ADHD Medical Clinic Of Mobile

Medical History Form

Patient Name _____ Date of Birth _____

Medical History Do you have or have you had any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
ADHD			Stroke			Menopausal Syndrome		
Allergies			Depression			Obsessive-Compulsive Disorder		
Anxiety			Diabetes Type I			Sleep Apnea		
Joint Pain			Diabetes Type II			Restless Leg Syndrome		
Arthritis			Acid Reflux			Seizure Disorder		
Asthma			Headache			Substance Abuse		
Coronary Artery Disease			High Cholesterol			Thyroid Disorder		
Cancer			High Blood Pressure			Mental Health Disorder		
Cardiac Dysrhythmia			Irritable Bowel Syndrome			Other		
Migraine			Learning Disability			Other		

Family Medical History Has an immediate family member (parent, grandparent, sibling, child) experienced any of the following? ***(please differientaite between maternal and paternal grandparents)***

Condition	Yes	No	Relation
ADHD			
Heart Attack			
Stroke			
Cancer			Type:
Diabetes Type I			
Diabetes Type II			
Hypertension			
Mental Health Disorder			
Suicide			
Other			

Surgical History Please list all former surgical procedures.

Procedure	Approximate Date

Allergies Please list all allergies.

Drug Allergies	
Food Allergies	
Environmental Allergies	

Social History Please answer the following questions.

Do you exercise? _____ If yes, how many days per week? _____

Do you use tobacco/nicotine?_____ If yes, how many packs or cans per day? _____
If no, did you formerly use tobacco/nicotine?_____

Do you drink alcohol? _____

Do you drink caffeine? _____ If yes, how much? _____(#of cups/cans/glasses)

Do you have problems falling asleep? _____ Staying asleep? _____

What is your education level? _____

If you are a student, what school do you attend? _____ grade/year _____

What is your occupation? _____

Who is your employer? _____

What is your maritial status? _____

Do you have children? _____ If yes, what are their ages? _____

ADHD Medical Clinic Of Mobile

Medication History

Patient Name _____ Date of Birth _____

Current Medication for ADHD

Medication _____ Dosage _____ # time(s) Daily_____
Side Effects (if any) _____ Effectiveness_____

Current Medications (Other)

Medication _____ Dosage _____ # time(s) Daily_____
Reason for taking _____ Effectiveness_____

Medication _____ Dosage _____ # time(s) Daily_____
Reason for taking _____ Effectiveness_____

Medication _____ Dosage _____ # time(s) Daily_____
Reason for taking _____ Effectiveness_____

Medication _____ Dosage _____ # time(s) Daily_____
Reason for taking _____ Effectiveness_____

Medication _____ Dosage _____ # time(s) Daily_____
Reason for taking _____ Effectiveness_____

Medication _____ Dosage _____ # time(s) Daily_____
Reason for taking _____ Effectiveness_____

ALL ALLERGIES: _____

Past Medications Both ADHD and Other (within last 2 years)

Medication _____ Reason for taking _____

Medication _____ Reason for taking _____

Medication _____ Reason for taking _____

Medication _____ Reason for taking _____

Medication _____ Reason for taking _____

Medication _____ Reason for taking _____

Medication _____ Reason for taking _____

Side Effects:_____

I the undersigned patient or patient representative do hereby authorize ADHD Medical Clinic of Mobile to obtain pharmacy records pertaining to the above named patient for documentation into our electronic health records system.

_____ _____
Patient/Patient Representative Date

ADHD Medical Clinic Of Mobile

Primary Care Physician

Patient Name _____ Date of Birth _____

Primary Care Physician _____ Group Name_____

_____I authorize the release of my medical records to the above physician.
_____Do not release records to the above physician without my express permission.

_____ _____
Patient Signature Date

Medical Professional Requesting Consultation

ADHD Medical Clinic of Mobile does NOT require you to have a referral to schedule an appointment, but it may be a requirement of your insurance company

Medical Professional_____

In order to ensure continuity of care, ADHD Medical Clinic of Mobile will send the referring professional a letter acknowledging the referral with diagnosis and treatment plan unless specifically told not to do so.

_____Do not provide information to referring professional.

_____ _____
Patient Signature Date

Preferred Pharmacy Information

Pharmacy Name: _____

Address: _____ Phone: _____

City: _____ State: _____

ADHD Medical Clinic Of Mobile

Financial Policy

This financial policy contains important information about payment for our professional services. It is intended to help us provide the best possible medical care while also controlling administrative costs. It outlines our responsibilities, and those of our patients, with regard to payment for services.

It is the patient's responsibility to make payment at the time of service for all services rendered if it is determined that the patient's insurance policy may NOT cover our services**. <u>If a patient finds that they will be unable to pay in full upon check-in, they will be required to reschedule their appointment</u>**. Payment for professional services may be made by cash, check, Visa, Mastercard, or American Express.

Additional Fees

No Show/Late Cancellation Follow-Up Appointment/Late Arrival (10 Minutes)	$100.00
Patient Case Management Program	$15.00 / Month
Accommodation Requests (Extensive)	$25.00
Returned Check	$35.00

An adult accompanying a child under 18 and the parent or guardian of the child is responsible for payment according to the terms described above.

You, the patient, have a contract with your insurance carrier. Our services may or may not be covered by your particular policy. It is your responsibility to contact your carrier to determine if these are covered services under your contract ***prior*** to the date of service.

A referral may be required by your insurance company for services to be paid. It is the ***patient's responsibility*** to obtain the required referral for treatment prior to the visit.

Our staff is happy to help with general questions relating to a claim or to provide additional information requested by your insurance carrier in order for the claim to be processed. However, patients should direct questions about coverage for specific procedures to a representative of their insurance company's member services department. The phone number for member services is usually located on the back of the insurance card.

I have read and understand the financial policy as stated.

_____ _____

Parent/Guardian/Patient Signature Patient Name (Please Print)

_____

Date

ADHD Medical Clinic Of Mobile

Case Management

ADHD Medical Clinic of Mobile patients will be charged **$15 per month** for Case Management. This service is not covered by your insurance policy.

Case Management allows ADHD Medical Clinic of Mobile to…

1. **Communicate with patients outside of office visits**

   ADHD treatment is complicated and there are often questions and problems that come up between visits. We find that email is an efficient way to communicate with your doctor for simple questions and medication adjustments that can often save you an office visit. Unfortunately, this convenience is not covered by insurance companies.

2. **Reduce the amount of time you have to spend in our office**

   Many offices require patients to come in for monthly visits to receive prescription refills. Once a patient is dose optimized, ADHD Medical Clinic of Mobile only requires the patient to have a follow-up appointment once every three to four months in order to receive prescription refills.

3. **Keep your out of pocket expenses down**

   The fee covers many of the behind the scenes costs of managing ADHD in the insurance environment. Many insurers have significant requirements for paperwork to ensure that we maximize your benefits to cover office visits, testing, and medication formulary issues. This helps us keep your out of pocket expenses down.

We believe case management is valuable to our patients and the goal is to save you time and money.

_____ _____

Parent/Guardian/Patient Signature Patient Name (Please Print)

_____

Date

ADHD Medical Clinic Of Mobile

Prescription Refill Policy

1. No Medication is dispensed from our office. You must take your paper prescription to your pharmacy to receive your medication.
2. **Our office requires 24 hours to process refill requests.** It is the patient's responsibility to notify the office in a timely manner when refills are needed. ***Please do not wait until you are out of medication to call.*** You will not receive a call back when the paper prescription is ready.
3. Please do not walk in expecting a paper prescription to be prepared while you wait.
4. Paper prescriptions will not be prepared on Saturdays, Sundays, or Holidays.
5. Paper prescriptions must be picked up by the patient or the patient's parent/guardian unless we are otherwise notified. Paper prescriptions can be mailed upon request.
6. ***Keeping your scheduled follow-up appointments*** ensures you receive timely refills. If you have not been re-evaluated by the doctor within his requested time period, you may have to be seen for a follow-up visit before receiving prescription refills.
7. Some medications require prior authorization. Depending on your insurance, this process may involve several steps by both your pharmacy and our office. Prior authorizations will be handled as quickly as possible, but do require extra time to be processed.

Office Policies

1. **Our office hours vary depending on our appointment schedule. For specific daily information please call the office.**
2. Patients who are unable to pay in full upon arrival will be required to reschedule their appointment. No Exceptions. We accept cash, check, Visa, Mastercard, Discover, and American Express.
3. All missed appointments will result in a $100 no show fee.
4. A total of three missed appointments will result in dismissal from our practice.
5. Appointments must be canceled 24 hours prior to the appointment time to avoid a $100 no show fee. Monday appointments must be canceled by 11 AM on Friday to avoid the fee.
6. Patients arriving more than 10 minutes late may be required to reschedule their appointment.
7. All no show fees must be paid before receiving prescription refills and prior to the next appointment.
8. **Appointment reminder calls are made as a courtesy by our office. It is the patient's responsibility to keep up with the appointment date and time. Not receiving a reminder call is not a valid excuse for missing an appointment.**

_____ _____ _____

Patient Signature Print Patient Name Date

ADHD Medical Clinic Of Mobile

Controlled Substance Agreement

The purpose of this agreement is to be certain that controlled substances are prescribed in the safest, most effective manner in compliance with current law. Please initial next to each statement.

_____ I understand that ADHD medications are controlled substances that are regulated by state and federal law because of their high risk for abuse.

_____ I understand that it is a felony to obtain these medications by fraudulent means, to possess these medications without a legitimate prescription, and to give or sell these medications to others.

_____ I agree not to seek ADHD medication from any other physician. I understand that obtaining stimulant medication from multiple providers is a crime that can be reported to the appropriate authorities.

_____ I understand that it is a crime to obtain controlled substances under false pretenses. I agree not to misrepresent myself to obtain medication.

_____ I agree to disclose any and all medications I am taking. I understand that failure to do so can result in dismissal from the practice.

_____ I understand that I am responsible for keeping my medication in a secure place.

_____ I understand that medication will not be replaced if it is lost or stolen, or if I run out before my next refill date.

_____ I agree to inform the medical staff of any past or present substance abuse.

_____ I acknowledge that ADHD Medical Clinic of Mobile has the right to request a drug screen at any time. I understand that refusal to cooperate will result in dismissal from the practice. I agree that I am responsible for any cost associated with the drug screen.

_____ I understand that ADHD Medical Clinic of Mobile has the right to discontinue controlled substance medications and discharge me from care if any part of this agreement is broken.

I hold ADHD Medical Clinic of Mobile harmless from any liability in the event I am dismissed from the practice for failure to abide by this agreement. I have read and understood the above policy.

_____ _____

Parent/Guardian/Patient Signature Patient Name (Please Print)

_____

Date

Updated 3/15/16

ADHD Medical Clinic Of Mobile

Non-Covered Services Policy

As our patients, we want to provide you the best care possible. Certain services that we feel are necessary may not be covered by your insurance carrier.

- **You will be expected to pay for those services in full at the time they are provided.**
- **Policy holders of insurance carriers other than those currently contracted with our Providers will be expected to pay in full at the time of service.**
- **A coded bill will be given to you to use when filing your insurance claim if your carrier is one other than contracted with our Providers.**

Listed below are procedure codes that you may use to check with your insurance carrier to determine if any percentage of the fees will be covered.

These procedures are provided by a medical doctor and may or may not be covered under your insurance policy.

Visit Types	***Procedure Codes***	***Pricing***
New Patient Consultation	99205	$197
Established Patient Follow-Up	99215	$134
New Patient Testing	***Testing/Assessment Codes***	***Pricing***
Qb Testing and Interpretation	96120	$60
CNS Vital Signs	96103	$85
Patient Case Management	None	$15/month
ADHD Diagnosis Types	***Diagnosis Codes***	
ADHD, Combined Type	314.01 (ICD 9) / F90.2 (ICD 10)	
ADHD, Inattentive Type	314.00 (ICD 9) / F90.1(ICD 10)	
ADHD, Hyperactive Type	F90.0 (ICD 10)	

I have read and understand that charges for services not covered by my insurance plan will be my responsibility to pay in full the day the services are rendered.

_____ _____

Parent/Guardian/Patient Signature Patient Name (Please Print)

_____

Date

ADHD Medical Clinic Of Mobile

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.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, or other medical professionals and personnel who are involved in taking care of you.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

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 the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to a Paper Copy of this 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 time.

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. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***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 the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact the Privacy Officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

_____ _____

Patient or Patient's Personal Representative **Date**

_____

Patient Name (Please Print):

Updated 4/21/15

ADHD
Medical Clinic Of Mobile

Consent for Use or Disclosure of Protected Health Information for Payment, Treatment and Health Care Operations

By signing below, you hereby consent for this Practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form.

You should read the Notice of Privacy Practices for PHI attached to this form before signing the Consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer for this Practice.

You have the right to request that the Practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to requested restrictions, however; if the Practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law. Please check the following if applicable:

_____ You may call my home and leave a message with someone or on an answering machine if I am not available
_____ You may call my place of employment and leave a message on an answering machine or with someone if I am not available.
_____ You may call my cell phone and leave a message on my answering machine if I am not available.
_____ You may communicate confidential information to me, including invoices for services, to the address and/or phone numbers that have been given in my patient information. If not, please indicate the address or phone number that we may use:_____
_____ You may discuss by email or phone, my child's symptoms (*if pediatric patient*), diagnosis and treatment with teachers and school representatives.
_____ I agree to use email communication for medication management including discussion of symptoms/side effects. I realize that email is not completely private and is permanent.
_____ I authorize ADHD Medical Clinic of Mobile to release my medical records to a referring physician should one be needed.
_____ I authorize ADHD Medical Clinic of Mobile to obtain my medication history from the pharmacy database.

_____ _____ _____
Individual Signature Relationship to Patient Patient Name (Please Print)

_____
Date

ADHD Medical Clinic Of Mobile

Designation for Release of Medical Information to a Family Member, Friend Or Legal Representative

It is the physicians' responsibility to ensure that the physician-patient relationship is confidential. The Health Portability and Accountability Act (HIPPA) allows physicians to use their professional judgment on disclosing certain personal health information to family, friends, etc. without an authorization. This form is an aid to the physicians in making a determination on disclosing such information. ADHD Medical Clinic of Mobile realizes that there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medical needs. Your doctor wants you to be able, if you so desire, to name a person to whom you want the office staff to speak with about your medical condition. To enable that, we would ask that you complete the form listed below. Please note the following points:

• the designation is valid until you cancel it in writing

• If you designate no one, ADHD Medical Clinic of Mobile will not release information to any family member or friend or legal representative.

Designation Statement

I, _____, designate the following person to be able to speak to a physician at ADHD Medical Clinic of Mobile, or other staff member, should it be necessary, on my behalf. I hereby give permission to ADHD Medical Clinic of Mobile through its physicians and staff to release to my designee any information about my medical condition or medical needs or the status of my account and I release ADHD Medical Clinic of Mobile, its physicians and staff, from any claim of confidentiality in connections with the release of this information.

Name of Designated Person: _____Relationship: _____ Phone _____

Name of Designated Person: _____Relationship: _____ Phone _____

Name of Designated Person: _____Relationship: _____ Phone _____

_____ None

Patient's Name:_____

Patient's Signature: _____Date: _____