used, infection, bleeding, discomfort, muscular-skeletal or internal injuries, nerve damage, paralysis, bruising, worsening of the condition and/or re-injury. Apart from using modified procedures and/or refusal of treatment, no practical alternatives exist.

- (c) **Medications/drug therapy**, which may be utilized in the care and treatment of patients. The risks associated with these types of Procedures include, but are not limited to, food-Drug-herbal interactions, allergic reactions, adverse reactions, drug dependency and both long-term and short-term side effects, which vary from medication to medication. Apart from varying the medication prescribed and/or refusal of treatment, no practical alternatives exist.
 - (d) **Repair of lacerations/cuts to tissues of the body**. The risks associated with this type of Procedure include, but are not limited to, fluid discharging through the suture line which would require additional treatment, scarring as part of the normal healing process, the wound may heal and stretch as time goes on causing some disfigurement, wound may heal with a thick scar which may be discolored and painful, edges of the wound may not be in perfect alignment and may overlap. Apart from refusal of treatment, no practical alternatives exist.
- (5) I consent to and authorize the persons participating in and responsible for my/my child's care to utilize the Procedures, such as those set forth above, as they may deem reasonably necessary or desirable in the exercise of their professional judgment, including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained. This consent shall also extend to the treatment of all conditions which may arise during the course of such Procedures including those conditions which may be unknown or unforeseen at the time this consent is obtained.
- (6) **By signing this form, I acknowledge and understand that I have been informed in general terms of the following:**
- (a) The nature and purpose of the Procedure(s);
 - (b) The material risks of the Procedure(s) and;
 - (c) The practical alternatives to such Procedure(s).

If I have further questions or concerns regarding these Procedures, I agree to ask my/my child's physician to provide additional information.

- (7) I understand that the practice of medicine is not an exact science and that no guarantees or assurances have been made to me concerning the outcome and/or result of any Procedure(s).
- (8) I understand that the physician, medical personnel and other assistants participating in the patient's care will rely upon the patient's documented medical history, as well as other information obtained from the patient, the family or others having knowledge regarding the patient, in determining whether to perform the Procedure(s) or the course of treatment for my/the patient's condition and in recommending the Procedure.