NORWOOD Clinic

Department_____ Account#_____
Staff Initials_____ Date_____

PATIENT INFORMATION

First Name		Middle Name		Last Name	
Date of Birth	Sex	Marital Status	Social Security #	Driver's License #	
Street Address		City		State	Zip Code
Home Phone #		Work Phone #		Cell Phone #	
Occupation		Employer		Employer's Phone #	
Employer's Address		City		State	Zip Code
Referring Physician		Contact person in case of emergency		Contact's Phone #	
Is visit due to an accident? Yes/No		Date of accident		Work Related? Yes/No	

Are you a resident of a nursing home? Yes No If yes, name of facility_____

Insurance Information

You are responsible for obtaining a referral by your insurance carrier. If we are participating providers with your insurance carrier, we will file your claim for your office visit or surgery and allow 45 days for payment in full. Should payment not be received within 45 days, the balance due will become the obligation of the guarantor on the account and must be pain within 30 days. If you don't have insurance or we are not participating providers with your insurance carrier, payment is expected today for services rendered.

Primary:_____
Insurance Company/Third Party Contract # / Group # Policy holder's Name/Relationship to patient/DOB

Secondary:_____
Insurance Company/Third Party Contract # / Group # Policy holder's Name/Relationship to patient/DOB

RESPONSIBLE PARTY

If patient is a minor, please indicate who is responsible party. This individual must be the person bringing the patient in for treatment and not another individual, and must be age nineteen or older.

First Name Middle Name Last Name Phone #

Responsible Party Address City State Zip Code

Relationship to Patient Social Sec. No. Occupation Employer

Employer's Address City Sate Zip Code

Payment is due from the patient at the time that services are rendered. The patient is responsible for payment and not the insurance company. As noted above, we will file claims for any insurance coverage which we are a participating provider: however, copayments, deductible and noncovered charges must be paid at the time that the services are rendered. If there are any questions regarding payment/insurance filing policies, please see on of the office staff at this time to make any necessary arrangements.

AGREEMENT TO PAY: The undersigned agrees to payment of all charges for services provided both before and after the date of this agreement and promises to pay said fee including the cost of collection, attorney fees, and court costs, if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama and any other state. The undersigned understands that accounts may be referred to an outside collection agency if the balance remains unpaid for sixty days unless alternate arrangements have been made and followed.

RELEASE OF MEDICAL RECORDS: I authorize Norwood Clinic to request/release any medical information from or to another physician or medical institution as necessary for my medical care or filing purposes.

SURGICAL BENEFITS: I authorize payment directly to Norwood Clinic for the surgical and/or medical benefits if any, otherwise payable to me for services rendered by Norwood Clinic. I realize the insurance benefits may not pay all of the bill and I agree to pay the difference or the entire bill if necessary, excluding contractual allowances.

Signature of patient_____Date_____

Signature of Responsible Party_____Date_____

NORWOODClinic

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Patient Date of Birth: _____

I have been presented with a copy of Norwood Clinic, Inc.'s ("Norwood") Notice of Privacy Practices, detailing how the above-named patient's information may be used and disclosed as permitted under federal and state law.

In the event of a medical emergency or if I am otherwise unavailable, I hereby allow Norwood to discuss billing, appointments, treatment, diagnosis, test results, and other protected health information regarding the above-named patient with the following persons who are involved with the patient's health care and/or payment related to the patient's health care:

Name	**Relationship**	**Contact #**

Contact Methods:

May we leave information on your answering machine at home?	Yes	No
May we leave information on your voicemail at work?	Yes	No
May we leave information on your cell phone?	Yes	No

My signature below is acknowledgement that I have received a copy of Norwood's Notice of Privacy Practices and that I agree to the conditions stated in the Notice of Privacy Practices and contained in this form.

_____ _____

Printed Name of Patient Date

_____

Signature of Patient

_____

Printed Name of Parent/Patient's Representative (If Applicable)

_____

Signature of Parent/Patient's Representative (If Applicable)

IM Health Questionnaire

HEALTH QUESTIONNAIRE

Name _____ **Date** _____

Current Medications (include **Non** – prescription and herbal supplements / vitamins)

Name of Medicine	Strength of Dose (Mg)	How Often Taken	Reason Taken

Allergies / Reactions

_____

_____

Vaccinations: (Year last Vaccinated)

Tetanus/TD _____ Influenza _____

Pneumonia _____ Hepatitis _____

Tuberculosis_____ Other _____

Pharmacy Name _____

Phone # _____ Fax # _____

Address _____

Employer Name _____

Phone # _____

Address _____

Past Medical History (please check all that apply)

☐ Unremarkable	☐ CVA/Stroke	☐ Depression	☐ Hernia: Inguinal
☐ Allergic Rhinitis	☐ Cerebrovascular Disease	☐ Diabetes – Type 1	☐ Hepatitis A
☐ Anemia	☐ C H F	☐ Diabetes – Type 2	☐ Hepatitis B
☐ Anxiety	☐ Cirrhosis	☐ Diverticulitis	☐ Hepatitis C
☐ Arrhythmia	☐ Colon Cancer	☐ Diverticulosis	☐ Hyperlipidemia
☐ Asthma	☐ Colon Polyps	☐ D V T	☐ Hypertension
☐ Atrial Fibrillation	☐ Constipation	☐ Erectile Dysfunction	☐ Hyperthyroidism
☐ Autoimmune Disorder	☐ C O P D	☐ Fibromyalgia	☐ Hypothyroidism
☐ Biliary Cirrhosis	☐ Coronary Heart Disease	☐ GERD	☐ Infertility
☐ Blood Transfusions	☐ C R F	☐ GI Bleed	☐ Insomnia
☐ BPH/Prostate Enlargement	☐ Crohn's Disease	☐ Gout	☐ Irritable Bowel Syndrome
☐ Brain Tumor	☐ C V A / Stroke	☐ Headaches	☐ KEY
☐ COPD	☐ DVT	☐ Hemochromatosis	☐ Kidney Disease
☐ CRF		☐ Hernia: Hiatal	☐ Kidney Stone
			☐ Liver Disease
			☐ Low Back Pain
			☐ MI
			☐ Neurologic Disorder
			☐ Obesity
			☐ Osteoarthritis
			☐ Osteoporosis
			☐ Peripheral Neuropathy
			☐ Prostate Cancer
			☐ PUD
			☐ PVD
			☐ Rheumatoid Arthritis
			☐ Seizure Disorder
			☐ Sleep Apnea
			☐ Syncope
			☐ Thyroid Disorder
			☐ TIA
			☐ Tuberculosis
			☐ UTI Recurrent
			☐ Urinary Retention
			☐ Valvular Heart Disease
			☐ Varicose Veins/Phlebitis

Past Surgical History (check all that apply)

☐ Cataract Extraction

☐ Unremarkable	☐ Carotid Endarterectomy	☐ Knee Arthroscopy	☐ Prostatectomy
☐ Abd Surg Type	☐ Carpal Tunnel	☐ Knee Replacement	☐ PTCA
☐ Amputation	☐ Cataract Extraction	☐ Kyphoplasty	☐ R-A-F Bypass
☐ Anesthesia Prob-No	☐ Cesarean Section	☐ L-A-F Bypass	☐ Rotator Cuff Repair
☐ Anesthesia Prob-Yes	☐ Cholecystectomy	☐ Mitral Valve Bypass	☐ Sinus Surgery
☐ Aortic Valve Replacement	☐ Colonoscopy	☐ Nephrectomy - Native	☐ Surgical Complications-No
☐ Appendectomy	☐ Colon Resection	☐ Nephrectomy - Transplant	☐ Surgical Complications-Yes
☐ AV Fistula Creation	☐ Coronary Stent	☐ Pacemaker	☐ TURP
☐ AV Graft	☐ Craniotomy	☐ Parathyroidectomy	☐ Tonsillectomy
☐ B A F Bypass	☐ Exploratory Laparotomy	☐ Pneumonectomy	☐ Total Colectomy
☐ Back Surgery	☐ Gastric Bypass	☐ Post-op Delirium	☐ Tunneled Dialysis Catheter
☐ Bronchoscopy	☐ Hemorrhoidectomy		☐ UPPP
☐ CABG	☐ Hop Replacement		☐ Urinary Incontinence Surgery
	☐ Interventional Pain Tx		☐ Vascular Access for Dialysis
	☐ Kidney Transplant		☐ Vertebroplasty

Family History (check all that apply)

☐ **Alcoholism**	☐ **Osteoporosis**
☐ **Anemia**	☐ **Seizures**
☐ **Arthritis**	☐ **Severe Allergies**
☐ **Anesthetic Complication**	☐ **High Cholesterol**
☐ **Anxiety**	☐ **Stroke**
☐ **Asthma**	☐ **Suicide Attempt**
☐ **Birth Defects**	☐ **Bowel Disease**
☐ **Blood Clots**	☐ **Heart Disease**
☐ **Blood Transfusions**	☐ **Kidney Disease**
☐ **Breast Cancer**	☐ **Respiratory Disease**
☐ **Cervical Cancer**	☐ **Liver Disease**
☐ **Colon Cancer**	☐ **S T D**
☐ **Depression**	☐ **Ulcers**
☐ **Diabetes**	☐ **Other Diseases**
☐ **Growth Development**	☐ **CHD Male <55**
☐ **Heart Disease**	☐ **CHD Female <65**
☐ **Angina**	☐ **Colon Cancer- father**
☐ **Hypertension**	☐ **Colon Cancer-mother**
☐ **High Cholesterol**	☐ **Lung Cancer**
☐ **Psychiatric Care**	☐ **Melanoma**
	☐ **Ovarian Cancer**
	☐ **Uterine Cancer**
	☐ **Other Cancer**
	☐ **Thyroid Disease**
	☐ **Weight Disorder**
	☐ **Headaches**
	☐ **Other Medical Problems**
	☐ **P M S**
	☐ **Endometriosis**
	☐ **Prostate Cancer**

Social History (check all that apply)

☐ **Current Smoker**	☐ **Drug Use-Yes**
☐ **Former Smoker**	☐ **Drug Use-No**
☐ **Never Smoked**	☐ **HIV/High Risk -Yes**
☐ **Counseled to Quit?**	☐ **HIV/High Risk -No**
☐ **Passive Smoke-Yes**	☐ **Regular Exercise-Yes**
☐ **Passive Smoke-No**	☐ **Regular Exercise-No**
☐ **Alcohol Use-Yes**	☐ **Hx Domestic Abuse**
☐ **Alcohol Use-No**	☐ **Religion Affecting Care**

NORWOOD Clinic

Patient Portal Registration and Referral Questionnaire

Norwood Clinic is proud to announce an online tool that will allow you to access your healthcare information easily and securely.

You may access the following:

- Schedule an appointment
- Check lab results
- Pay your bill
- Ask the billing department question(s)
- Update your information

Please complete the below information:

Patient Name: _____ Birthday: _____

Email Address: _____

Would you like to receive electronic billing statements? ☐ **Yes** ☐ **No**

Referral Information

How did you hear about Norwood Clinic? (Another patient, friend of the patient, relative, dental office, yellow pages, newspaper, school, work, mail out, billboard, radio commercial, etc.)

_____

Signature: _____ Date: _____

FOR STAFF USE ONLY-MUST BE COMPLETED

□ **Linked** □ **Not linked**

Enrollment Completed by: _____

Date: _____

NORWOOD Clinic

E-PRESCRIBE CONSENT FORM

E-Prescribe is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program. These include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – Provides the physician with information about medications that the patient is already taking to minimize the number of adverse drug interactions.
- **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled. It also allows the physician to be notified when the patient needs a refill of their medications.

☐ **I DO want to participate.**

By signing this consent, you are agreeing to allow Norwood Clinic, Inc. to request and use your prescription medication history from other healthcare providers and/or third party benefit payers for treatment purposes. Understanding all of the above, I hereby give informed consent to Norwood Clinic, Inc. to enroll me in the **E-Prescribe program**.

_____

Pharmacy Name City Phone Number

☐ **I do NOT want to participate.**

I do hereby decline enrollment in the E-Prescribe program. If I decide at a later time that I want to participate, then it is my responsibility to inform my physician and his/her staff.

_____ _____

Patient Name (Print) Date of Birth

_____ _____

Signature of Patient or Guardian Date Signed

Patient Name: _____ DOB: _____ Pt. ID#: _____

STATEMENT/ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY:

We appreciate you choosing us as your healthcare provider. Payment for services rendered is considered part of your overall treatment. Thus, your understanding of the following financial policies is important to our professional relationship.

Private Insurance Benefits and Coverage Disclosures

As a courtesy, Norwood Clinic, Inc. ("Norwood") will assist in filing insurance claims as appropriate, but this in no way guarantees that any benefits will be paid by the patient's insurance company. Your insurance benefit is a contract between you and your insurance company. You are responsible for notifying Norwood of any insurance coverage and any changes in your insurance coverage. Norwood will assist with, but is not responsible for, obtaining any needed insurance referral(s) or prior authorization(s). Required insurance referral(s) or prior authorization(s) are ultimately the responsibility of the patient. All efforts relating to the collection of the patient's insurance benefits are for the patient's convenience and do not represent a guarantee of collection or a credit to the patient's account until such time as payment is received by Norwood.

The patient's insurance plan's eligible charges or maximum allowed amount(s) are the most the patient's insurance company is required to pay under the terms of the patient's insurance plan. These eligible charges or maximum allowed amounts are determined by the patient's specific insurance plan. Under many insurance plans, Norwood is a non-contracted provider and may not have information about the patient's insurance plan's eligible charges or maximum allowed amount(s) until after a claim has been processed. As a non-contracted provider, Norwood may bill the patient or his or her parent, guardian, or personal representative for any fees relating to care received at Norwood that are not paid by the patient's insurance company even when the patient's insurance carrier has paid the plan's eligible charges or maximum amount(s) for those services.

If the patient no longer meets the plan's qualifications or if the criteria of the plan's benefit guidelines are not met (including but not limited to, referral or prior authorization procedures, benefit exclusion and/or eligibility, etc.), the patient or his or her parent, guardian, or personal representative will be responsible for payment of all non-covered claim charges relating to the care provided by Norwood. If the patient is not able to provide proof of insurance at the time of appointment or if insurance is not able to be verified, the patient or his or her parent, guardian, or personal representative will be responsible for payment.

All services provided must be paid for, regardless of whether the patient's insurance company covers those services. The patient or his or her parent, guardian, or personal representative is ultimately financially responsible for all charges not covered by insurance payments.

Private Pay/Self-Pay Patients

If the patient does not have insurance coverage of any kind, the patient or his or her parent, guardian, or personal representative will solely be responsible for payment of all charges relating to the care provided by Norwood.

Payment Due Dates and Policies

Regardless of whether or not the patient has insurance coverage, the patient or his or her parent, guardian, or personal representative is ultimately responsible for payment for services rendered by Norwood. It is the policy of Norwood to collect payment at the time the service is rendered, including co-pays, deductibles, payments for non-covered services, and payments by private pay patients. In addition, for patients having an outstanding balance at the time of an appointment, payment of the outstanding balance is due prior to any additional services being rendered. Payment may be made by cash, check, or credit/debit card.

If the patient or his or her parent, guardian, or personal representative is unable to pay the amount due in full at the time of the appointment, the following procedures shall apply:

- Norwood will accept payment of one-third (1/3) of the amount due at the time of the appointment. An additional one-third (1/3) is due thirty (30) days later, and the final one-third is due thirty (30) days after that.

- If the patient is unable to pay one-third (1/3) of the amount due at the time of the appointment, established patients may be allowed to enter into a payment plan agreed to by Norwood.

- If the patient is unable to pay any of the amount due at the time of the appointment, in non-emergent situations, the patient will be asked to reschedule their appointment for a later date when payment can be made.

In the event a filed insurance claim has not been paid within a reasonable amount of time, the patient or his or her parent, guardian, or personal representative will be billed and responsible for payment. If Norwood later receives payment from the insurance company, the refund procedures discussed below will apply.

Any amounts due that are not paid timely may be turned over to an attorney or collection agency. The patient or his or her parent, guardian, or personal representative is responsible for all collection and attorney fees, as well as finance or interest charges, associated with such accounts.

Norwood reserves the right to impose a charge for all returned checks. Norwood reserves the right to impose finance charges on overdue balances. In the event that a check is returned making an account balance overdue, both a returned check charge and finance charge may apply.

In the event the patient or his or her parent, guardian, or personal representative has overpaid on an account, any credit balance will be applied towards an outstanding balance. In the event the patient does not have an outstanding balance, a refund will be made in accordance with Norwood's refund policies.

Acknowledgement

By signing below, I acknowledge the following:

- I have read and understand the information contained in this Statement/Acknowledgment of Financial Responsibility.

- I was provided with the opportunity to ask questions about the information contained herein. Any questions asked have been answered to my satisfaction.
- I understand that I am financially responsible for all charges for services rendered that are not covered by insurance.
- The decision to receive care from Norwood was voluntary.

Patient Signature	Printed Name	Date
Parent/Guardian/Personal Representative Signature (If applicable)	Printed Name	Date