PATIENT REGISTRATION FORM

Patient Name: _____
Address: _____ City: _____
State: _____ ZIP: _____ Gender: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
SSN (REQUIRED): ____-____-_____ Age: _____ Date of Birth: ____/____/____
Home Phone: _____ Cell: _____ Work: _____
Email Address: _____
Employer Name: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Referred By: _____ Phone: _____
Family Physician: _____ Phone: _____

SPOUSE (OR PARENT) INFORMATION

Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Home Phone: _____ Cell: _____ Work: _____
Employer Name: _____ Employer Phone #: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____
Insured's Name: _____ Employer: _____
Insured's DOB: ____/____/____ Insured's SSN: ____-____-____
Insured's Address: _____
Patient Relationship to Insured: ☐ Spouse / ☐ Domestic Partner / ☐ Parent / ☐ Stepparent ☐ Grandparent / ☐ Other _____
Contract #: _____ Group #: _____

Secondary Insurance Carrier: _____
Insured's Name: _____ Employer: _____
Insured's DOB: ____/____/____ Insured's SSN: ____-____-____
Insured's Address: _____
Patient Relationship to Insured: ☐ Spouse / ☐ Domestic Partner / ☐ Parent / ☐ Stepparent ☐ Grandparent / ☐ Other _____
Contract #: _____ Group #: _____

Preferred Pharmacy: _____
Phone #: _____ Location: _____

_____ _____

Patient Signature **Date**

NAKEETSHA DRYER C.R.N.P.

Thank you for choosing Nakeetsha Dryer N.P. We are committed to building a successful physician/patient relationship with you. Your clear understanding of our Patient Office and Financial Policies is important to our professional relationship. After you have read this document in its entirety, please sign the last page. Your signature constitutes an agreement to the procedures and policies of our practice. **If you have any questions or would like a copy of this form or the Notice of Privacy Policy for your records, please ask us.**

OFFICE POLICY

Appointment cancellations, rescheduling, late arrivals, and missed appointments:

1. If you know you will be late, please contact our office as soon as possible so that we can determine whether you can keep your appointment or whether you must reschedule.
2. Please remember that, although we will attempt to make a reminder call, it is the patient's responsibility to keep an appointment and know when their appointment is.
3. You are required to notify us 24 hours in advance of your appointment to cancel or reschedule. If it is after normal business hours, you may leave a voicemail for the front office staff.
4. Failure to keep a scheduled appointment 3 times in a row may result in discharge from the practice. Excessive missed or cancelled appointments in a one-year period may result in discharge from the practice.

Social Security Disability claims:

1. If you file for Social Security Disability, we will send your medical records as requested by the Disability Determination Service.
2. **You will be referred to another provider/facility for continuing services. Nakeetsha Dryer N.P. is not a Medicare provider and does not accept patients with Medicare insurance as cash pay.**

Specialty paperwork fees:

1. If you request special paperwork to be completed (FMLA, SSI, Disability, etc.), you will be charged according to the amount of time required to complete the forms.
2. **The fee is $75.00 for 15 minutes.**
3. This is not covered by your insurance and is due from the patient prior to finalized forms being sent.

Prescription refill request:

1. Prescription requests outside of scheduled appointments will not be called in. The office staff will offer to schedule an appointment to pick up a written prescription.
2. If your medication is a controlled substance and is lost, stolen, or "short", it may not be refilled. This applies to either the written prescription or the actual medication. You can make an appointment to see Nakeetsha Dryer N.P. to discuss the situation, however this does not necessarily mean that it will be refilled.
3. If your insurance carrier requires prior authorization for medication, we will complete the necessary forms. The fee for this is $20-$40 depending on the type of request. This fee is due before the request is sent.
4. Refill requests faxed from the pharmacy will have a $10 fee.

Medical records charges:

1. We reserve the right to timely "process" of your records. It is **NOT** possible for your records to be released the same day of the release request.
2. There is no charge to release your records to another physician directly *if* you are in good standing with this office.
3. You will be charged for copies of medical records that are released to you. The fee shall be a search fee of $5.00, pages 1-25 at $1.00 each, additional pages are $0.50 each. In addition, postage fees may also be applied. Payment is due when the records are picked up. This is not covered by insurance.

Termination:

I understand that Nakeetsha Dryer N.P. has the right to discharge any patient from this practice at any time for various reasons, including but not limited to:

1. Frequent no-shows or last minute or retroactive cancellations. Patients who continually fail to keep appointments prevent us from being able to offer those appointment slots to others.
2. Inappropriate behavior or language to staff or other patients.
3. Noncompliance of recommended treatment plan.
4. Drug-seeking activity.
5. Falsifying insurance or health information.
6. Repeated abuse of our office policies.
7. Past due accounts when no good faith effort to meet a payment schedule has been made.

FINANCIAL POLICY

Forms of payment:

1. Cash
2. Visa
3. MasterCard
4. Discover
5. Money Order

****Personal checks are NOT an accepted form of payment****

New patients:

1. New patients must present their insurance card and proof of identification (e.g. Driver's license). Although we do not take insurance we need your insurance information in case a Prior Authorization is needed on your medication.

Submission of claims:

We do not file insurance however we will provide you with the form needed so that you can submit.

Payment of Visit:

1. Payment is due in full at time of check-in.
2. You may be asked to reschedule your appointment if you are not prepared to make payment.
3. Outstanding balances are to be paid in a timely fashion.

Please read and sign the following. Your signature constitutes an agreement to the policies and procedures of our practice.

Patient Financial Responsibility:

I acknowledge full financial responsibility for services rendered by Nakeetsha Dryer N.P. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the nurse practitioner to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance claim submissions. I assign directly to Nakeetsha Dryer N.P. all medical benefits, if any, otherwise payable to me for services rendered.

I understand that I am responsible to prompt payment of any portion of the charges not covered by insurance, including deductibles and co-pays. I understand payment of co-pays is expected at time of service, as well as any prior balance I may owe. I agree to all attorney fees and collection costs in the event of default of payment of my charges.

I request that payment of authorized benefits under any private or government insurance program that covers me, be made on my behalf to Nakeetsha Dryer N.P. for any services furnished to me by Nakeetsha Dryer N.P.

_____ _____

Patient/Guardian Signature Date

Consent for Purposes of Treatment, Payment, and Healthcare Operations:

I hereby give my consent to Nakeetsha Dryer N.P. to use or disclose, for the purpose of carrying out treatment, payment, or healthcare operations, all protected health information contained in the patient record of _____. For a more detailed description of this consent and other uses and disclosures please review our Notice of Privacy Practices. I understand that Nakeetsha Dryer N.P. reserves the right to change its privacy practices that are described in the Notice. I also understand that any Revised Notice will be available at the office or I may request a copy be sent to me by mail.

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 by 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/Guardian Signature Date

Notice of Privacy Practices:

I hereby acknowledge receipt of Nakeetsha Dryer N.P. Notice of Privacy Practices. The Notice of Privacy Practices provides details information about how the practice may use and disclose my confidential health information.

I understand that Nakeetsha Dryer N.P. has reserved the right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided or made available to me.

_____ _____

Patient/Guardian Signature Date

Nakeetsha Dryer C.R.N.P.
1015 Airport Road, Suite 204
Huntsville, AL 35802
Office: 256-883-7031
Fax: 256-883-7032

Communicating through email or text message

If you elect to communicate with me by email or text messaging at some point in our work together, please be aware that these forms of communication are not completely confidential. There are risks associated with email and text messaging as outlined below:

1. All emails and text messages are retained in the logs of the email/phone/internet service provider. While patient information is protected on GRU servers, the same may not be true for email and text message copies that are retained in the logs of your and my phone/internet service providers. Although under normal circumstances no one looks at these logs, they are in theory, available to be read by the systems administrator(s) of the service providers.
2. Copies of emails or text messages may exist even after the sender and/or recipient has deleted his or her copy.
3. Email and text senders can misaddress an email or text and send the information to an undesired recipient.
4. Emails and text messages can be intercepted, altered, forwarded, or used without authorization or detection.

Conditions of the use of email and text messages:

1. I cannot guarantee but will use reasonable means to maintain the security and confidentiality of email and text information sent and received, including a pass code lock on my phone.
2. Email and text messaging is not appropriate for urgent or emergency situations. I cannot guarantee that any particular email and/or text message will be read and responded to within any particular period of time.
3. Email and text messaging should be concise. Unless we have agreed to a specific exception, sensitive or complex situations should be discussed during a scheduled appointment.
4. If emails or text messages contain information relevant to your treatment, they may be retained in your medical record or a summary of the content may be included in a clinical note in your record.
5. If you choose to use email or text messaging, you agree that I may reply to your email and text message and that I may include information that I deem appropriate, including information that would otherwise be considered confidential.
6. You agree that if you do not receive a timely response from an email or text message to me that you will follow up with a phone call to the office or other contact number that has been provided to you.
7. It you choose to use email or text messaging, you agree not to hold me liable for improper disclosure of confidential information that is caused by you or any third party.

By signing below, you agree that you have read and understand the risks associated with communication via email and text message and that you consent to the conditions outlined above.

Patient/Guardian Signature _____ Date _____

Controlled Substances Agreement/Notification

In the event that a medication that is controlled is recommended and/or prescribed by your provider, these are our policies to ensure safe and proper use. Please initial and sign below to show that you have read and agree to our policies.

_____1. Do not change the dose of your medication on your own without talking to the provider. Repeated early refills or running out early will result in tapering and discontinuation of the medication.

_____2. Notify us immediately if another controlled substance is prescribed to you in order to avoid the risk of interactions. Pain medicines (opiates) and anxiety medicines (benzodiazepines) should not be taken together.

_____3.Random urine drug screens are a part of monitoring your progress and your care if you are prescribed a controlled substance for more than three months in a row. Please make sure to update your contact information, in the rare event that we have to contact you in between appointments for a repeat urine drug screen.

_____4. The presence of illegal drugs or substantial amounts of alcohol in your urine drug screen is considered a violation of our agreement. (No amount of alcohol is safe if you are taking a benzodiazepine.) Repeated presence of these substances may result in discontinuation of the controlled medication and/or discharge.

_____5. Obtaining similar medications from more than one provider will result in discharge.

_____6. Please safeguard your medications and do not share them. Lost or stolen medications may not be replaced.

_____

Patient Signature/ Date

_____

Provider Signature/Date

MEDICAL APPOINTMENT CANCELLATION/ NO SHOW POLICY

Thank you for trusting your mental health care to Nakeetsha Dryer, CRNP. When you schedule an appointment with us, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our Appointment Cancellation/No Show Policy below:

□ Effective October 1, 2022, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a No Show and charged a $25.00 fee.

□ Any new patient who fails to show for their initial visit may not be rescheduled.

□ The fee is charged to the patient and is due at the time of the patient's next office visit.

□ As a courtesy, when time allows, we send reminder texts for appointments. If you do not receive a reminder, call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact us and we may be able to waive the No Show fee, but it will be at our discretion and will not be waived for habitual No Shows. You may contact our 24 hours a day, 7 days a week at the number below. (Emailing the provider will not suffice as she does not handle scheduling.)

Should it be after regular business hours Monday through Thursday, or a weekend, you may leave a message.

256-883-7031

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature (Patient/Legal Guardian) Date