ALPHA MED
PHYSICIANS GROUP, LLC

Dear Patient,

On behalf of the physicians and staff of Alpha Med Physicians Group, we would like to welcome you to our practice. We realize that you have choices, and we appreciate that you have entrusted us with your care. We will strive to make your visit as pleasant and comfortable as possible. We have included a New Patient Packet to streamline the registration process. Please complete the following enclosed forms:

Patient Information Form: Provides us with up-to-date information.

HIPAA Authorization Form: Indicates to whom we may release your medical information and the method of contact.

HIPAA Consent Forms: Acknowledges that we have provided you with a copy of our Notice of Privacy Practices Form.

Pharmacy Consent Form: We prefer to e-prescribe your prescriptions for fast and accurate dispensing. This form allows us to electronically submit prescriptions to your pharmacy of choice.

In addition to the forms above, please bring the following to your appointment:

*All pertinent test results provided by your doctor.

*Current list of all medications, including over-the-counter and herbal supplements. You may bring the medication bottles instead of a list, if you prefer.

*List of questions or concerns that you would like to discuss with the doctor.

*Most recent insurance and prescription cards along with a photo I.D., and a referral from your primary care physician when necessary.

We welcome and encourage family and friends to accompany you to your visit. For the safety of our patients and staff, Alpha Med Physicians Group asks that you try to limit visitors to one or two people.

Please note that we do not allow children in the Lab. Children must remain in the Lobby area under the supervision of a parent or guardian at all times.

If there is anything that we can do to make your visit more pleasant, or if you need assistance or clarification, please do not hesitate to contact any of our staff members.

Thank you for choosing Alpha Med Physicians Group.

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Patient Information Form

Name:_____**Date:**_____

Home Address:_____ **SSN#:**_____-_____-_____

City:_____ **State:**_____ **ZIP:** _____

Home Phone:_____ **Work Phone:** _____ **Cell Phone:** _____

Birthdate: _____**Marital Status:** _____ **Name of Spouse:** _____

Email Address:_____

Patient's Occupation: _____**Patient's Employer:** _____

Patient's Primary Care Physician: _____

Patient Allergies: (drug, latex, environmental):_____

Emergency Contact: _____**Relationship:** _____

Emergency Contact Phone Number(s):_____

The U.S. Government requests this information in connection with this practice's implementation of electronic health records. If you do not wish to provide this information, please indicate by writing "refused" and initial each question.

Language Spoken: _____ **Race:** _____ **Ethnicity :☐ Hispanic OR ☐ Non-Hispanic**

Insurance Information:

***Primary* Insurance:** _____ **Name of Policy Holder:** _____

Policy Number: _____**Group Number:** _____

Eligibility Telephone Number: _____**Patient's Relationship to Policyholder:** _____

Date of Birth: _____**SSN:** _____ **Co-pay Amount:** _____

***Secondary* Insurance:** _____ **Name of Policy Holder:** _____

Policy Number: _____**Group Number:** _____

Eligibility Telephone Number: _____**Patient's Relationship to Policyholder:** _____

Date of Birth: _____**SSN:** _____ **Co-pay Amount:** _____

I have provided medical insurance information and copies of my insurance card(s). I authorize payment of medical benefits to Alpha Med Physicians Group, LLC. I authorize the release of any medical information necessary to process my claims.

X_____

I authorize release of my medical tests and/or records to Alpha Med Physicians Group, LLC.

X_____

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HIPAA Consent to Share Information

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communication or that communication be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

Patient Name: _____Date of Birth: _____

Please indicate your preferred method of contact:

☐ Home Phone _____ May we leave a detailed message? Yes No

☐ Cell Phone _____ May we leave a detailed message? Yes No

☐ Work Phone _____ May we leave a detailed message? Yes No

I authorize Alpha Med Physicians Group, LLC to release my medical information to the person(s) listed below. I understand that the person(s) named on this authorization will be given access to obtain results/information on my behalf. I authorize the person(s) indicated to pick-up materials pertinent to my medical care.

Name	Relationship to Patient	Telephone Number

Patient Signature: _____ Date: _____

In lieu of patient signature, I, _____, as a staff member of Alpha Med Physicians Group, LLC, state that _____has been provided with current Notice of Privacy Practices.

Staff Signature: _____ Date: _____

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HIPAA Consent Form

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I *(name of patient or authorized agent),* _____, date of birth _____,

Hereby give my consent to Alpha Med Physicians Group, LLC to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of *(patient name)* _____.

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available in the office as well as online at www.alphamedphysicians.com.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Patient Signature: _____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____

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Consent form Definitions

The term “Health care operations” refers to a large number of activities, including:

1. Conducting quality assessment and improvement activities, including outcome evaluations and development of clinical guidelines, provided that obtainment of generalizable knowledge is not the primary purpose of any studies resulting from such activities; patient safety activities (as defined in 42 CFR 3.20); population-based activities related to improving health or reducing health care costs; protocol development; case management and coordination of care; contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment.
2. Reviewing the competence or qualifications of health care professionals; evaluating practitioner and provider performance; health plan performance; conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers; training of non-health care professionals; accreditation, certification, licensing, or credentialing activities.
3. Except as prohibited under 45 CFR 164.502 (a)(5)(i), underwriting, enrollment, premium rating, and other activities related to creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess loss of insurance).
4. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs.
5. Business planning and development, such as conducting cost management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment, or coverage policies.
6. Business management and general administration activities including (but not limited to): (a) management activities relating to HIPAA privacy rule compliance; (b) customer services, including the provision of data analyses for policy holders, plan sponsors or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor or customer; (c) resolution of internal grievances; (d) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity; and (e) creating de-identified health information, fundraising for the benefit of the covered entity, and marketing for which an individual authorization is not required.

The term “Payment” relates to the activities undertaken by the physician to obtain reimbursement for the provision of health care. The activities referred to in this definition relate to the individual to whom health care is provided and include (but are not limited to):

1. Determination of eligibility coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims.
2. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance, and related health care data processing.
3. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges.
4. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services.
5. Disclosure to consumer reporting agencies of any of the following information related to reimbursement: name and address, date of birth, Social Security number, payment history, account number, and name and address of the physician.

The term “Treatment” pertains to the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers related to a patient; or the referral of a patient for health care from one health care provider to another.

The term “Use” is related to sharing, employment, application, utilization, examination, or analysis of patient information within the physician’s practice that maintains such information.

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Pharmacy Consent Form

Patient Name: _____ Date of Birth: _____

Account Number: _____

Alpha Med Physicians Group, LLC (AMPG) is enrolled in an electronic prescribing program. This program is meant to help our providers understand what medications our patients are currently using in order to provide the best possible treatment.

By signing this consent form you are agreeing that Alpha Med Physicians Group, LLC (AMPG) may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Alpha Med Physicians Group, LLC (AMPG) to enroll me in the ePrescribe program.

_____ _____

Signature of Patient or Representative Date

Pharmacy Name: _____

Address (or cross streets and town): _____

Phone Number: _____

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Photograph Consent Form

Patient Name: _____ Date: _____

I hereby consent to have an identification photograph, and photographs of the treatment position, taken. This is to be done by an Alpha Med Radiation Oncology employee. These photographs will be used for identification and treatment purposes only.

Signature of Patient: _____

Signature of Witness: _____

If the patient is a minor or unable to sign, please complete the following:

A) The patient is a minor _____ years of age.

B) The patient is unable to sign due to the following reason:

_____

_____

The undersigned certifies by his/her signature that he/she is duly authorized to accept the terms on behalf of the patient.

Signature of Responsible Party: _____

Relationship to Patient: _____

Witness: _____