NOMS HEALTHCARE

Date:_____

Legal Last Name_____First Name_____Middle Initial_____ Nickname_____

Social Security #_____Date of Birth____/____/____Sex: Male ☐ Female ☐

Address_____Apt_____

City_____State_____Zip_____

Marital Status: Married ☐ Single ☐ Legally Separated ☐ Divorced ☐ Widowed ☐

Race_____Language_____Ethnicity_____

Home Phone_____Cell Phone_____Work Phone_____

Leave Message ☐ Yes ☐ No Email _____

Primary Care Physician_____Referring Doctor_____

Pharmacy_____ City, State_____

Employer _____ Employer Addess_____

City_____State_____Zip_____Phone Number_____

Occupation_____ Status: Full Time ☐ Part Time ☐ Retired ☐

Are You Homeless? Yes ☐ No ☐ Do You Have Any Special Communication Needs? Yes ☐ No ☐

If your food runs out for the month, do you have money to buy more? Yes ☐ No ☐

●●

Person Responsible for Any Patient Balance (Head of Household): _____

Address_____City_____State_____Zip_____

Home Phone_____Employer_____Work Phone_____

●●

Spouse's Name_____Date of Birth____/____/____SS#_____

Are you covered under your Spouse's insurance: Y N Employer_____Work Phone _____

●●

In case of an emergency who should we contact?

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

●●

Is this a work related injury? Yes ☐ No ☐

MCO:_____Claim#:_____Date of injury____/____/____Time of injury_____

1st Report of Injury complete? **Yes or No** Employer at time of injury_____

Employers Phone_____ Employers Fax _____

Insurance Information:

Primary Insurance_____Policy Holder Name_____

Check if below policy holder information is same as front ☐ Patient ID Number _____

Date of Birth____/____/____Sex: M ☐ F ☐ SS#_____Relationship to Patient_____

Address_____City/State/Zip_____Home Phone_____

Employer_____Work Phone_____

Address_____City/State/Zip_____

●●

Secondary Insurance_____Policy Holder Name_____

Check if below policy holder information is same as front ☐ Patient ID Number _____

Date of Birth____/____/____Sex: M ☐ F ☐ SS#_____Relationship to Patient_____

Address_____City/State/Zip_____Home Phone_____

Employer_____Work Phone_____

Address_____City/State/Zip_____

●●

If you are covered under your parents insurance, OR a minor, you MUST complete the following:

Mother's Name_____Date of Birth____/____/____SS#_____

Are you covered under your mother's insurance? Y or N Employer_____Work Phone_____

Check if below is same as above ☐

Address_____City/State/Zip_____Home Phone_____

Father's Name_____Date of Birth____/____/____SS#_____

Are you covered under your father's insurance? Y or N Employer_____Work Phone _____

Check if below is same as above ☐

Address_____City/State/Zip_____Home Phone_____

In the event that I (or in the case of a minor, the personal representative of said minor) cannot be reached directly to discuss Patient Health Information, NOMS Healthcare is authorized to leave a message by voice mail, answering machine, with any individual listed above as Emergency Contact(s), or with any individual who answers any of the telephone numbers as listed on Page One (I) of this form.

Patient Signature:_____Date:_____

Parent of Guardian Signature:_____Date:_____

Initials of person completing the form, if other than the patient: _____

NOMS HEALTHCARE

Patient: _____

Patient Date of Birth: _____

1.03 HIPAA Patient Acknowledgment

I hereby permit Northern Ohio Medical Specialists to release any information acquired throughout the course of my examination and treatment as needed to process any claims on my behalf.

HIPAA Notice of Patient Privacy Practices

I hereby agree, in accordance with HIPAA regulations, that I have been advised of NOMS Healthcare privacy policy. I may request a paper copy of the NOMS Healthcare Notice of Privacy Practices at any time. I permit NOMS to release or obtain any information throughout the course of my examination and treatment as needed to process any claims on my behalf. I permit NOMS Healthcare to send me any information via email or by calling the telephone number (s) I have authorized, regarding my account, treatment, appointments and/or any advertisements or specials offered by the offices. In the event that I cannot be reached directly, I give my consent for NOMS Healthcare to leave a message on my voicemail, answering machine or with any individual who answers any of the telephone numbers I've provided.

I give permission for the following individuals to receive my medical information:

☐ Patient only

_____ (name)	_____ (relationship)	_____ (phone number)	_____ (leave message Yes/No)
_____ (name)	_____ (relationship)	_____ (phone number)	_____ (leave message Yes/No)
_____ (name)	_____ (relationship)	_____ (phone number)	_____ (leave message Yes/No)
_____ (name)	_____ (relationship)	_____ (phone number)	_____ (leave message Yes/No)
_____ (name)	_____ (relationship)	_____ (phone number)	_____ (leave message Yes/No)

PAYMENT AUTHORIZATION

I HEREBY AGREE TO PAY ANY AND ALL CO-PAYS, DEDUCTIBLES, CO-INSURANCE, AMOUNTS OVER UCR, AND/OR EXCLUDED CHARGES FROM INSURANCE COMPANIES WITH WHOM NOMS HEALTHCARE DOES NOT ACCEPT ASSIGNMENT, AND ANY AND ALL CO-PAYS, DEDUCTIBLES AND CO-INSURANCE WITH THOSE THEY DO ACCEPT ASSIGNMENT.

I hereby request my insurance carrier to pay on my behalf insurance benefits to NOMS Healthcare for services rendered. I understand this authorization will be effective until revoked in writing. I understand that if necessary, a credit bureau report may be obtained. I understand in some cases it may be necessary to obtain insurance / employer verification. NOMS Healthcare cannot be held responsible for collecting my insurance claim(s) nor for negotiating a settlement(s) on a disputed claim(s). NOMS Healthcare fees are not established by insurance companies. I am responsible for my account. It is solely my responsibility to know who my insurance is in net-work with.

No Show Policy

I hereby understand that NOMS Healthcare has a posted No-Show Policy and that if I do not cancel an appointment 24 hours prior to the scheduled appointment, I may be subject to the fees associated with said policy.

Permission to Communicate with Your Primary Care Physician, Other Community Care Providers and/or Mental Health Providers

In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician and other community care providers including mental health providers, and to your insurance company. These communications may include information about your medical treatment and mental health or substance abuse treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of your care.

Many insurance companies require us to document whether or not you will allow your clinician to communicate with your primary care physician, Health Insurance Company and/or mental health providers.

Consent for RX Hub Inquiry

I herby provide my consent for NOMS Healthcare, LLC to obtain my Rx History using the SureScripts-RxHub network or the Ohio Automated Rx Reporting System (OARRS). I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts-Rx Hub has certified that Rx History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy. All queries and responses are made automatically through secure system-to-system communications.

Imaging Radiation Exposure

Your physician has ordered a procedure, which requires the use of radiation. The radiation exposure enables the radiologist to view the area of interest and then submit a written report to your doctor. By signing below you give consent to have this procedure and any future procedures performed that requires radiation.

Health Information Exchange

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying Human Resources or the IT Department.

Signed _____ Date_____