Haidar, Almhana, Nieding LLC

223 Miller Road
Avon Lake, Ohio 44012
Phone (440) 930-2002 Fax (440) 930-2085

Patient Registration

Date: _____

Patient Name: _____ **Gender:** _____

DOB: _____ Last Four Digits of Social Security Number: _____

Marital Status: *Single* *Married* *Divorced* *Widowed*

Street Address: _____ City: _____ Zip: _____

Home Phone Number: _____ OK to Leave Message? *Yes* *No*

Cell Phone Number: _____ OK to Leave Message? *Yes* *No*

Work Phone Number: _____ OK to Leave Message? *Yes* *No*

Is Patient a Minor? *Yes* *No* **Name of School:** _____ **Grade:** _____

Patient Employer: _____ Occupation: _____

Spouse's Name: _____ DOB: _____

Emergency Contact: _____ Relationship to Patient: _____

Home Phone Number: _____ OK to Leave Message? *Yes* *No*

Cell Phone Number: _____ OK to Leave Message? *Yes* *No*

Work Phone Number: _____ OK to Leave Message? *Yes* *No*

Primary Care Physician: _____

Referral: _____

Pharmacy: _____

Responsible Party Name (if other than patient): _____

DOB: _____ Gender: _____

Street Address: _____ City: _____ Zip: _____

Home Phone Number: _____ OK to Leave Message? *Yes* *No*

Cell Phone Number: _____ OK to Leave Message? *Yes* *No*

Work Phone Number: _____ OK to Leave Message? *Yes* *No*

Relationship to Patient: *Legal Guardian (if applicable)* *Power of Attorney (if applicable)*

Primary Insurance: _____

Identification Number: _____ Group Number: _____

Policy Holder: _____ Gender: _____

DOB: _____ Last Four Digits of Social Security Number: _____

Relationship to Patient: _____ Insurance Phone Number: _____

Secondary Insurance: _____

Identification Number: _____ Group Number: _____

Policy Holder: _____ Gender: _____

DOB: _____ Last Four Digits of Social Security Number: _____

Relationship to Patient: _____ Insurance Phone Number: _____

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Please present your insurance card (s) to the receptionist so that a copy can be made for our records.

Assignment and Release

I request that payment of authorized Medicare or insurance benefits be made either to me or on my behalf to Haidar, Almhana, Nieding, LLC for any services furnished to me by any provider of this group. I authorize any holder of medical information about me to release to the appropriate party for benefit determination and payment for services I received. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay any claims. I understand that I am financially responsible for all charges whether or not paid by my insurance.

Patient/Guardian:	Date:
Printed Name:	Relation to patient:
Witness:	Date:

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Practice Policy Statement & Consent

Welcome to the office of Haidar, Almhana, & Nieding LLC. The goal of our practice is to give the best of care to all patients, regardless of race, creed, sex, or financial status. To help you get acquainted with our office, below is some general information.

- The office hours are Monday through Friday with varying hours. Please contact the office for specific times.
- Psychiatrist Initial evaluations are $300.00, and follow-up appointments are generally $120-$200, depending on the complexity of the appointment.
- You are responsible for any co-payment at the time of service unless other arrangements have been made in advance. Payment may be made in cash, check, or by credit card. However, there is a $40 charge for returned checks and future payments must be made in cash or with a credit card.
- As a service to you, we will complete and mail all insurance claims to your insurance company. Signing this form will allow the release of information, written or verbal, necessary to secure payment from your insurance company. You are responsible for any amount not paid by your insurance, (i.e. co-payments, deductibles, etc.) so please contact them to learn what coverage you have. Some plans cover only a certain number of visits, and it is your responsibility to keep track of this. You are responsible for getting any authorizations that are required by your insurance plan for the first set of visits with each provider. Failure to obtain the required authorization from your insurance company means that you will be financially responsible for all visits denied by the insurance.
- If you need to speak with the office or want to leave a message for a return call, you may leave your name, telephone number and a brief message on our voice mail. If there Is an emergency, go to the nearest emergency room if you need immediate care.
- We require 48 hours notice if you need to reschedule or cancel your appointment. If you do not cancel or reschedule your appointment at least 48 hours before the scheduled time, you will be charged $60. If you do not show up for your appointment, you will be charged a $120.00 no show fee. These charges are not covered by your insurance and must be paid before another appointment can be set up.
- Any combination of two or more cancellations or no shows may be grounds for dismissal from the practice. An inactive patient account of 6 months or more may also be grounds for dismissal from the practice.
- If an appointment cancellation results in additional refills being needed, there may be a refill fee applied to the account of $30, Care without an appointment fee.
- We understand emergencies can happen. Therefore, we allow for one late cancellation with waiver of the late cancellation change, if you reschedule your appointment at the same time you cancel.
- No records can be sent out of the office unless your account is paid in full.
- The office paperwork processing fee is $35 and must be paid before paperwork/records will be released.
- If you see more than one provider in this office, most insurance companies do not allow you to see more than one provider in a day. Therefore, only one visit would be covered by insurance, and the other visit would be paid out of pocket. It is your responsibility to keep track of your appointments.
- Confidentiality is of the utmost importance. However, confidentiality can be breached if: You are a danger to yourself, you are a danger to another person or There is a report or suspicion of any child abuse.

We hope this information is helpful to you. Signing this form indicates that you have read and understand our office policies.

Patient/Guardian:	Date:
Printed Name:	Relation to patient:
Witness:	Date:

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Practice Privacy Statement & Consent

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.

This Is a formal notification, as required by the government concerning the privacy policy of this practice. This practice has an obligation to maintain all medical information in the strictest of confidence. Our practice cannot release information without your written consent, including medical records, conversations, reminder calls, test results and other confidential issues. Patient information about health care is identified as 'PHI" or Protected Health Information. This new policy requires that you, the patient, identify at the time of registration with us specific information about release information. You can change this Information at any time with either written notification or verbal notification followed up in writing. Changes can only impact the care or information from that point in time forward.

Your PHI is part of your medical care, and can be used or disclosed as follows:

- For your treatment in this practice and other locations under our immediate care for care needs. This may include any mental health assessment. psychotherapy. medication management. referral for services, diagnostic tests or treatment related to your medical care needs.
- For obtaining payment for treatment with your Identified health care program. This would include any documentation related to this care, including assessments or progress notes. This would include eligibility, verification, prior authorization and claim submission.
- For operations of this practice, such as enrolling with insurance programs, hospital privileges. accounting and compliance with federal and state laws and regulations.
- Appointment reminders and health related benefit services only with your consent identified on the registration form.
- Consent is not required for emergency care and treatment. An emergency is identified as a medical condition that, Ianthe Judgment of the physician, requires Information for care on your behalf.

Certain disclosures can be made without your consent as follows:

- Disclosure required by the government or law enforcement agencies. An example would be victims of abuse.
- Information used for public health purposes, medical examiners or related to a person's death or for the health department for disease tracking.
- Information used for health care oversight, such as a site review by an insurance program.

Your rights for your health Information include: The right to request limits on the uses and disclosure at registration or any time during your care. The right to choose how we send this information to you, including an alternate address. The right to see and obtain copies of your PHI. but there may be a copy and postage fee. The right to get a listing of who we have made disclosures to regarding your PHI. The right to correct your file through an amendment process if appropriate.

This practice reserves the right to modify or change this Privacy Statement and process at any time. Revision to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice.

If you have a concern or complaint about how your protected health information is being used, from this time forward you should first contact our Practice Administrator at our Business Office to resolve your concerns, or your main contact the office of Civil Rights or the Ohio Medicare Carrier, GBA Palmetto.

Office of Civil Rights — Regional Manager
Department of Health & Human Services
223 N. Michigan Ave.. Suite 240
Chicago, Illinois 60601

Palmetto GBA
Part B Operations — HIPPA Compliance Concerns
P.o. Box 18957
Columbus, Ohio 43218

Patient/Guardian:	Date:
Printed Name:	Relation to patient:
Witness:	Date:

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Controlled Medications Statement & Consent
Medical Marijuana

Dear Patient,

Controlled medications can be treatment options but must be closely monitored for compliance and misuse; therefore, paper or electronic prescriptions specify the number of tablets and directions for correct usage are generally given directly to the patient or sent electronically and must be requested at the time of the appointment. Such medications are NOT called in to the pharmacy.

NO CONTROLLED SUBSTANCES PRESCRIPTIONS will be sent without an appointment. It is the state law that patients be evaluated every three (3) months to maintain controlled substances prescriptions.

Please Inform your Physician if refills are needed for **any** medication at your appointment.

If a prescription is either lost, stolen or misplaced a replacement prescription will not be given. Controlled medication prescriptions are not taken lightly. The DEA closely monitors these medications to prevent the possible abuse of medication.

Please be advised that this office will now require random urine drug screenings. If you test positive for other medication which are not being prescribed, you will be dismissed from this practice.

Medical Marijuana:

Although the state of Ohio has legalized both recreational and medical Marijuana/Cannabis this remains highly illegal from the Federal governments point of view. Therefore, our providers will NOT prescribe any controlled substances in conjunction with Medical Marijuana.

You are signing this document to affirm your knowledge and receipt of the office policy regarding controlled medication.

Patient/Guardian:	Date:
Printed Name:	Relation to patient:
Witness:	Date:

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HIPAA Statement & Consent

This consent Is required by the Health Insurance Portability and Accountability Act of 1996 to Inform you of your rights for privacy with respect to your health information.

I hereby give my consent to Haidar, Almhana & Nieding, LLC to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize this psychiatry practice, and any employee working under the direction of the physician, to provide medical care to me, or to this patient for which I am the legal guardian. This medical care includes therapy, medical management, assessment of my condition and supportive care and services related to my mental health, drug and/or alcohol related conditions. This may include (but Is not limited to) evaluation of my mental status, medication management, psychotherapy, diagnostic testing, therapeutic care, rehabilitative, counseling, assessment or review of physical status/function of the body and the prescribing of drugs, or other services required for care. This consent includes contact and discussion with other health care professionals, such as social workers, psychologists or medical physicians for my care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice. My medical record may include information about mental health concerns, drug or substance abuse, and HIV or AIDS related diagnosis.

Consent related to the Privacy Notice: I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand the terms of the Practice Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand that I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If the practice does agree to my restrictions on PHI use, it is bound by this agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time. If I revoke this consent, the revocation does not take effect until the practice receives it.

Patient/Guardian: _____ Date: _____

Printed Name: _____ if not patient, relationship: _____

Revocation: I hereby revoke the consent above. Patient: _____ Date: _____

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amount applied to deductible and other amount' that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Patient/Guardian:	Date:
Printed Name:	Relation to patient:
Witness:	Date:

Haidar, Almhana & Nieding LLC dba
Quest Therapeutics of Avon Lake
223 Miller Rd
Avon Lake, OH 44012
P 440.930.2002 F 440.930.2085

Authorization to Disclose/Release Information

1. Patient Information	
Name	Date of Birth
Address	City State Zip
Phone	Email

2. Receive or Release Information From/To	
Name of Provider/Facility	Name of Family or Friend
Address	City State Zip
Phone	Fax

3. Purpose of Disclosure of Information (check all that apply)

	Continuity of Care		Family/Friend Support		Financial/Payment purpose
	Legal Purpose		Emergency Situations		Other

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health information.

I, understand that my records or information about my mental health or alcohol/drug abuse treatment and counseling are confidential: they are protected by applicable state and federal laws, and can not be disclosed or re-disclosed without written consent, unless otherwise provided for in state or federal regulations. I also understand that any information about me concerning AIDS, HIV Infections, AIDS Related Complex, counseling, and the performance of any test/results cannot be released without my authorization. I understand that I may revoke this consent at any time.

This Authorization and consent will expire One Year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice presented to Haidar, Almhana & Nieding, LLC. Any revocation will not apply to information that has already been released in response to this authorization.

If Patient Revoke this release of information at any time, _____
Date **Initial**

_____
Signature of Patient/Guardian Date

_____
Patient Printed Name Relationship if not Patient