Cedar Street Medical Associates, LLC
220 Cedar Street
Hartselle, Alabama 35640

WE DO NOT PARTICIPATE IN WORKMAN'S COMP OR NO FAULT

Date: _____/_____/_____ Chart # (office use): _____ Office Staff: _____

Patient Information (Please Print)

Provider to see: _____ Pharmacy: _____

Last Name: _____ First Name: _____ MI: ___ Male / Female

Nickname: _____ (preferred name)

Address:_____

City: _____ County: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Other: _____

Can we send text reminders to your cell phone: Y / N

SSN: _____ Date of Birth: _____ married / single / widowed / divorced

Email: _____

Employer: _____ Employer Phone: _____

Race: ___ White ___ Black/African American ___ Native Hawaiian/Island Pacifican

___ American Indian/ Alaskan Native ____ Asian ____Declined/unknown ___ Other

Mother's Name / DOB (if under 21): _____

Father's Name / DOB (if under 21): _____

Primary Insurance: _____

Policy Holder: _____ DOB: _____ Employer: _____

Relationship to insured: ___ self ___ spouse ___ child ___ other

Secondary Insurance: _____

Policy Holder: _____ DOB: _____ Employer _____

Relationship to insured: ___ self ___ spouse ___ child ___ other

Emergency Contacts (other than inside the home)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

PATIENT RESPONSIBILITY DISCLOSURE STATEMENT

Your signature below forms a binding agreement between Cedar Street Medical Associates, LLC (the provider of medical services) and the Patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years of age). The Responsible Party is the individual who is financially responsible for payment of medical bills.

PLEASE INITIAL ALL

_____ I am responsible for and expected to pay Cedar Street Medical Associates, LLC for the following:

1. Any co-payment as set by my insurance carrier
2. Any unsatisfied deductible or termination of coverage
3. Any amount my insurance carrier deems my responsibility
4. Any amount considered non-covered by my insurance carrier
5. Any amount for paperwork/letters completed by the physician/CRNP (FMLA, medical letters, etc.)

_____ **Co-Pays**: All co-pays are due at the time of service. If your insurance requires any additional co-pays, you will be responsible for payment and will be billed for it.

_____ **Authorization to pay benefits to the physician**: Any and all insurance checks that may go directly to the patient MUST be signed over to Cedar Street Medical Associates, LLC for payment for services rendered. Failure to do this, will result in the patient receiving a bill for services. I hereby authorize payment for medical services provided directly to Cedar Street Medical Associates, LLC physician. If I should receive any insurance payments, I am to sign the check over to Cedar Street Medical Associates, LLC

_____ **To obtain Payment for Treatment:** We may use and disclose your PHI (Protected Health Information) in order to bill and collect payment for the treatment and services provided to you. We reserve the right to disclose your information to our business associates such as billing companies, claim processing companies, collection agencies, and others that process our healthcare claims.

_____ **Workman's Compensation/No Fault**: Cedar Street Medical Associates, LLC is not a provider for No Fault or Workman's Compensation injuries. By initialing, you acknowledge your understanding that injuries of this class will not and cannot be submitted to your insurance company by your or Cedar Street Medical Associates, LLC for reimbursement.

_____ In the event the charges incurred are not paid in full when due, and collection activity is instituted, whether by a collection agency or an attorney (or both), **I agree to be responsible for, and pay,** in addition to the charges incurred, all costs associated with such collection activity including, but not limited to, reasonable collection fees, attorney fees, court costs, contingent fees to collection agencies of not less than thirty percent (30%).

_____ Cedar Street Medical Associates, LLC reserves the right to transfer unpaid balances to outside entities for collection, such as banks or financial institutions who may report unpaid balances to credit bureaus.

_____ The provider of service has the right to terminate services based on noncompliance of this agreement.

I also understand that I will be responsible for any charges incurred by not providing the most current, correct insurance information to Warehouse Primary Care & Specialty Clinic, Inc..

Patient Name: _____ Date: _____

Signature or Parent / Guardian: _____

Name _____ DOB _____ Chart # _____

Patient HIPAA Awareness

As a results of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the U.S. Department of Health and Human Services Office for Civil Rights, we are not permitted to release patient information except stated in the Notice of Privacy Practice, or in accordance with your wishes as stated below.

This waiver authorizes Cedar Street Medical Associates, LLC to send/give medical information as noted:

Patient Name (First) _____ (Last) _____ (Please Print)

Please answer the following. Circle Yes or No.

1. **YES or NO** Leave a voicemail recording including my Personal Health Information on my home / cell phone.

2. **YES or NO** Speak to an individual of my choosing (Personal Representative_ regarding my Personal Health and Billing Information and permit him/her to receive prescriptions and/or test results on my behalf

   Name of Representative _____

   Relationship _____

   Phone Number _____

3. **YES or NO** Speak to and individual in the event of a medical emergency _____(check if same as above)

   Name of Emergency Contact _____

   Relationship _____

   Phone Number _____

4. **YES or NO** Send an email/ text notifying me to contact the office to discuss my lab/test results (we will **not** send Personal Health Information over the internet).

   Email Address _____

   Cell Phone for Texts: _____

Provide ***initials*** of responsible party below.

____ **Diagnostic/Lab Testing:** I understand that if testing outside of the clinic is ordered, I am financially responsible for any charges not covered by my insurance(s). I also understand that as a courtesy the clinic will provide my insurance information that I have provided Cedar Street Medical Associates, LLC to the testing facility.

____ **Authorization for Release of Information:** I hereby authorize Cedar Street Medical Associates, LLC to release any information requested by this insurance company necessary to collect benefits on this claim. Unless noted below, this authorization includes, but is not limited to, the release of information related to drug, alcohol, HIV antibody and/or psychiatric testing. I further authorize any physician or institution that attended this patient previously to furnish medical records or other information that may be requested by Cedar Street Medical Associates, LLC

____ I consent for photos to be made of me or my child (or for the person whom I am legal guardian). I understand that the information is used in my medical record for identification and some instances for my care.

On this date _____, I reviewed/received Cedar Street Medical Associates, LLC Notice of Privacy Practices, which describe how my medical information may be used and disclosed, and explains how I can get access to this information.

The authorizations made on page 3, the Patient HIPAA Awareness Form ,will remain in effect until I notify Cedar Street Medical Associates, LLC in writing, by certified mail, of requested changes.

_____	_____
Signature of Patient or Legal Guardian	Patient's Name
_____	_____
Print Name of Patient or Legal Guardian	Today's Date

Name _____ DOB _____ Chart # _____

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program

ePrescribing is a way for doctors to electronically send an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- Medication history transaction – Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at Cedar Street Medical Associates, LLC as well as other health care providers involved in you care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent in the release of this and other health sensitive information.***

Consent

By signing this consent form, you are agreeing that your provider at Cedar Street Medical Associates, LLC may request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to receive medical care, payment for your medical care, or your medical care benefits. Your choice to give or deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing, but if you do it will not have an effect on any actions taken prior to receiving the revocation. Understanding all of the above, I hereby provide informed consent to Cedar Street Medical Associates, LLC been answered to my satisfaction.

_____ Print Patient Name _____ DOB

_____ Signature of Patient or Guardian _____Today's Date

_____ Relationship to Patient