SHARP & STONE OB/GYN, PC

2700 10th Avenue South, Suite 306
Birmingham, AL 35205

Charles E. Sharp, Jr., M.D. Tim L. Stone, M.D. Robert P. Goolsby, M.D.

PATIENT INFORMATION

Name_____ Soc. Sec. No._____

Preferred Name_____ Date of Birth_____ Age_____ Race_____

Email Address_____ Referred to us by_____

Street Address_____

City, State, Zip Code_____

Home Phone (____)_____ Cell Phone (____)_____ Work Phone (____)_____

Patient's Employer (Indicate if Student)_____

Employer's Street Address_____

City, State, Zip Code_____

Spouse's or Parent's Name_____ Spouse's SSN_____

Date of Birth_____ Home Phone (____)_____ Business Phone (____)_____

Spouse's or Parent's Employer_____

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance Company_____ Contract Number_____

Group Number_____ Effective Date_____ Expiration Date_____

Policy Holder Name (If Different Than Above)_____

Policy Holder's Relationship to Patient _____ Sex_____ Date of Birth_____

SECONDARY INSURANCE INFORMATION

Name of Secondary Insurance Company_____ Contract Number_____

Group Number_____ Effective Date_____ Expiration Date_____

Policy Holder Name (If Different Than Above)_____

Policy Holder's Relationship to Patient _____ Sex_____ Date of Birth_____

IN CASE OF EMERGENCY

Name_____ Home Phone(____)_____ Business Phone (____)_____

Relationship to Patient_____

EXPLANATION OF PAYMENT POLICY AND INSURANCE FILING PROCEDURES

I hereby authorize Sharp & Stone OB/GYN, PC to release any and all information acquired in my examination, treatment and diagnosis to my insurance carriers and other treatment physicians. If I am covered by insurance, I will furnish my insurance card and signature.

I hereby assign and authorize payment directly to Sharp & Stone OB/GYN, PC any medical and surgical benefits otherwise payable to me. Should an insurance payment be received that is less than the physician's usual charge for the services provided, I will be responsible for the difference. I understand if my insurance provider denies payment for any service for any reason I will be responsible for those charges.

I also agree to pay all cost of collection including, but not limited to reasonable attorney's fee, and waiver all claims of exemption under the law of the state of Alabama. Form must be signed and dated by patient or responsible party.

Date_____ **X**_____

Patient and/or Responsible Party

Sharp and Stone OB/GYN, P.C. Notice of Privacy Practices Effective Date September 23, 2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.
Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How we may use and disclose health care information about you:
For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. *Example: If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. *Example: Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*

For Business Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. *Example: We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal or written permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

Your rights regarding your PHI
You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
- Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.
- Right to Request Confidential Communication. You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- Right to a Copy of this Notice. You have the right to a copy of this notice.

Website Privacy
Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site.
Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches:
You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints: If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at *Sharp and Stone OB/GYN, PC.* If you have questions and would like additional information, you may contact us at (205) 933-4020.

I acknowledge that I have reviewed the privacy practices of Sharp & Stone OB/GYN, P.C. (Must be reviewed annually)

Patient Signature _____ Date _____

SHARP & STONE OB/GYN, P.Cc
Financial Responsibility Agreement

- **CO-PAYMENTS:** Co-payments are required at the time of service.

- **BALANCES:** Balances must be paid in full before seeing the physician.

- **FMLA/DISABILITY FORMS:** There is a minimal **$10.00 fee** for form completion. This fee is not reimbursed by your insurance, and payment is required prior to completion. Once completed, it is our policy to not fax these forms. However, you may pick them up or we will be happy to mail them to you.

- **NON-COMPLIANCE IN KEEPING APPOINTMENTS:** There is a **$25.00 fee** for appointments that are not kept.

- **ANNUAL EXAMS:** The annual/preventative medicine exam fee is covered by insurance. However, please note that lab work or other ancillary services associated with this visit may not be paid by your insurance and you will be asked to pay at the time of service.

- **OBSTETRICAL SERVICES:** Our staff will contact your insurance company to determine what they will pay towards your delivery. If your insurance will not pay for your obstetrical care/delivery in full, or if you do not have insurance, we will let you know the amount owed. We will work with you on payment arrangements; however, we require the amount be paid in full by your 24th week of pregnancy.

- **PAYMENT FOR SURGICAL SERVICES:** Our staff will contact your insurance company to determine what they will pay towards your surgical procedure. You will be responsible for any deductibles, co-payments, or remaining balance. Payment in full is required three days prior to your scheduled surgery date. If payment is made less than three days prior to surgery please be prepared to pay by cash or credit card.

- **REFERRALS:** If your insurance requires you to have a referral from a primary care physician, it must be obtained prior to seeing one of our physicians. It is the patient's responsibility to obtain the referral from the insurance company. If we have not received the referral, payment in full is required at the time of service or your appointment may need to be rescheduled.

- Because there are numerous insurance policy contracts, each one being different, it is our policy that the patient be knowledgeable of their contract and benefits with their insurance policy.

- Your physician may order blood work, pap smear, urine culture, etc. in order to diagnose your condition. Our practice utilizes outside laboratories and pathologists to process these specimens. We will forward your information, including insurance, so that a claim can be filed. However, please keep in mind that you may receive a bill from these providers for these services.

Due to the increase cost for billing, patient's failure to fulfill their financial obligations, and other changes in healthcare regulations, it is necessary for our office to implement the above policies. If you have any questions or concerns regarding these policies, you may contact our Practice Administrator.
I fully understand my financial responsibility for services rendered at Sharp & Stone OB/GYN, P.C. and understand that failure to comply with these policies will result in having to reschedule any appointments until I am able to fulfill my responsibility.

_____ _____

Signature of Patient, or Responsible Party Date

_____

Printed Name of Patient, or Responsible Party

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

Please understand that it may be necessary for us to release some or all of the information contained in your medical records to other physicians, nurses, and/or healthcare providers. At times, other providers assist us in assessing a patient's conditions. Screening for potential problems or providing consultation under certain circumstances. All healthcare providers are required by law to keep your information confidential.

Also due to the increased awareness of quality care it may be necessary to disclose information regarding your care to healthcare agencies, both private and governmental. Your insurance company and/or your self-insured employer are such agencies. Regarding the information going to your employer other than information needed to verify your insurance coverage; the data released will consist of statistical information only.

_____ **I do not wish to have test results or other medical information released to any person other than myself**

_____ **I do wish to have test results or other information released to the following person(s) (these individuals are people other than medical personnel)**

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

It is the responsibility of the patient to notify this office of any changes to the above information if changes do occur. The patient must fill out another Authorization form with this new information.

_____ _____

Patient Signature Date

_____ _____

Printed Name Social Security Number

_____

Witness