

**PATIENT REGISTRATION FORM**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Marital Status: Single/Married/Domestic Partnership/Divorced/Widowed/Separated

SS#: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred By: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Present Medications: \_\_\_\_\_

Have you had previous mental health treatment? YES NO

If yes, WHERE? WHEN? \_\_\_\_\_

**PARENT (for patients under 18yrs old) OR SPOUSE/DOM. PARTNER INFORMATION:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's DOB: \_\_\_\_\_ Insured's SS#: \_\_\_\_\_

Group #: \_\_\_\_\_ Patient's Relationship to the Insured: \_\_\_\_\_ Employer Name: \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's DOB: \_\_\_\_\_ Insured's SS#: \_\_\_\_\_

Group #: \_\_\_\_\_ Patient's Relationship to the Insured: \_\_\_\_\_ Employer Name: \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I the undersigned have insurance coverage with \_\_\_\_\_ and assign directly to **Regina Doody, MD**, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

**X** \_\_\_\_\_  
Signature of Insured/Guardian

**X** \_\_\_\_\_  
Date

I request that payment of authorized insurance benefits to me or on my behalf to **Regina Doody, MD**, for any services furnished on me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for the related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. My signature authorizes releasing of the information to the insurer or agency shown.

NATIONAL SECURITY

**Regina Doody, MD** may disclose medical information to federal officials for intelligence and other national security agencies as required by law.

INMATES

If you are an inmate, **Regina Doody, MD** may disclose medical information about you to the institution or official to which you are assigned.

SITUATIONS WHICH REQUIRE AUTHORIZATION

Other uses and disclosures of medical information will be made only with specific, written authorization. You have the right to revoke an authorization at any time except in the instance where the entity has already taken action in reliance on this authorization.

COMPLAINTS

If you have a question or complaint about the way your protected health information is handled; please contact the privacy officer whose name is listed below.

PRIVACY OFFICER

**Alabama Behavioral Health at 190 Lime Quarry Road, Suite 117, Madison, AL 35758 - Phone: 256-464-0222.** You may also file complaints with the Secretary of the Federal Dept. of Human Services. You will not be penalized or suffer retaliation if you file a complaint regarding a known or suspected violation of your privacy rights.

REVISION OF NOTICE

This notice may be revised or updated from time to time. If the notice is revised or changed, you will be provided a copy of the revised notice. Any revision of the notice will apply to all protected health information that is maintained by **Regina Doody, MD**. We will also post any revised notice in the front office.

EFFECTIVE DATE

This notice is effective on April 16, 2007.

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**ACKNOWLEDGEMENT OF RECEIPT**

NOTICE OF PRIVACY PRACTICES

Your signature acknowledges that you have received a copy of the NOTICE OF PRIVACY PRACTICES.

Patient Name \_\_\_\_\_

Signature of Patient \_\_\_\_\_

Date Signed \_\_\_\_\_

Patient Representative (if applicable) \_\_\_\_\_

Relationship of Representative (if applicable) \_\_\_\_\_

# NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. Please review it carefully.

## RIGHTS

Patients of **Regina Doody, MD** have the right to the following:

- You have the right to request restrictions on certain uses and disclosures of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to any restriction and will advise you if this is the case.
- You have the right to receive confidential communications of your protected health information and may request to receive information from us by alternative means or at alternate locations.
- You have the right to inspect and copy protected health information about yourself. If you desire to review and inspect your medical record, a request to do so may be made in writing to the Privacy officer whose name and telephone number are listed below. You will receive information on the dates available for inspection of your record within 30 days of your request. If you desire to copy any part of all of your medical record, you may also make a request for copies to the Privacy Officer. The copies will be made and forwarded to you by mail within 30 days of receipt of your request. A charge of \$30.00 will be assessed to cover the costs of copying the material.
- You have the right to request amendments or revisions to your protected health information and to receive a response to your request for an amendment or revision. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- You have the right to receive an accounting of disclosures of protected health information that were provided without your written authorization. This accounting will be provided one time per year at no cost to you,
- You have the right to obtain a paper copy of this notice if this form is provided electronically.

**Regina Doody, MD** shall from time to time provide information about you without requesting specific authorization for treatment, payment, and healthcare operations. This is not a complete listing, but is provided as example of how the information may be used:

### TREATMENT

**Regina Doody, MD** may confer about your needs and will share pertinent information about you as needed for on call coverage. **Regina Doody, MD** may share protected health information about you with hospitals or other healthcare providers.

### PAYMENT

Information about your health will be shared with your insurance company to provide the information they require in order to pay your claim for the services rendered. We may also disclose medical information to your insurance company to obtain prior authorization for treatment and procedures. We may also disclose information about your health or medical billing information to third party billers or outside medical services.

#### HEALTH CARE OPERATIONS

**Regina Doody, MD** may use health information for operations and activities such as quality control, quality assurance, and financial planning that are necessary to provide efficient and quality care for our patients.

#### APPOINTMENT REMINDERS

**Regina Doody, MD** staff will contact you by phone to remind you of your scheduled appointments. If you do not wish to have these reminders by phone, please contact the receptionist or the Privacy Officer.

#### SITUATIONS WHICH DO NOT REQUIRE AUTHORIZATION

We are allowed to release medical information about you to the following without an authorization:

##### PUBLIC HEALTH ACTIVITIES

**Regina Doody, MD** may disclose medical information about you for public health activities such as control of disease, injury, or disability, reporting of child abuse or neglect, reporting of medication adverse events, and in situations related to defective medical products.

##### ORGAN TISSUE DONATION

**Regina Doody, MD** may disclose medical information to organizations that handle organ transplantation if you are an organ donor.

##### MILITARY AND VETERANS

**Regina Doody, MD** may release medical information about you to military authorities if you are a member of the armed forces for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Dept. of Veterans Affairs of your eligibility for benefits, or to foreign military authorities if you are a member of that foreign military service. We may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

##### WORKER'S COMPENSATION

**Regina Doody, MD** may disclose medical information about you for worker's compensation programs if you have a work related injury.

##### AVERTING SERIOUS THREAT TO HEALTH OR SAFETY

**Regina Doody, MD** is required to disclose medical information when necessary to prevent a serious threat to your health and safety of others.

##### HEALTH OVERSIGHT

**Regina Doody, MD** may disclose medical information to a health oversight agency such as audits, investigations, and inspections.

##### LAW ENFORCEMENT

**Regina Doody, MD** may disclose medical information to law enforcement officials to the extent that the law requires such use or disclosure.

##### CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS

**Regina Doody, MD** may disclose medical information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death.