New Leaf Medical Clinic, LLC
Patient Registration

Patient Name_____
Last Name First Name Middle Name

Address_____

City_____State_____Zip_____

Phone #_____SS #_____Marital Status_____

Birth Date_____ Age _____ Driver's Lic #_____

Gender at Birth_____ Gender Identity_____ Preferred Pronouns _____

Email Address _____How did you hear about us? _____

Language: ☐ English ☐ Spanish ☐ Other (specify) **Race**: ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ I decline to answer
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ I decline to answer

Preferred Pharmacy_____Phone #_____

Patient's Employer _____ Emp Phone # _____

Employer Address _____

Name of Spouse _____

Spouse's Employer _____

Insurance_____ Subscriber name/DOB_____

Policy/ID _____Group # _____

If Patient is a Minor
Mother's Name_____Address_____

Father's Name_____Address_____

Mother's Ph #_____Father's Ph #_____

I, the undersigned, realize all medical charges incurred are my responsibility and payable by me regardless of what my insurance pays. I hereby authorize and direct my insurance carrier(s) to pay directly to New Leaf Medical Clinic, LLC, any benefits due under my insurance plan. I agree to pay the balance of expenses not paid under this plan, including deductibles and co-payments.
I authorize New Leaf Medical Clinic, LLC, or any other providers designated by them, to provide medical services as may be determined to be in my best interest. This authorization shall remain in effect until revoked by me in writing.

_____ _____
Signature of patient (if minor, parent, or legal guardian must sign) Date

Revised 07/01/2023

New Leaf Medical Clinic, LLC

Medical History *Date ____/____/____*

Name _____ Age _____ Birthdate _____/_____/_____

Preferred Pronoun(s)_____ Sex: ■ Male ☐ Female

Address _____ Mobile phone_____

_____ Mobile Carrier_____

Occupation _____ Emergency contact _____

Work Phone: _____ Phone_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If married, spouse's name _____

Children's names and ages _____

Allergies to Medications, X-Ray Dyes, or Other Substances ■ No ☐ Yes

_____ _____ _____ _____

_____ _____ _____ _____

Past Medical History and Review of Systems

Please circle if <u>you</u> have had problems with or are presently experiencing any of the following:

- ☐ High blood pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart disease
- ☐ Chest pain/chest tightness
- ☐ Shortness of breath
- ☐ Swollen ankles
- ☐ Palpitations
- ☐ Lightheadedness
- ☐ Frequent urination
- ☐ Rheumatic fever
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Persistent cough
- ☐ T.B.
- ☐ Hay fever
- ☐ Abdominal discomfort
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Ulcers
- ☐ Change in bowel habits
- ☐ Unexplained weight gain/loss
- ☐ Hemorrhoids
- ☐ Gall bladder disease
- ☐ Colitis
- ☐ hepatitis or jaundice
- ☐ Thyroid disease
- ☐ Head or neck radiation
- ☐ Headache
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Difficulty urinating
- ☐ Arthritis
- ☐ Low back problems
- ☐ Skin diseases
- ☐ Blood disorders
- ☐ Venereal diseases
- ☐ Anxiety
- ☐ Depression
- ☐ Anemia
- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Gout
- 49. _____
- 50. _____
- 51. _____
- 52. _____

Gynecologic and Obstetric History

Age at onset of periods: _____ Frequency: _____ Length of period: _____

Pregnancies: _____ Live Births: _____

Please List and Supply the Date of:

Surgeries: _____ _____ _____

_____ _____ _____

Hospitalizations other than for surgery: _____ _____

_____ _____ _____

Immunization history – have you had:

Tetanus Immunization?	☐No ☒Yes	When? _____
Hepatitis B?	☐No ☒Yes	When? _____
Flu immunization?	☐No ☒Yes	When? _____
Pneumovax Immunization?	☐No ☐Yes	When? _____
COVID-19?	☐No ☐Yes	When? _____
Other _____	☐No ☐Yes	When? _____

Screening Tests - ***When was your last:***

Pap smear: _____ Breast exam: _____ Colonoscopy/Stool check for blood: _____

Mammogram: _____ Cholesterol check: _____ Prostate exam: _____

Family History

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	**Which family members?**	**Approx. age when diagnosed**
Thyroid Disease (describe)		
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart disease/heart attack		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc.)		
Drug or alcohol addiction		
Glaucoma		
Bleeding diseases		
Other		

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose

Prevention

Do you wear seat belt?	☐ Yes ☐ No	If no, why not? _____
Do you wear a bike helmet?	☐ Yes ☐ No ☐ N/A	
Do you exercise regularly?	☐ Yes ☐No	If yes, type, duration and # of times per week? _____
Do you smoke/vape/chew or dip tobacco?	☐ No ☐ Yes	If yes, how much and how often per day? _____
Do you drink alcoholic beverages?	☐ No ☐ Yes	If yes, how much per week? _____
Do you drink caffeine? (Coffee, tea, energy drinks)	☐ No ☐ Yes	If yes, how many per day? _____
If there is a gun in your home, do you keep it unloaded and out of children's reach?	☐ Yes ☐ No ☐ N/A	
Do you use drugs? (marijuana, cocaine, crack, etc.)	☐ No ☐ Yes	If yes, explain: _____
Have you ever engaged in any activity which has put you at risk of getting HIV?	☐ No ☐ Yes	If yes, explain: _____
Do you wish to be tested for HIV?	☐ No ☐ Yes	
Have you ever worked with chemicals, paints, asbestos, or other hazardous material?	☐ No ☐ Yes	If yes, explain: _____

New Leaf Medical Clinic, LLC
Healthcare with a heart

Phone Message Consent Form

Notice of Privacy Practices – Patient Acknowledgement

We, at the New Leaf Medical Clinic, are committed to safeguarding the privacy and confidentiality of your medical records including the personal information that you share with us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). From time to time, it may be necessary or desirable to contact patients by phone. To expedite your health care and in the interest of convenience, if you are not available to speak with us directly, we would like to leave a message whenever possible.

To assist us in protecting your privacy, please complete the following:

Patient Name: _____

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CIRCLE ALL THAT APPLY)

HOME PHONE: _____

LEAVE A DETAILED VOICE MAIL MESSAGE? ☐ YES ☐ NO

LEAVE A MESSAGE WITH CALL BACK NUMBER? ☐ YES ☐ NO

CELL PHONE: _____

LEAVE A DETAILED VOICE MAIL MESSAGE? ☐ YES ☐ NO

LEAVE A MESSAGE WITH CALL BACK NUMBER? ☐ YES ☐ NO

OTHER REQUESTS: _____

May we speak to someone else regarding your medical care? YES NO

Name of Person: Relationship:

_____

_____

I understand that I may revoke this consent at any time.

Signature: _____Date:_____

Revised 07/01/2023

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Cancellation and No-Show Policy

In order for each patient to receive the proper care we ask that you please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who has an urgent need of treatment. **IF** it is necessary to cancel your scheduled appointment, we require a minimum of 24 hours' notice to be given. Your thoughtfulness will give another person the possibility to have access to timely medical care.

Please note missing more than two appointments may result in you being discharged from New Leaf Medical Clinic, LLC.

I have read and understand this Cancellation and No-Show Policy. I understand my responsibility to plan appointments accordingly and notify the appropriate person if I need to cancel an appointment. I understand that missing more than two appointments may result in being discharged from this practice.

_
Patient/Guardian's signature Date

I give permission to New Leaf Medical Clinic, LLC, to send text messages for appointment reminders to my cell Phone.

___
Patient/Guardian's signature Date

Revised 07/01/2023

New Leaf Medical Clinic, LLC
Financial Policy

Thank you for choosing New Leaf Medical Clinic, LLC as your health care provider. We are committed to providing you with quality and affordable health care. The financial policy was developed to assist with questions you have or that may arise with regard to financial issues. We believe that stating our expectations with regards to financial issues helps us concentrate on our mission of providing excellent care.

1. **Insurance-** We participate in most insurance plans. If you are not insured by a plan we have a contract with or you are insured but do not have a copy of a current card, payment is due in full at time of service. We will bill your insurance company once we receive a copy of your current card, but payment in full will be your responsibility at the time of service.
2. **Deductibles-** Because more insurance companies are issuing policies with very high deductibles, we will need to collect at least $50 at time of service. Anything overpaid or underpaid will either be credited or billed to you after insurance has processed your claim.
3. **Co-payments-** All copays and deductibles must be paid at the time of service.
4. **Non-covered services-** It is virtually impossible for us to have knowledge of what services each insurance plan covers. ***Knowing your insurance benefits is your responsibility.*** Any questions you may have regarding those benefits or dispute of any services not covered should be directed to your insurance company.
5. **Annual Wellness Coverage-** Most insurance companies will pay for an annual wellness exam. In order for this to be billed as preventative, the provider will not be able to consider new issues, write a prescription for a new problem or perform diagnostic testing. If new problems are discussed and treated an additional office visit code is required by your insurance company. You may owe a copay or deductible for this add on service.
6. **Assignment of Benefits-** I, the undersigned, realize all medical charges incurred are my responsibility and payable by me regardless of what my insurance pays. I hereby authorize and direct my insurance carrier(s) to pay directly to New Leaf Medical Clinic, LLC, any benefits due under my insurance plan. I agree to pay the balance of expenses not paid under this plan, including deductibles and co-payments.

I have read and understand the financial policy and agree to abide by it.

Signature of patient (if minor, parent or legal guardian must sign) Date

Revised 07/01/2023

New Leaf Medical Clinic, LLC
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HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name: _____DOB: ____/____/_____

Address: _____ City, State & Zip Code: _____

Social Security Number: _____/_____/_____ Phone Number:_____

I, _____authorize:

_____
Name and address of Organization / Provider

_____
to release information concerning the patient identified above, in accordance with state and federal laws, to the following: **New Leaf Medical Clinic, LLC, 710 W. Hobbs Street, Athens, AL 35611**
Phone: 256-800-2105 Fax: 256-800-2107

1. Specific information to be disclosed (mark all that apply)
   ☐ Discharge summary ☐ Psychological Evaluations ☐ Progress Notes ☐ History and Physical Examination ☐ Lab Reports ☐ Radiology Reports ☐ Consultation Reports ☐ EKG / Stress Test ☐ ER Records ☐ Home health ☐ Other _____
   For the following date(s) of treatment or medical conditions:
   _____
2. With the exception of psychotherapy notes, I authorize all information that may be contained in my medical records pertaining to psychiatric/ mental health, chemical dependence, and or AIDS/HIV-related illness/testing to be released unless otherwise specified here:
   _____
3. I am requesting this information be released for one of the following purposes:
   ☐ Continued Care ☐ Insurance Claim ☐ Personal use ☐ Attorney Review
4. I understand I may revoke this authorization by written request at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization
5. I understand there may be a fee to process this information
6. This authorization will automatically expire one year from the date of my signature
7. New Leaf Medical Clinic, LLC, will not condition my continued treatment upon me signing this authorization.

_____
Patient or Patient's Legal representative's Signature Date

_____
Relationship if other than patient

Revised 07/01/2023

New Leaf Medical Clinic, LLC
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Acknowledgement of Receipt of Notice

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices with effective date of July 1, 2023.

Signed: _____ Date: _____

Print Name: _____Telephone: _____

If not signed by the patient, please indicate your relationship to the patient:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient

Name of Patient: _____

Revised 07/01/2023

New Leaf Medical Clinic, LLC
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Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we have shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we will tell you why in writing within 60 days.
- Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.
- Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Get a list of those with whom we have shared information
- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- Get a copy of this privacy notice
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.
- File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page one.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This notice of Privacy Practices applies to New Leaf Medical Clinic, LLC

Privacy Officer:
Compliance Manager/Privacy Officer
710 West Hobbs Street
Athens, AL 35611

256-800-2105 newleafmedicalclinicllc@gmail.com

Effective Date: July 1, 2023