Patient Profile

Doctor: ______

PATIENT INFORMATION

Name: ______

Patient ID #: ______ Sex: [ ]M [ ]F

Address: ______

Date of Birth: ______

Social Security #: ______

City,State: ______

Marital Status: [ ]Married [ ]Single [ ]Divorced

Phone: ______ [ ]Home [ ]Work [ ]Other

Referring Physican: ______

Phone: ______ [ ]Home [ ]Work [ ]Other

Primary Physician: ______

Email: ______

Race: ______

Preferred Method of Contact: [ ]Letter [ ]Phone Call [ ]Email [ ]Fax

Ethnicity: [ ]Hispanic/Latino [ ]Non Hispanic/Latino [ ]Other/Undetermined

ARE YOU A RESIDENT OF A NURSING HOME? YES NO Nursing Home Name: ______

ARE YOU ENROLLED IN HOSPICE? YES NO Hospice Name: ______

PATIENT EMPLOYMENT

[ ]Employed [ ]Retired [ ]Unemployed [X]Other

Phone: ______

Employer: ______

CONTACTS

Name	Relation to Pt	Phone

GUARANTOR

[ ]Same as Patient

Name: ______

Address: ______

City,State: ______

Employer: ______

Phone: ______

Phone: ______

Social Security #: ______

Date of Birth: ______

PRIMARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: ______

Insured Phone: ______

Company: ______

Date of Birth: ______

Relationship to Primary Insured/Guarantor: ______

Social Security #: ______

Insured ID: ______

Policy Group: ______

SECONDARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: ______

Insured Phone: ______

Company: ______

Date of Birth: ______

Relationship to Primary Insured/Guarantor: ______

Social Security #: ______

Insured ID: ______

Policy Group: ______

Agreement to Pay: I agree to pay all charges for services provided both before and after the date of this agreement including the cost of collection, attorney fees and court cost if such becomes necessary. I waive the right to claim exemption under the laws of the State of Alabama or any other state. I understand that outstanding balances may be referred to an outside collection agency if unpaid for sixty days and no other arrangements have been made. I understand that I am responsible for payment and not the insurance company. As noted above, Norwood Clinic will file claims for any insurance coverage for which we are a participating provider; however, copays, deductibes and noncovered charges should be paid at the time of service. I understand that in circumstances which insurance coverage does not fully cover the cost of care, I will be responsible for the remaining balance less contractual allowances.

Release of Medical Records: I authorize Norwood Clinic, Inc to request/release any medical records from or to another physician, medical institution, or insurance carrier as necessary for my medical care or billing purposes.

Benefit Assignment: I authorize payment directly to Norwood Clinic of all surgical or medical benefits if any, otherwise payable to me for services rendered by Norwood Clinic.

Signature of Guarantor: ______ Date: ______

MEDICAL HISTORY QUESTIONAIRE

Patient Name ______________________________ Primary Care Doctor____________________

Current Occupation________________________Disabled_____________Retired____________

Living Arrangements: Private Home____ Assisted Living____ Nursing Home____ Group Home ______

Do you wear contact Lenses? Yes___ No___ Glasses? Yes ____No____ Do you drive? Yes___ No___

Do you smoke? Yes___ No___ Have you ever? Yes ___ No___

Do you use alcohol? Yes ___No___ Occasional___

List ANY and ALL surgeries you have had in the past______________________________________

____

List any drug allergies ____

List all current medications ____

____

FAMILY HISTORY: Anyone in your family has

	Which family member	Moms side	Dads side
Glaucoma	________________	________	________
Macular Degeneration	________________	________	________
Heart Disease	________________	________	________
Hypertension	________________	________	________
Diabetes	________________	________	________
Cancer	________________	________	________

____

REVIEW OF SYSTEMS

GENERAL	No	Yes
Fatigue	___	___
Weight loss	___	___
Other	___	___

EYES	No	Yes
Blurring	___	___
Double vision	___	___
Irritation	___	___
Eye pain	___	___
Glare	___	___
Other	___	___

EAR/NOSE/THROAT	No	Yes
Hearing problem	___	___
Sinus problem	___	___
Chronic cough	___	___
Dry mouth	___	___
Other	___	___

CARDIOVASCULAR	No	Yes
Chest pains	___	___
Palpitations	___	___
High BP	___	___
Heart Problems	___	___
Cholesterol	___	___
Other	___	___

RESPIRATORY	No	Yes
Emphysema	___	___
COPD	___	___
Short of Breath	___	___
Asthma	___	___
Other	___	___

GASTROINTESTINAL	No	Yes
Stomach ulcers	___	___
Intestinal disease	___	___
Hernia	___	___
Other	___	___

GENITOURINARY	No	Yes
Bladder problems	___	___
Liver problems	___	___
Kidney problems	___	___
Enlarged prostate	___	___
Other	___	___

MUSCULOSKELETAL	No	Yes
Joint pain	___	___
Arthritis	___	___
Osteo arthritis	___	___
Rheumatoid arthritis	___	___
Other	___	___

SKIN	No	Yes
Skin cancer	___	___
Psoriasis	___	___
Warts	___	___
Acne	___	___
Other	___	___

NEUROLOGIC	No	Yes
Seizures	___	___
Tremors	___	___
Vertigo	___	___
Multiple sclerosis	___	___
Dizziness	___	___
Epilepsy	___	___
Headaches	___	___

PSYCHIATRIC	No	Yes
Depression	___	___
Anxiety	___	___
Memory loss	___	___
Insomnia	___	___
Other	___	___

ENDOCRINE	No	Yes
Diabetes	___	___
Thyroid	___	___
Other	___	___

HEME/LYMPHATIC	No	Yes
Bleeding	___	___
Blood clots	___	___
Anemia	___	___
Other	___	___

ALLERGIC/IMMUNOLOGIC	No	Yes
Lupus	___	___
Sjogren's	___	___
Hives	___	___
Other	___	___

FEMALES	No	Yes
Pregnant	___	___
Nursing	___	___
Other	___	___

CANCER	___	___
Location		

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)

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

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 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: ____

The 40.00 refraction charge (measuring your eyes for glasses) is not a procedure covered by your insurance company.

This charge plus co-pay, is the patient's responsibility, payable at the time of the office visit.

Thank You.

______________________ ______________

Signature **Date**