Deanah Maxwell Stafford, MD

Physical Address
3805 West MLK Hwy Tuskegee, AL 36083 Mailing Address
P.O. Box 831077 Tuskegee, AL 36083
Office - (334) 226-1915 Fax – (334) 226-1918

# PATIENT REGISTRATION FORM

## PATIENT INFORMATION (PLEASE PRINT CLEARLY)

Last Name: _________________ First Name: _____________________ Middle: _______________

Address: _____________________________________ Social Security Number: ______ - ______ - _________

City: __________________ State: _______ Zip code: _________ Date of Birth: _____/________/________

Home Phone Number: (_____) ______ - ____________ Cellphone Number: (______) ________ - __________

Email Address: _____________________________________________ Gender: ___ M ___F

If under 18, Parent/Guardian's Name: ________________ Parent/Guardian Number:(____) ______ - _________

Preferred Pharmacy: _______________________ Pharmacy Number:(_____) _______ - ___________

## EMERGENCY CONTACT INFORMATION

Name: __________________________________ Phone Number:(_____) __________ - ______________

Relationship: ______________________________

## PATIENT DEMOGRAPHICS (PLEASE ANSWER ALL QUESTIONS)

Ethnicity: (Please circle one) Hispanic/Latino Non-Hispanic/Latino prefer not to answer

Race: (Please circle one) Black /African American White Asian Hawaiian / Pacific Islander

American Indian prefer not to report.

Marital Status: (Please circle one) Single Married Divorced Separated Widow

Name of Employer: ____________________________ Work Number:(______) ______ - ________

## INSURANCE INFORMATION (IF NOT INSURED, SKIP THIS SECTION)

Primary Insurance: ________________ Insurance ID: _____________ Group # ______________
Policy Holder's Name: ______________________ Date of Birth _____/______/________
Secondary Insurance: ______________ Insurance ID: ______________ Group # ______________
Policy Holder's Name: ______________________ Date of Birth _______/_______/_________

Patient Name _________________________________ Birth Date______/______/________

# PATIENT CONSENT FOR TREATMENT

By signing below, I, (or my authorized representative on my behalf) authorize Rhema Health and Wellness to conduct any diagnostic examinations, tests, and procedures, as well as provide any. medications and treatment necessary to effectively assess and maintain my health. I understand that, excluding emergencies or extraordinary circumstances, it is the responsibility of my individual treating health care providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment or medication recommended or deemed medically necessary by my individual treating health care Providers. I also understand that refusal of recommended procedures, test or evaluations may result in less than optimal outcomes.

Notice of Patient Privacy Practices

I understand that as a patient of Rhema Health and Wellness, all information collected will be kept confidential under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I acknowledge that I have received the Notice of Privacy Practices from Rhema Health and Wellness.

Signature: ___________________________________________ ___________________
Patient/Parent/Legal Guardian Date

RHEMA HEALTH & WELLNESS
"For I know the plans I have for you..." Jeremiah 29:11



Patient Name ______________________________ Birth Date______/______/_________

# STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Payment is expected at time of service. Payment may be made by cash, check, or major credit card. Any fees, deductibles, co-insurance, or co-payment is payable at time of service.

PAYMENT RESPONSIBILITY: The undersigned assumes responsibility for payment for services in accordance with the standard rates and terms of Rhema Health and Wellness. As the undersigned, I fully understand: (a) my insurance, if any, is a contract between myself and the insurance company, except in certain cases where Rhema Health and Wellness has a specific contract with my PPO, HMO, or other third-party payer; Rhema Health and Wellness does not explain nor determine if services are covered by my insurance, if any, so any inquiries to explain or determine insurance coverage for services is between myself and the insurance company; (b) any balance remaining after insurance, approves or denies payment is my responsibility to pay; if my insurance company denies a claim for services for any reason, whether at the time or subsequent to receiving services, I assume full responsibility for payment in accordance with the standard rates and terms of Rhema Health and Wellness.

- ☐ Initial ___________ I understand that if I am uninsured or have insurance that is not accepted at the practice, that I will be responsible for payment in FULL at the time of service.

- ☐ Initial___________ I understand that all medical procedures are not covered by insurance and that I will be responsible for payment in FULL at the time of service.

- ☐ Initial__________ I understand all insurance copays must be paid in full at the time of appointments and all deductibles must be current to be seen. Failure to make payments when requested could result in legal action. The undersigned agrees to pay all cost for collections, including a reasonable fee, and hereby waives his/her rights of exemption under the laws of the State.

- ☐ Initial_________ I understand that I will be responsible for payment of any deductible and copayment/ co-insurance as determined by your contract with your insurance carrier(s). We expect these payments at the time of service. Many insurance companies have additional stipulations that might affect your coverage. You are responsible for 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.

## STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

- ☐ Initial_________ I authorize the release of medical information to referring physicians, to consultations if needed, as well as all records necessary to process insurance claims, insurance applications and prescriptions. I also authorize the release of medical records to 3rd Party PA processor, specialty pharmacy, or specialty drug program, if applicable.

### SELF PAY

In the event you do not have insurance, we are pleased to offer a self-pay option for our patients. Effective January 1st, 2021, Rhema Health and Wellness will charge $125 for a new self-pay patient appointment. The self-pay fee covers the office visit and administration cost. If other services or a followup appointment is needed additional fees will apply. A price list for self-pay services is available upon request. Additionally, the patient will be responsible for the cost of any medications prescribed during the visit. Please let us know when you are scheduling your appointment if you would like to utilize our selfpay option.

- ☐ Initial __________ If I do not have health insurance or have a health insurance that is not accepted by Rhema Health and Wellness, I will be responsible for services rendered by Rhema Health and Wellness. I agree to pay the practice for the entire amount of treatment given to me or to the above-named patient at each visit.

Signature: _____________________________________ ____________________
Patient / Parent / Legal Guardian Date

Patient Name: ______________________________ Date of Birth: ______/______/_______

# RHEMA HEALTH AND WELLNESS POLICIES

Phone calls and Appointments

- The appointment line voicemail is checked every hour. Your calls will be returned in the order they were received. Please do not leave multiple messages, it will not result in faster service.
- All patients will be given an Appointment arrival time for each visit.
- It is the patient's responsibility to confirm all contact and insurance information is up to date.
- Minors must be accompanied by an adult at all times. Late arrival
- Patients that arrive at the front desk more than 15 minutes after their scheduled arrival time maybe asked to reschedule their appointment. Cancellation Policy
- Patients can cancel or reschedule an appointment by calling Rhema Health and Wellness or by leaving a message or by leaving a message at (334)226 – 1915.
- Appointment cancellation requires 24 – hour advanced notice by calling the office or leaving a voicemail.
- Failure to cancel an appointment may result in a "no show" fee of $75. Which will be placed on your account, the account balance must be cleared prior to scheduling another appointment.

Recurrent Late / No Show Patients

- Patients who are repeatedly late for scheduled appointments will be placed on a walk-in only list. These patients will lose the ability to schedule appointments ahead of time and will need to call the office for available walk-in appointment times.

Referrals

- Please allow 7 days for referral request to be sent. You will be notified of appointment through patient portal or by telephone.
- In some instances, the consultant or your insurance may require additional testing or evaluation before an appointment can be scheduled.
- You are responsible for assuring insurance coverage and any necessary authorizations
- If it has been more than 2 weeks since your request please contact our office at (334)226-1915 and select option 5

Lab and Test Results

- Some test and lab results can take up to 10 – 14 days. Your abnormal results will be called to you. Your normal results will be available on the patient portal. You may contact the office for a copy of your results.

## RHEMA HEALTH AND WELLNESS POLICIES

Medical Records request/Paperwork request

- A medical release form must be on file before records can be released.
- Medical records request must be made in person, in writing or via fax at (334)226-1918 - Medical records requested from outside providers will be sent at no cost to the patient - Medical records requested by patient can be provided at no cost up to 20 pages. Additional pages will be $.10 per page.
- Please allow up to 14 business days for records request to be processed.
- Medical forms to be completed by doctor that are submitted during office visit will be at no additional cost to the patient
- Medical forms to be completed by doctor that are submitted outside of an office visit will incur a $25 fee, which is due at the time the request is made.
- Please allow up to14 business days for completion of any paperwork. In certain situations, an additional office visit maybe required for certain types of paperwork to be completed.

Medication Refill

- Rhema utilizes electronic prescribing and medication verification
- Refills for general prescription request require 48 hour notice. Ensuring that your medication refills are up-to-date at every clinic visit is the safest, most efficient way to ensure you do not run out of essential medications
- Refill request can be submitted via your pharmacy using the ERX system. This method results in the quickest response time.
- Refill request can also be requested via patient portal or by calling the office and making a request via the refill line. Please leave your full name, DOB, name of medication requested, pharmacy name and pharmacy phone number.

- If you have not been seen by your practitioner within a specified time period, medications maybe declined, or only be prescribed for 30 days to allow you time to schedule an appointment.
- Medications may NOT be refilled after office hours or on the weekends
- Prescriptions for medications that this office has not previously prescribed for you will NOT be filled.
- If you receive controlled substances, you will be required to bring medications to each appointment. You will also be required to participate in periodic screening to ensure proper use of medication.

My signature below confirms that I understand and accept Rhema Health and Wellness Policies

Signature:_______________________________________ Date:__________________
Patient / Parent / Legal Guardian

Patient Name ____________________________________________ Birth Date _______________

# RHEMA HEALTH & WELLNESS NARCOTICS/CONTROLLED SUBSTANCES POLICY

Narcotics/Controlled Substances Policy

Our physician and practitioners are committed to evaluating and treating pain at every visit. There is a multitude of options for treating pain including oral medications, physical therapy, exercise, relaxation techniques, use of heat and/or cold, and acupuncture that we may prescribe or refer patients for. In most cases, treatment of the underlying medical condition will result in alleviation of pain. We offer conservative, narcotic-free treatment of chronic pain that is associated with numerous conditions. Our clinic is not set up for the management of chronic pain with narcotics or opioids. In accordance with recommendations by the Federation of State Medical Boards, we will direct those patients in need of the use of controlled substances to pain specialists and experts for further evaluation, treatment, and monitoring.

On some occasions, the use of narcotics or other controlled substances may be an essential tool in the care of a patient. In accordance with the oversight of the Alabama Medical Board which governs safe and effective medical practices, our practices policies are as follows:

1. On a first new patient visit, no narcotics or other controlled substances will be prescribed in the absence of a clear, acute injury.

2. In the interest of safety, patients requiring chronic pain medications other controlled substances must agree to obtain medications from only one physician and one pharmacy.

3. Prescriptions will not be filled outside of normal business hours and will be subject to our customary medication refill policies.

4. New prescriptions will not be written for lost or stolen prescriptions.

5. If all the prescribed medication is taken prior to the refill date, then the refill request will be denied.

6. Chronic pain or pain beyond that which is normally expected for a specific condition that continues to require narcotic medication may be referred to a pain management clinic.

7. Patients receiving narcotics or other controlled substances will be required to participate in routine monitoring which may include: urine drug screens, pill counts, monthly office visit.

Signature: ___________________________________________ _______________

Patient / Parent / Legal Guardian Date

## Rhema Health and Wellness 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.

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how Rhema Health and Wellness (RHW) may use and disclose medical information about you to carry out treatment, payment for our health care services and for other health care operations or purposes that are permitted or required by law. It also describes your rights to access and control medical information about you. As a patient of RHW, one of the responsibilities you have entrusted to us is the protection of your personal medical information. Our physicians and staff take this responsibility very seriously.

The uses and disclosures listed below may be limited by Alabama Requirements described under Regulatory Requirements.

Uses and Disclosures of Protected Health Information (PHI) for Treatment, Payment and Health Care Operations The following describes the different ways that we (RHW) may use and disclose your PHI for treatment, payment and health care operations.

For Treatment – We may use PHI about you to provide you with medical treatment or services. For example, we may disclose your PHI to doctors, nurses, technicians, training doctors, or other health care professionals who are involved in taking care of you.

For Payment – We may use and disclose PHI about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may disclose your PHI to your insurance company so that they will pay for our services rendered to you.
For Healthcare Operations – We may use and disclose your PHI for health care operations. Some of these operations include the use or disclosure of your PHI for quality improvement, doctor/employee review activities, compliance, and the training of medical residents and other health care professionals, which includes preceptorships for health care affiliates. For example, we may compare the treatment you received to other similar episodes of care to ensure that RHW continues to provide the highest quality services.

Business Associates
We may disclose PHI to "business associates", who perform services on behalf of our practice. Some examples of our business associates are transcription services, collection agency, and call answering service. Whenever an arrangement between our Practice and a business associate involves the use or disclosure of your PHI, we will have a written contract with that business associate that will protect your privacy.

Uses and Disclosure of Protected Health Information (PHI) Based upon Your Written Authorization
Other uses and disclosures of PHI not covered by this notice or the laws that apply to our Practice (described below) will be made only with your written permission.
If you provide us permission to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, thereafter we will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

Uses and Disclosures That May Be Made with Your Agreement or Opportunity to Object
Unless you object, we may disclose some of your PHI to a family member, other relative, friend, or other persons you identify. We may also notify these people about your location and condition. When you are unable to agree or object, we may still disclose your PHI for these purposes in certain circumstances.

Continued on page 9,

Other Permitted and Required Uses and Disclosure That May Be Made Without Your Authorization
In addition to using and disclosing your PHI for treatment, payment and health care operations, we may use or disclose your PHI without your written authorization in the following situations:
• As required by law: We may use or disclose your PHI when required to do so by applicable law. For example, in certain circumstances, we may also disclose PHI to report about an individual that we reasonably believe to be a victim of abuse, neglect, or domestic violence.
• For public health purposes.
• For health oversight activities authorized by law: We may disclose your PHI to the government for oversight activities, such as audits, I
investigations, inspections, licensure and disciplinary actions, and other activities necessary for monitoring the health care system.
• For Workers' Compensation claims. (These programs provide benefits for work-related injuries or illnesses.)
• To a coroner, medical examiner or funeral director for the purpose of identifying a decedent, determining a cause of death, or as necessary to enable such parties to carry out their duties. • For cadaveric organ, eye or tissue donations.
• For medical research purposes.

- To prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- For specialized government functions: In certain circumstances, we may use and disclose your PHI if you are a veteran or in the military. We may also disclose your PHI to authorized federal officials for intelligence and other national security activities, for the protection of the

President or others, and for special investigations. If you are an inmate of a correctional institution or under custody of a law enforcement officer, we may disclose your PHI to the correctional facility or official in certain circumstances.

Communication

We may use and disclose your PHI to contact you (by telephone or mail) and remind you of an appointment, or to inform you of treatment alternatives or other health-related benefits and services that may be of interest to you. We may be required to leave a message on your answering machine, when contacting you by telephone to remind you about an appointment, provide instructions prior to a diagnostic test or procedure, or to discuss payment. We may also use and disclose your PHI to encourage you to purchase or use a product or service through face-to-face communication or by giving you a promotional gift of nominal value.

Your Rights Regarding Medical Information About You Right to Inspect and Copy

You have the right to inspect and copy PHI that may be used to make decisions about your care. To inspect and copy PHI, you must submit your request in writing to our Privacy Officer. You will be notified when you record is ready to inspect or copies are completed. If you request a copy of the information, we will charge you a reasonable fee for the cost of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain circumstances.

Right to Amend

If you feel that medical information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have a right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing to our Privacy Officer, and it must explain why you are requesting an amendment to your PHI. We may deny your request in certain circumstances. If this request is denied, HFM will send you a written letter supporting reason for denial.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosure." This is a list of certain disclosures we have made of your PHI. You must submit your request in writing to our Privacy Officer. Your request must state a time period that may not be longer than six years and not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the cost but we will notify you of this charge before it is incurred to you.

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Right to Request Restrictions

You have the right to request a restriction or limitation on the PHI we use or disclose. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to our Privacy Officer. In your request, you must tell us: 1) what information you want to limit; 2) whether you want to limit our use, disclosure or both; and, 3) to whom you want the limits to apply. Any previous restrictions given verbally or written to a RHW employee are no longer valid and must be requested in the above manner.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request in writing to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. Any previous requests given verbally or written to a RHW employee are no longer valid and must be requested in the above manner.

Right to a Paper Copy of This Notice

Even if you agreed to receive this notice electronically, you have a right to request a paper copy by writing our Privacy Officer or asking for a copy at the reception/check-in desk at our RHW facility.

Regulatory Requirements

We are required by law to maintain the privacy of your medical information, and we must abide by the terms of this notice. (That is, the version that is currently in effect). We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for the medical information we already have about you, as well as any information we receive in the future. We will post a copy of the current notice, with the effective date listed in the bottom right-hand corner of the last page. In addition to the privacy protections provided under federal law (which are described in this notice), Alabama law (referred to in this notice as the Alabama Requirements) requires us in certain situations to get your written consent (or, under some statutes or rules, written consent from your attorney, guardian, or upon court order) before we can use or disclose your information. The Alabama Requirements may apply:

- If you qualify as a patient that suffers from a sexually transmitted disease;
- If you qualify as a patient that receives benefits from the State of Alabama for certain developmental disabilities or mental retardation;
- If you qualify as a patient that the Alabama Medicaid program has asked us to serve as a Case Management Service Provider for;
- If you qualify as a patient that receives rehabilitative services through the Alabama Medicaid program;
- If you qualify as a patient that receives certain benefits under the Alabama Medicaid's Preventive Health Education program.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services (or his or her designee). To file a complaint with RHW, contact our Privacy Officer at the address below. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

If you have any questions about RHW's Notice of Privacy Practices, please contact the Privacy Officer listed below. Privacy Officer
P.O. Box 831077 Tuskegee,
Alabama 36083
Facsimile: (334) 226-1915
Effective date: April 14, 2003

My signature below confirms that I have read and understand Rhema Health and Wellness Notice of Privacy Practices

Signature: ________________________________________ Date:____________________
Patient / Parent / Legal Guardian

PATIENT HIPAA ACKNOWLEDGEMENT / DISCLOSURE

I understand Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits disclosure of my protected health information ("PHI"). This authorization is being signed because it is crucial that my medical providers readily give my protected medical information to the person(s) designated below in order to allow me the advantage of being able to discuss and obtain advice from my family and/or friends.

I, _____________________, authorize Rhema Health & Wellness to disclose the following information:

All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of healthcare providers, whether past, present or future, and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person(s) or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give full authorization to ANY protected medical information to the person(s) named in this authorization.

By signing this authorization, I acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the person(s) whose name(s) are written below, and the information, once disclosed, will no longer be protected by the rules created in HIPAA. This authorization shall remain in effect until my WRITTEN MODIFICATION and/or REVOCATION is received by Rhema Health & Wellness.

## Person's authorized to receive my protected health information (PHI)

Last Name: ________________________ First Name: ______________________________

Phone Number: ____________________________ Date of Birth: _______________________

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Last Name: ________________________ First Name: ______________________________

Phone Number: ____________________________ Date of Birth: _______________________

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Your signature below acknowledges that you have read and understand Patient HIPAA disclosure and authorize listed persons to receive your protected health information (PHI)

____________________________ ________________________ __________

Patient Name printed Patient Signature Date

________________________________________________________________________________

Signature of Patient's Representative Relationship to Patient Reason Patient is unable to sign

## Rhema Health and Wellness Medical Release Form

From (Releasing Facility) To (Receiving Facility)

Facility Name ____________________________ Rhema Health & Wellness

Deanah Maxwell Stafford, MD

Address ________________________________ 3805 West MLK HWY Tuskegee, AL 36083
City __________________________________ (Mailing) P.O. Box 8310077 Tuskegee, AL 36083
State & Zip _____________________________ Phone: (334) 226-1915 Telephone
____________ Fax ______________ Fax: (334) 226-1918

Patient Information
Patient Name: ________________________________ Date of Birth: ________________________
Social Security Number: ______________________ Medical Record Number: ______________
Address: ____________________________________ Telephone: __________________________
____________________________________
____________________________________

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Please release the following medical/health information:
☐ Complete Medical Record ☐ Radiology (X-rays, MRI, CT) ☐ Other (Please Specify) __________
☐ Clinical Notes ☐ Ultrasound ______________________________
☐ Laboratory Reports ☐ Billing/Accounting ______________________________
Dates of care from _________________________ to _____________________________________

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The information released may be used for the following purposes: ______________________________
______________________________________________________________________________

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I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I hereby release the Receiving Facility and the Releasing Facility from any liability related to the release, use, or disclosure of this information as described herein.

I understand that I may revoke this authorization at any time, and unless expressed otherwise, this authorization shall expire six months from the date of my signature below.

Patient Signature: ______________________________________ Date: ______________________

Witness Signature: ______________________________________ Date: ______________________

Expiration Date: ________________ (If not indicated, expires six months from date signed by patient.)

# Patient Medical History