PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Single ❑ Married	Referring Physician:

Social Security Number	Daytime Phone ( )	Cell Phone ( )	Birth Date / /	Age	Gender ❑ Male ❑ Female

Address	City	State / Zip

Email Address	Spouse Name	Spouse Birth Date / /	Spouse Phone ( )

Preferred Language:	❑ Ethnicity: *(optional)*

Are you: (check one) ❑ Employed ❑ Student ❑ Retired	Employer	Employer Phone ( )

GUARANTOR (IF PATIENT IS A MINOR OR NOT THE POLICY HOLDER)

Person Responsible for Charges	Birth Date / /	Social Security Number	Phone ( )

Address (if different)	Employer	Employer Phone ( )

INSURANCE INFORMATION

PLEASE GIVE YOUR ID AND INSURANCE CARD(S) TO THE RECEPTIONIST

Is the patient covered by health insurance? ❑ Yes ❑ No ❑ Worker's Compensation

Policy Number ___________________

PRIMARY Insurance Company Name: ____

Group Number ___________________

Who is the subscriber? ❑ Patient ❑ Spouse ❑ Parent/Guardian ❑ Other

⇨ Subscriber's Name: Subscriber's Birth Date: / / Subscriber's SSN:

SECONDARY Insurance Company Name: ____ Policy Number ___________________

Who is the subscriber? ❑ Patient ❑ Spouse ❑ Parent/Guardian ❑ Other

Group Number ___________________

⇨ Subscriber's Name Subscriber's Birth Date: / / Subscriber's SSN:

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Phone ( )

The above information is true to the best of my knowledge. I authorize *Dr. Abdelaziz Group* to administer treatment to the above patient. I authorize payment directly to *Dr. Abdelaziz Group* of the medical insurance benefits otherwise payable to me for medical services rendered. I understand I am financially responsible for any charges not covered by insurance. I reviewed a copy of and agree to *Dr. Abdelaziz Group* policies including *Notice of Privacy Practices, Controlled Substances Policies* and *Statement Of Financial Responsibility.*

X ____

PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

1417 NW 150th St
SUITE P
EDMOND, OK 73013

TEL: (405) 896-6777
DrAbdelazizGroup.com
Staff@DrAbdelazizGroup.com

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Statement of Patient Financial Responsibility

Patient Name: ____ **DOB:** _______________________

Guardian/ Guarantor Name: ____

Dr. Abdelaziz Group appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for pre-authorization of coverage and any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

Co-Pay Policy: Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at each visit.

Self-Pay: If you do not have health insurance, you understand that you will be responsible for services rendered at **Dr. Abdelaziz Group** and agree to pay the full and entire amount for services provided to you or to the above named patient prior to each visit, unless (on a case by case basis) a discount or a payment plan agreement is authorized by **Dr.Abdelaziz Group.** Self-Pay pricing:

- **New Patient Assessment/ Evaluation: $400**
- **Follow up, medications only: $150**
- **Follow up, Therapy and medications: $300**
- **Urine Drug Screening: $50 Confirmation of drug screening results: $300**

Consent for Treatment and Authorization to Release Information: You authorize **Dr.Abdelaziz Group**, through its appropriate personnel, to perform upon you, or the above named patient, appropriate assessment and treatment procedures. You further authorize **Dr. Abdelaziz Group**, to release to appropriate agencies any information acquired in the course of your or the above named patient's examination and treatment.

Cancellation / No Show Policy: We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment and to reschedule at that time. We will attempt to remind you of your upcoming appointment.

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Cancelled appointments without a 24-hours' notice or a No Show may result in a $25 charge. If you do not show for two consecutive appointments or cancel more than three appointments in 3 months period, you may be discharged from care. In such case, **Dr. Abdelaziz Group** will notify you in writing, via certified mail, that you are discharged from care.

Services not covered by your insurance: Some services are not covered by your insurance. Time spent on providing those services is time taken away from helping other patients with their medical needs. Please try to minimize such requests if possible. Examples are:

- **Cancelled appointments without a 24-hours' notice or No Show: $50**
- **Mailing scripts (instead of pick up): $10**
- **One page Form: $25**
- **One page concise report / letter: $50**
- **Two to Five page detailed Form: $50**
- **Two to Five page detailed report / letter: $100**
- **Legal matters/ Communications with Attorneys/ Court related matters, Functionality (Disability) assessments:** Will be discussed on a case by case basis (Has to be done in person and scheduled as an appointment in advance).
- **Test interpretation, collaboration with other professionals outside what it is covered by your insurance:** You will notified of cost and given a reasonable notice prior to service.

I have read the above policy regarding my financial responsibility to **Dr.Abdelaziz Group**, for providing services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to **Dr.Abdelaziz Group**, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Name: ____ **DOB:** ____________________

Guardian/ Guarantor Name:_ ____

Patient (Guardian/Guarantor) Signature____________________________________**Date**___________________

(Financial Policy, Page2)

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Controlled Substances Policy

To insure proper medical care to our patients, we ask that you adhere to the following rules regarding controlled substances:

- Once controlled medications are prescribed to you or your child, you will be required to have follow-up office visits to assess your (or your child) medical need to continue receiving those medications. Your medications will not be refilled if you are unable to keep these appointments (except on case by case basis only).

- As long as you receive treatment at Dr. Abdelaziz Group, we should be the only place to prescribe controlled psychiatric medications to you. It is your responsibility to notify us of any other physician who is prescribing controlled medications to you. It is also your responsibility to inform other physicians that we are prescribing and managing your controlled psychiatric medications.

- Excessive calls requesting controlled psychiatric medications or an increase in the dose or frequency of your medications is viewed as drug seeking behavior and is not tolerated. You will be asked to make an appointment to see the doctor before any changes are made.

- Controlled psychiatric medications refill requests are handled Tuesday through Thursday from 11:00 AM to 3:30 PM only. Prescription refill requests are not processed on Friday, Saturday, Sunday, Monday, Holidays or after hours. Prescription refills will be processed within 3 business days of the request.

- Lost, stolen, or misplaced controlled prescriptions or medications will not be replaced. Your medications and prescriptions are your responsibility.

- You consent to a random drug screening at any point throughout your treatment.
- Refusal of a drug screen test and/or drug seeking behavior constitute grounds for discharge from our service.

Patient Name *(Print)*: ____

Guardian Name *(if applicable)*: ____

Patient or Guardian Signature: ______________________________ **Date:** _____________

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Medications

Patient Name:____ **Date:** ___________________

Current Medication	Dose and Frequency	Reason for taking	Prescriber	Date Started	Side effects?
EXAMPLE: Tylenol	*100 mg once daily*	*Headaches*	*Dr. John Smith*	*12/3/2000*	*none*
Discontinued Medications	**Dose and Frequency**	**Reason for taking**	**Prescriber**	**Date Started** **Date Stopped**	**Side Effects** **Reason Stopped**

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Initial Intake

Name:____**Date:** __________________________

Referral Source: (Please indicate if you were referred by family/friend/School/Physician/Counselor or ordered to be evaluated):

____

Reason for Visit: *(Please list current problems and a time line)* ____

____

____

____

____

Evaluation/Treatment Goals:____

Current Suicidal thoughts/plans? ____

Past Suicidal thoughts/plans? *(Please include dates):* ____

Current Alcohol/Substance use/Smoking:____

Past Alcohol/Substance use/Smoking: *(Please include dates):* ____

____

Current Treatments/ Counseling/ Psychiatrist *(Please include dates):*____

____

Past Conditions/ Treatments/ Counseling/ Psychiatrist *(Please include dates):* _______________________________

____

____

Inpatient Admissions *(Please include dates):* ____

____

Family History of Mental illness:____

____

Developmental History *(Birth issues, milestones, Speech, Delays...etc):*____

____

Social History *(Marital status/ Children/ Housing/ Employment/ Education/ Disability):*___________________________

____

____

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Notice of Privacy Practices

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.

SUMMARY

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've 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.

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- *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. In order to access and inspect your protected health information, we ask that you request in writing using the **Oklahoma Standard Authorization to Use or Share Protected Health Information (PHI) Form**. 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. Oklahoma State allows us to charge $0.50 per page for hard copies or $0.30 per digital copy.

- *Ask us to correct your medical record:*

You can ask us to correct health information about you that you think is incorrect or incomplete. We ask that you submit your request in writing to us. We may say "no" to your request, but we'll tell you why in writing within 60 days. If you need assistance, please ask and we will refer you to the appropriate representative.

- *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've shared information:*

You can ask for a list (accounting) of the times we've 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 you asked us to make. We'll 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 directly by mail, phone or fax. 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 *(we may ask that you request this in writing using the* **Oklahoma Standard Authorization to Use or Share Protected Health Information (PHI) Form***;* 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.

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- *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 have to 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're 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

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- 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.

***Privacy official contact*:** **Operations Administrator**
Email: Operations@DrAbdelazizGroup.com
Phone: 405-896-6777
Address: *1218 E 9th St. Suite 1, Edmond, OK 73034* ***Tel:*** *405-896-6777*
Effective Date of this Notice: 10/21/2015

Acknowledgement of Notice of Privacy Practices

By signing below, I acknowledge that I have reviewed a copy of Dr. Abdelaziz Group's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Operations Administrator listed above. Dr. Abdelaziz Group will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified or changed in any way. I also understand that a copy of these documents has been made available to me upon request.

X____ X____________________
SIGNATURE OF PATIENT AND/OR LEGAL REPRESENTATIVE ***DATE***

X____
PRINTED NAME OF PATIENT (AND/OR LEGAL REPRESENTATIVE IF APPLICABLE)

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OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name:________________________________ Medical Record #:____________________________

Date of Birth:__________________________________ Social Security #:____________________________

I hereby authorize ____
Name of Person/Organization Disclosing PHI

to release the following information to ____
Name and Address of Person/Organization Receiving PHI

Information to be shared:

☐ Psychotherapy Notes (if checking this box, no other boxes may be checked) ☐ Entire Medical Record

☐ Billing Information for___________________________________ ☐Mental Health Records

☐ Substance Abuse Records ☐ Medical information compiled between___________ and ___________

☐ Other:____

The information may be disclosed for the following purpose(s) only:

☐ Insurance ☐ Continued Treatment ☐ Legal ☐ At my or my representative's request

☐ Other:____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event:____

____

____________________________________ ___________________________________
Signature of Patient or Legal Representative | Date

____________________________________ ___________________________________
Description of Legal Representative's Authority | Expiration date (if longer than one year from date of signature or no event is indicated)

Oklahoma State Department of Health
Community and Family Health Services/ Administration HIPAA Document - retain for a minimum of 6 years
ODH 206
August 2014

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