Grayson and Associates, P. C.

PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Social Security Number _____ - _____ - _____ Male □ Female □

Mailing Address _____

City _____ State _____ Zip _____

Primary Phone ( ) _____ Secondary Phone ( ) _____

RESPONSIBLE PARTY

Person Responsible for Payment _____

Mailing Address _____

City _____ State _____ Zip _____

INSURANCE

Primary_____
Insured's Name_____
Relation to Insured _____
Employer_____
Contract Number_____
Group Number_____
Soc Sec # of Policy Holder_____
Referred by_____

Secondary_____
Insured's Name_____
Relation to Insured_____
Employer_____
Contract Number_____
Group Number_____
Soc Sec # of Policy Holder_____
Referred by_____

Have you been referred by an Employee Assistance Program (EAP)? Yes No If yes, which EAP? _____

Are you a Medicaid patient in the Patient's First Program? *Yes No*

******** I understand that I or my responsible party is responsible for my bill, not my insurance company. If my insurance does not pay in a timely fashion, I will pay the bill in full. ********
********I will be billed a $5.00 service charge for not making a payment at the time of service********

I, the undersigned, hereby agree to pay all amounts and charges for services rendered by Grayson and Associates, P.C., no later than thirty (30) days of the rendering of said services unless other specific written arrangements are made. In the event of default in the payment of said services, I waive, as to the debt, all rights of exemptions and laws of Alabama, or of any other state, as to personal property, and agree to pay all costs of collection or securing or attempting to collect or secure said indebtedness, including all reasonable attorney's fees.

- ***I understand that I will be receiving automated appointment reminders at any phone number I submit to Grayson and Associates, P.C.***
- ***I also understand that unless a cancellation of appointment is made twenty-four (24) hours in advance of said appointment, that I will be subject to a charge for the time reserved.***
- ***I authorize the release of any medical information to my insurance company that is necessary to process my claims and request payment to Grayson and Associates P.C.***
- ***I authorize the release of any medical information to my pharmacy or insurance company that is necessary for filling or refilling me prescriptions.***

Signature_____ Date_____
Patient or Responsible Party

Updated 4/25/08

Grayson and Associates, P. C.

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge receipt of Grayson and Associates, P.C.'s Notice of Privacy Practices

_____ _____

Signature of Patient/Personal Representative Date

_____

Printed Name of Patient/Personal Representative

If Personal Representative, relationship to patient:_____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgment

☐ An emergency prevented us from obtaining acknowledgment

☐ Other (please specify)

_____

_____

_____

GRAYSON & ASSOCIATES, P.C.
NOTICE OF PRIVACY PRACTICES

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.

Effective as of April 1, 2003.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related care services. We are required to abide by the terms of our Notice of Privacy Practices ("Notice") currently in effect. We reserve the right to make changes to the terms of our Notice and to make such new Notice provisions effective as to all your protected health information ("PHI"). We will post each revised Notice in our office, make copies of the revised Notice available upon request and post the revised Notice on our web site.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION WITHOUT YOUR CONSENT.

Treatment. We may use or disclose your PHI to provide and coordinate your health care and related services. This may include communications with other health care professionals regarding your health care, including your referral to another health care provider. For example, we may share PHI with other health care providers involved in your treatment, such as [sending a copy of your medical records to a specialists to whom you are referred] or [sending certain PHI to a laboratory that is conducting your tests] or [with a pharmacy when calling in your prescription].

Payment. We may use or disclose your PHI to obtain payment or be reimbursed for the health care and related services we provide for you. Such disclosures can be made to billing services, collection departments or credit bureaus. For example, even before you receive services, we may disclose your PHI with your health plan(s) to determine coverage eligibility.

Health Care Operations. We may use or disclose PHI in connection with certain administrative, financial, legal and quality improvement activities that are necessary for us to run our practice and to support our functions of treatment and payment. For example, we may use or disclose your PHI for quality assessments and improvement activities, employee training programs, licensing requirements, or conducting a medical review or audit.

Incidental Use or Disclosure. An "incidental use or disclosure" is a use or disclosure that cannot reasonably be prevented, is limited in nature and occurs as a result of another permissible or required use or disclosure. We have set up reasonable safeguards that protect against impermissible uses and disclosures and limits incidental uses or disclosures. We also have policies and procedures that set limits to ensure that, as applicable, only the reasonable minimum necessary amount of your PHI is used, disclosed and requested for certain purposes.

You Can Object to Certain Uses or Disclosures. For each of the uses or disclosures of your PHI listed below, if you are present and able, we will either (1) obtain your oral permission, (2) give you the opportunity to object, or (3) reasonably infer from the circumstances, based on our professional judgment, that you do not object. If you are unable to object, we will use our professional judgment to disclose only such PHI as is directly related to such person's involvement in your health care. For uses or disclosures:

- to a relative, friend or other person identified by you only your PHI that is directly relevant to that person's involvement in your health care or payment for health care;
- to a family member, personal representative, or other person responsible for your care only your PHI necessary to notify such individuals of your location, general condition or death; or
- to a private or public agency for disaster relief purposes. (Even if you object, we are still permitted to share your PHI as necessary for emergency circumstances.)

Required Uses or Disclosures. We are required by law to disclose your PHI to you pursuant to your patient right of access and accounting as described below. We are also required to disclose your PHI to the Secretary of the Department of Health and Human Services when required for their investigation of our compliance with privacy laws.

Our Contact with You. We may use or disclose your PHI to provide you with appointment reminders (such as sending postcards or leaving a voicemail message, etc.), to provide you information regarding treatment alternatives or other health-related benefits and services that may be of interest to you, [and to raise funds for us.]

Business Associates. We may use and disclose your PHI with our business associates. A "business associate" is a person or entity that provides certain functions, activities or services on our behalf pursuant to a written agreement that contains terms regarding protection of your PHI.

Other Uses and Disclosures. We may use or disclose your PHI when such use or disclosure is:

- required by law or used for law enforcement purposes;
- necessary for public health activities;
- necessary to report abuse, neglect or domestic violence;
- for health oversight activities;
- for judicial and administration proceedings;
- for medical research;
- to coroners, medical examiners or funeral directors;
- for cadaveric organ, eye or tissue donation purposes;
- to avert a serious threat to the health or safety of a person or the public;
- for specialized governmental functions; or
- for workers compensation.

ALL OTHER USES AND DISCLOSURES OF YOUR PHI REQUIRES YOUR WRITTEN AUTHORIZATION. You may authorize us to use or disclose your PHI for other purposes. You may revoke this authorization in writing at any time; however, your revocation will not apply to any uses or disclosures that were being processed before we received your revocation.

YOUR PATIENT RIGHTS.

Restrictions. You have the right to ask us to restrict our uses or disclosures of part or all of your PHI for treatment, payment, health care operations or to individuals involved in your care. However, we are not required to agree to your requested restriction. If we do agree to your restriction, we will only use and disclose your PHI in accordance with such restriction, unless otherwise permitted or required by law. You may request a restriction by contacting Medical Records at (205)8716926.

Confidential Communications. You have the right to request that communications about your PHI be delivered by an alternative means or at alternative locations. For example, you may request that we contact you at your workplace about appointments. You must make such requests in writing. We will accommodate reasonable requests, but may condition such accommodations upon our receipt of a satisfactory explanation of how payments for your services will be handled and an alternative address or other method of contact. Please contact Medical Records, at (205)8716926, to request a Confidential Communications Request Form.

Access. You have the right to inspect and obtain a copy of your PHI contained in clinical, billing and certain other records used to make decisions about you, except in certain limited situations. Your request must be in writing, and we will charge you reasonable cost-based fees for expenses (such as copying and employee time). Instead of copies we may provide you with a summary of your PHI, if you agree to the form and cost of such summary. We may, in some cases, deny your request and will notify you in writing of the reasons for our denial and provide you with information regarding your rights to have our denial of your request reviewed. You may request to see and receive a copy of PHI by sending a request to 2200 Lakeshore Drive Suite 150 Birmingham, AL 35209.

Amendments. You have the right to request an amendment to your PHI contained in clinical, billing and certain other records used to make decisions about you, except in certain limited situations. Your request must be in writing and provide a reason to support the requested amendment. We may, in some cases, deny your request for amendment and will notify you in writing of the reasons for our denial, provide you with information regarding your rights to submit a written statement disagreeing with such denial and provide information on how to file such statement. You may request an amendment of your PHI by sending a request to 2200 Lakeshore Drive Suite 150 Birmingham, AL 35209.

Accounting. You have the right to receive a listing of disclosures of your PHI made for purposes other than treatment, payment, health care operations, upon your request, your authorization, to individuals involved in your care or as allowed by law. You may request all such disclosures made during the last 6 years (but not any disclosures made prior to April 14, 2003). If you request this list more than once in a 12-month period, we may charge you reasonable cost-based expenses to comply with your additional request. You may request a listing of disclosures by calling (205)8716926.

Electronic Notice. If you received this notice by email or off our web site, you have the right to receive this notice in written form upon your request. You may request a written copy of this Notice by contacting our business office.

QUESTIONS AND COMPLAINTS.

If you have any questions or feel that your privacy rights have been violated by us or want to complain to us about our privacy practices, you can contact our Privacy Officer at 2200 Lakeshore Drive Suite 150 Birmingham, AL 35209. Telephone (205)8716926.

You may also submit a written complaint to the U.S. Department of Health and Human Services. We will not retaliate in any way against you if you choose to file a complaint with us or the U.S. Department of Health and Human Services.