MR #: _____ **Date:** __ __ / __ __ / __ __ __ __

Registration Form

Patient Information

Patient's Legal Name: _____
First Middle Initial Last

Former Name: _____ **Nickname:** _____

Birth Sex: Male Female **Social Security Number:** _____- _____- _____ **Date of Birth:** _____/_____/_____

Phone: _____ _____ _____
Home Work Cell

Current Address: _____

City: _____ **State:** _____ **Zip Code**: _____

Email Address: _____

Emergency Contact

Name: _____**Relationship**: _____ **Phone:** _____

Patient Demographics: (circle your response)

Sexual Orientation: Heterosexual/Straight Lesbian or Gay Bisexual Other_____

Don't Know (patient does not know) Choose not to disclose Unknown

Gender Identity: Male Female Transgender Male Transgender Female Other Choose not to disclose

Marital Status: Single Married Divorced Widowed Annulled

Race: White Black or African American Other Pacific Islander Native Hawaiian American Indian or Alaska Native

Asian Indian Chinese Filipino Japanese Korean Vietnamese Other Asian Guamanian or Chamorro

Samoan More than one Race Unreported/Refused to Report Race

Ethnicity: Not Hispanic, Latino/a or Spanish origin Hispanic or Latino/a Mexican/Mexican American/Chicano

Puerto Rican Cuban Another Hispanic, Latino/a or Spanish Origin Choose not to disclose

Preferred Language: English Lao Vietnamese Other: _____

Homeless status: Not Homeless Homeless Other: _____

Agricultural/Fishing Worker Status: Not a Farm Worker Migrant Worker Seasonal Worker

Language Barrier: Yes No

Public Housing: No Other Public Housing Tenant Based Voucher

Veteran Status: Yes No

MR #: _____ **Date:** ___ / ___ / ____

Patient Employment:

Employer Name: _____ **Employer Phone**: _____

Annual Household Income: _____

Family Size: 1 2 3 4 5 6 7 8 9 10

Guarantor Information (*Information of person financially responsible for patient*)**:**

☐ Check if same as above patient; If not please fill out the following:

Name: _____ Relationship: _____

DOB: _____/_____/_____ SSN: _____- _____- _____ Phone: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Guarantor Employer Name: _____ Employer Phone: _____

Insurance Information

Primary Insurance Plan Name: _____

Policy ID: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____/_____/_____

Subscriber SSN: _____- _____- _____ Subscriber Relationship to Insured: _____

Secondary Insurance Plan Name (*If applicable*): _____

Policy ID: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____/_____/_____

Subscriber SSN: _____- _____- _____ Subscriber Relationship to Insured: _____

Preferred Pharmacy:

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Location: _____

Patient/Legal Guardian Signature: _____ Date: _____

MR #: | | **Date:** | | | / | | | / | | | | |

ACCORDIA HEALTH

INFORMED CONSENT FOR VERBAL/ EMAIL EXCHANGE OF INFORMATION

I, _____ hereby consent to the verbal/ email exchange of information between
(Print patient name)

Accordia Health and: _____
(Name of person or organization and contact information)
_____
(Name of person or organization and contact information)
_____
(Name of person or organization and contact information)
_____
(Name of person or organization and contact information)

regarding_____
(Information that will be discussed)

For admission of _____ and for the following purpose:
(Date of admission)

☐ Facilitate Evaluation and Treatment
☐ Participate in treatment
☐ Other
Specify: _____

I understand that this consent will expire on _____ (Two years from the signature date) **or** at the time of my discharge from this program, whichever comes first. I understand that I may revoke this consent at any time. The revocation may be given *verbally or in writing*, and it will not apply to information that was discussed prior to my revocation of this consent.

I have been informed that copies of my medical record can only be released by my signing an authorization giving my permission to do so.

_____ _____
Patient Signature Date

_____ _____
Guardian/ Legal Representative Signature Date

_____ _____
Witness Signature Date

_____ _____
Witness Signature (if appropriate) Date

MR #: _____ **Date:** __ __ / __ __ / __ __ __ __

Accordia Health
STATEMENT OF UNDERSTANDING

PATIENT NAME: _____

Review each area:

Payment Agreement: For and in consideration of services rendered by Accordia, the patient (responsible person) hereby agrees to and guarantees payment of all Accordia charges incurred. I understand that if an agency or company is responsible for payment of services, that agency or company will have the right to review the services I receive at Accordia. I also understand that I may be charged a fee or co-payment for services and that it is expected, if I am responsible for the payment of these services, to pay for them as they are received. I further understand, I should contact Accordia if there are any changes to my insurance.

Methods of Payment: Our office accepts the following payment methods: Cash, Personal Check, Credit Cards and Money Orders. ***There will be a $25.00 NSF charge for all returned checks.***

Fee Schedule: I understand that I am responsible for payment of services rendered by Accordia Health, Inc. at its standard rates provided to me on the fee schedule.

Sliding Fee Scale Program: Accordia Health maintains a system in place to determine eligibility for patient discounts adjusted based on the patient's ability to pay. Qualified individuals may apply to participate in the reduced fee program by completing an application available at the Receptionist desk. Once a patient's ability to pay is determined, the patient is expected to pay for services based on the assigned percentage of charges they are deemed able to pay.

Self-Pay: I agree to pay Accordia in full for services rendered.

Co-Payments and Deductibles: All Co-payments and Deductibles are to be paid at the time of service.

Late Shows: If you are 15 minutes late or greater for your appointment, it will be at the discretion of the Provider to see you.

Medicaid: Patient certifies that the information given in applying for payment under Title XIX (19) of the Social Security Act is correct. Patient authorizes any holder of medical or other information about the patient to release to the respective State Medicaid Agency or its intermediaries or insurance carriers any information needed for this or a related medical claim. Patient requests that payment of authorized benefits be made on his/her behalf.

Medicare: Patient certifies that the information given in applying for payment under Title XVIII (18) of the Social Security Act is correct. Patient authorizes any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or insurance carriers any information needed for this or a related medical claim. Patient requests that payment of authorized benefits be made on his/her behalf.

Assignment of Insurance Benefits and Agreement to Pay Any Balance: Patient (responsible party) irrevocably assigns and transfers to Accordia all right, title and interest to medical reimbursement benefits under any and all applicable medical insurance policies covering Patient, for the payment of treatment and medical care being provided. Patient (responsible party) authorizes payment directly to Accordia Health of said medical reimbursement benefits. Patient (responsible party) is responsible for any co-payments, co-insurance, deductibles, and/or other amounts specified by my insurance. In the event the said medical insurance coverage is not sufficient to satisfy the Accordia charge in full, Patient (responsible party) acknowledges that the resulting balance is not covered by this assignment and agrees to be fully responsible for the payment. I understand that my agreement with my insurance carrier is a private one, and that Accordia does not routinely research why my insurance carrier has not paid or why it paid less than anticipated for care.

Health Information Exchange (HIE): Accordia participates in a HIE called Care Quality and other designated HIEs. I understand that any physician or hospital that participates in the HIE either directly or indirectly may request for the purpose of my continuity of care the following limited set of records regarding my care: Allergies, Demographics, Labs, Immunizations Medications, and Problem Lists. You may choose to Opt-Out of allowing your health information to be shared through the HIE by requesting an Opt-out form.
All other releases will follow the practices explained in your Notice of Privacy Practices.

Patient Rights Statement: I understand that Accordia subscribes to a Patient Rights Statement, which has been made available to me. I have had the opportunity to have the Patient Rights Statement explained to me.

Referral Management: I understand that I will be provided referral information if appropriate.

Procedure to Review Records: I have been furnished with a copy of the Procedure to Review my health record and had it explained to me.

Notice of Privacy Practices: I have been furnished a copy of the Notice of Privacy Practices and have had it explained to me. I understand that the information concerning the treatment of _____ will be held in confidence by the Accordia staff unless I give specific written consent for the release of information. In case of emergency Accordia is authorized to request or release that information which is essential to handle the emergency. Also, Accordia staff will not release any information except as required by law or Court Order under compelling disclosure, or in a situation deemed potentially life-threatening, and in the following instances: Suspected Child Abuse, threats of physical harm to self and/or others, espionage or sabotage.
The confidentiality of your participation may also be protected by federal and state laws and regulations. The violation of federal requirements is a crime, and suspected violations may be reported. Federal regulations do not protect from disclosure of information related to a patient's commission of a crime against Accordia property or personnel, or reports under state law of suspected child abuse or neglect (See 42 U.S.C. 290 ee 3 for federal laws 42 CFR Part 2 for federal regulations).
Please refer to the Health Information Exchange section of this document for HIE information.
Advance Directives: ___ I have a medical advance directive and have provided a copy to Accordia. __ I do not have a medical advance directive and have been provided information by Accordia.

Rehabilitation Act: It is the policy of Accordia, in compliance with Section 504 of the Rehabilitation Act of l973, to afford qualified handicapped persons an opportunity to receive benefits or services that are equal to that offered non-handicapped persons. Any person who feels he/she has not received treatment in accordance with this policy may submit a complaint with the Patient Relations Department, Accordia Health, 5750-A Southland Drive., Mobile, Al. 36693.

Primary Care Telehealth Services: I have been furnished information regarding Telehealth. I understand that the information obtained while using Telehealth may be used for diagnosis, therapy, follow-up, referral, and/or consultation, and may include one or both of the following: Live two-way audio and video and output data from medical devices and sound and audio files. The interactive tele-video equipment and telecommunication lines used are HIPAA approved for patient security and privacy. I understand the expected benefits and potential risks of participating in Telehealth. I also understand that my telehealth services will be provided by Accordia Health Credentialed Staff.

****By signing below, I agree and have reviewed the Statement of Understanding and consent forms required by Accordia Health. ****

_____

Print Patient's Name | Patient's Signature | Date

_____ _____

Parent/Legal Representative Signature | Date | Witness Signature | Date

_____

Second Witness Signature **(required when signed with a mark)**

Created: 3/14/18 Revised 10/11/2022 NB-83

MR #: ____________ Date: __ __ / __ __ / __ __ __ __

CONSENT FOR TREATMENT AND DISCLOSURE OF HEALTH INFORMATION

PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Treatment: I hereby authorize Accordia to provide me with needed medical treatment and services by the Doctors and Certified Nurse Practitioners (CRNP) of this Primary Medical Care clinic. I understand that treatment and services may include lab tests, screening tests, diagnostic tests, and routine exams (Including tests for HIV and COVID-19).

Purpose of Consent for Disclosure: As part of my healthcare, Accordia Health originates and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third- party payer can verify that services billed were actually provided,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals,
- A basis for Accordia Health to review my health information and consider my potential eligibility for recruitment into various clinical trials.

Notice of Privacy Practices: I have been furnished a copy of the Notice of Privacy Practices and have had it explained to me. I understand that the information concerning the treatment will be held in confidence by the Accordia staff unless I give specific written consent for the release of information. In case of emergency Accordia is authorized to request or release that information which is essential to handle the emergency. Also, Accordia staff will not release any information except as required by law or Court Order under compelling disclosure, or in a situation deemed potentially life-threatening, and in the following instances: Suspected Child Abuse, threats of physical harm to self and/or others, espionage, or sabotage. The confidentiality of your participation may also be protected by federal and state laws and regulations. The violation of federal requirements is a crime, and suspected violations may be reported. Federal regulations do not protect from disclosure of information related to a Patient's commission of a crime against Accordia property or personnel, or reports under state law of suspected child abuse or neglect (See 42 U.S.C. 290 ee 3 for federal laws 42 CFR Part 2 for federal regulations).

E-mail Communications: By signing below and providing the relevant contact information I consent to allow Accordia Health to communicate with me via e-mail. I understand that communications via e-mail may not be secure, and my personal health information could be intercepted and breached. I agree that the company will not be liable for the protection of my health information that I have requested be communicated via e-mail.
E-mail address: ____
Cell phone number including area code: ____

Consent for Residents, Interns, and Medical and Nursing Students to Participate in my Treatment: I am aware that, residents, interns, medical and nursing students, could be present for educational purposes. I understand that in the educational process they may observe or participate in my or my child's treatment and/or review my or my child's medical record.

Consent to Photographs: I consent to have my photograph taken by the staff at Accordia as part of the admission process. I understand that this photograph will be placed in my individual medical record in keeping with this facility's system of patient identification and will be used for identification purposes only when necessary, during the course of my treatment.

MR #: | | **Date:** | | | / | | | / | | | | |

Right to Revoke: You have the right to revoke this Consent at any time by giving written notice of my revocation submitted to Accordia Health. Please understand that revocation of this Consent will *not* affect any action we took prior to this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the consents listed above and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

_____ _____/_____/_____
Signature of Patient Date

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

_____ _____/_____/_____
Signature of Personal Representative Date

Relationship to Patient _____

MR #: _____ **Date:** ☐☐ / ☐☐ / ☐☐☐☐

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

All information contained in this questionnaire is strictly confidential and will become a part of your medical record.

Name: _____
Last First MI

Sex: ☐ Male ☐ Female Date of Birth: _____/_____/_____ Age: _____

What is the main reason for your visit today? _____

Is it related to an accident? ☐ No ☐ Yes, it is ☐ Work Injury ☐ Motor vehicle accident ☐ Other:_____

ALLERGIES: Do you have any drug/food allergies or intolerances? ☐ No ☐ Yes; please describe below

_____

_____

MEDICATIONS: Please list all medications that you are taking, including non-prescription medications (Advil, Aleve, Motrin, Tylenol, etc.), vitamins, and supplements.

Name of drug	Dose (strength and times taken per day)	How long have you taken this?

IMMUNIZATIONS: Please enter the year of any vaccinations you have had.

☐ Hepatitis A _____ ☐ Flu Shot _____ ☐ Meningitis _____ ☐ MMR _____

☐ Hepatitis B _____ ☐ Pneumonia _____ ☐ Shingles _____ ☐ Tetanus _____

☐ HPV _____ ☐ Chicken Pox (shot or illness) _____ ☐ Other: _____

Have you had a colonoscopy/sigmoidoscopy?

☐ No ☐ Yes; when and where was it performed? _____

WOMEN ONLY:

Number of pregnancies: _____ Number of children: _____ Number of miscarriages: _____ Number of abortions: _____

Last pap smear (date and location): _____ Have you had an abnormal pap smear? ☐ Yes ☐No

Last period: _____ Age at first period: _____ Age at menopause: _____

Last bone density scan (date and location): _____

Last mammogram (date and location): _____

MEN ONLY:

Last prostate exam (date and location): _____

Last PSA (prostate blood test) (date and location): _____

HOSPITALIZATIONS/SURGERIES: Please list the hospitalizations and/or surgeries and the reason:

Year	Reason for surgery/hospitalization	Hospital

MR #: _____ **Date:** ☐☐ / ☐☐ / ☐☐☐☐

PAST MEDICAL HISTORY: Do you now or have you had any of the following?

☐ Alcohol/Drug abuse	☐ Allergy (hay fever)	☐ Anemia
☐ Arthritis	☐ Asthma	☐ Blood clot
☐ Bruising	☐ Cancer (type _____)	☐ Cataracts
☐ Depression/ Anxiety	☐ Diabetes	☐ Difficulty breathing
☐ Dizziness	☐ Eczema	☐ Emphysema
☐ Eye pain	☐ Fainting or loss of consciousness	☐ Fatigue
☐ Fractures (broken bones)	☐ Gallbladder disease	☐ Glaucoma
☐ Gout	☐ Hair loss	☐ Hearing loss
☐ Heartburn/ Reflux	☐ Heart attack (when _____)	☐ Heart problems
☐ Hepatitis	☐ High blood pressure (hypertension)	☐ High cholesterol
☐ HIV/AIDS	☐ Hyperthyroidism	☐ Hypothyroidism
☐ Jaw pain/TMJ	☐ Kidney disease/ problems	☐ Leg pain/swelling
☐ Liver disease/ problems	☐ Memory loss	☐ Migraine headaches
☐ Muscle weakness	☐ Nausea	☐ Night sweats/hot flashes
☐ Osteoporosis	☐ Pneumonia	☐ Prostate disease/ problems
☐ Psoriasis	☐ Seizure/Epilepsy	☐ Skin conditions/rashes
☐ Sleep apnea	☐ Stomach ulcer	☐ Stroke (when _____)
☐ Urination increase/decrease	☐ Vision problems	☐ Vomiting, persistent

☐ Other: _____

MEDICAL PROVIDERS: Please list the names of other healthcare providers and the problems for which they are treating you.

_____

_____

_____

FAMILY HISTORY:

	Living?	Age (current or at death)	Current medical problems or cause of death
Father:	☐ Yes ☐ No		
Mother:	☐ Yes ☐ No		
Brothers:	☐ Yes ☐ No		
Sisters:	☐ Yes ☐ No		
Daughters:	☐ Yes ☐ No		
Sons:	☐ Yes ☐ No		

SOCIAL HISTORY:

Do you exercise regularly? ☐No ☐ Yes; how often? _____

Do you drink alcohol? ☐No ☐ Yes If yes, how many drinks per day? _____ How many per week? _____

Do you currently or have you ever smoked? ☐No ☐ Yes If yes, how much? _____ For how long? _____

Do you currently or have you ever used smokeless tobacco? ☐No ☐ Yes If yes, how much? _____ For how long? _____

Have you used drugs other than those required for medical reasons? ☐No ☐ Yes

How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons? _____

Are you currently or have you ever been sexually active? ☐No ☐ Yes Are your sexual partners: ☐ Male ☐ Female ☐ Both

Thank you for taking the time to complete this form.

_____ _____

Signature of Patient or Legal Representative *Date*

MR#: | | | | | | |

Date: M M – D D – Y Y Y Y

ACCORDIA HEALTH

INFORMED CONSENT FOR PSYCHIATRIC/PRIMARY CARE TELEHEALTH SERVICES

Patient Name: _____

Healthcare Practitioner: Accordia Health Credentialed Provider

Introduction

Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual consumer health information for the purpose of improving consumer care. **This consent is valid for twelve months.** The information obtained may be used for diagnosis, therapy, follow-up, referral, and/or consultation, and may include one or both of the following:

- Live two-way audio and video
- Output data from medical devices and sound and video files

The interactive tele-video equipment and telecommunication lines used are HIPAA approved for consumer security and privacy.

Expected Benefits

- Improved access to psychiatric/primary care by enabling a consumer to have a session with a psychiatrist/provider while remaining at a remote site,
- More efficient medical evaluation and management.

Possible Risks

There are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment,
- In very rare instances, security protocols could fail, causing a breach of privacy of personal health information.

By signing this form, I understand the following:

1. The laws that protect privacy and the confidentiality of psychiatric/primary care information also apply to telehealth, and that no information obtained in the use of telehealth, which identifies me, will be disclosed to other entities without my written or verbal consent.
2. I have the right to withhold or withdraw my consent (either written or verbally) to the use of telehealth in the course of my care at any time.
3. I understand that the health care provider is off site at a remote location.
4. I understand that none of the teleconference will be recorded or photographed.
5. I understand that in the event of technical difficulties an employee of the IT department, as well as additional staff, may be present during my session.
6. I may have to travel to see a health care practitioner in-person if I decline the telemedicine service.
7. If I decline the telemedicine services, the other options/alternatives available for me, including in person services, are as follows:_____
8. The information from the telehealth service (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my **additional** written consent.
9. I will be informed of all people who will be present at all sites during my telemedicine service.
10. I may exclude anyone from any site during my telehealth service.
11. I may see an appropriately trained staff person, or employee, in-person, immediately after the telemedicine service if an urgent need arises. **OR,** I will be told ahead of time that this is not available.
12. I may contact the healthcare provider at phone number _____ for any questions I have related to medical services received through a telemedicine provider/site.

I understand that this consent will expire on _____ (Twelve months from the signature date) **or** at the time of my discharge from this program, whichever comes first.

I have read this document carefully, and my questions have been answered to my satisfaction.

Printed Name of Patient: _____

Signature of Patient: _____ Date: _____

OR Signature of Parent or Legal Representative: _____ Date: _____

Signature of Witness & Credentials/ Title Obtaining Telemedicine Consent: _____ Date: _____

Created 9-22-2020

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