L & A Pediatrics & Adult Clinic

Sherwan Ahmad, DO

452 North Thompson Lane, Murfreesboro, TN 37129

Phone: 615-900-3301 Fax: 615-962-9328

Patient Registration

Last Name:_____ First Name:_____ MI: _____

Address:_____City: _____State: _____Zip:_____

Phone Number: (___) _____**DOB: ___/___/ _____** SSN: ___ _____

Alternate Phone #: (____) _____-____ Email: _____

Language Spoken:_____ Sex: Male_____ Female_____

Pharmacy: _____ Pharmacy Address:_____

Emergency Contact: _____ Phone: _____

Please list insurance information:

Name: _____ID#: _____Group #:_____

Name: _____ID#: _____Group #:_____

Communication Authorization

I request that any communication regarding my health information be limited to the following as indicated. This may include but not be limited to appointment scheduling, follow-up appointment at our clinic, procedures and/or results, and referral scheduling/confirmation.

Contact Name:_____
Relationship: _____ DOB: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: (_____) Cell: (_____)

In regards to persons under the age of 18, communication will be directed to custodial parents or approved contact in all cases with the exception for pregnancy and/or sexually transmitted diseases. These communications are confidential with the patient ONLY.

_____ _____

Signature of parent/guardian **Date**

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PROTECTED HEALTH INFORMATION RELEASE

Patients Name: _____

Social Security Number: _____ DOB: _____/ __ /____

I hereby authorize Dr. Sherwan Ahmad to request and have released to them any health information they may request from the following physician or facility. This may include all and or specified medical records. I understand the information disclosed pursuant to this authorization may be subject to redisclosure by Dr. Sherwan Ahmad is no longer protected by federal privacy regulations.

Records requested from
Physician/Facility: _____
Address: _____
_____
Phone :(___) ____ - _____
Fax :(__)____-_____

In regards to the release of my medical information to other physicians and or facilities, I request the following not to be released without my specific written consent. If no indications are made, records may be released as requested.

_____All Records____ Substance____ Abuse_____ AIDS/HIV

_____Psychiatric/Psychological: _____ Other, Labs, X-rays, referrals

Expiration or revocation of authorization- I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the affixed below. Use of a copy of this authorization may be utilized with the same effectiveness as an original.

Signature: _____Date: _____

Name of person authorized to sign for patient (print): _____

Relationship: _____

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HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2013. Many of the policies have been our practice for years. This form is a "friendly" version.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than the office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality of HIPPA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may add, change, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

Name _____ Date _____ do hereby consent and acknowledge my Agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.