NAPA
NORTH ALABAMA
PSYCHIATRIC ASSOCIATES, P.C.

Heath Penland, MD
Heidi Hollinger, CRNP, PMHNP
James Taylor, LPC
953 Jeff Rd. NW Huntsville, AL. 35806
(P) 256-322-6272* (F) 256-322-4987

PATIENT REGISTRATION FORM

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____

Social Security #: _____ Date of Birth: _____ Age: _____ Gender: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____Work #: _____

Employer Name: _____ **Marital Status:** Single Married Divorced Widowed

Responsible Party Information (If patient is less than 18 years old)

Responsible Party is Patient: ☐ Yes ☐No If "Yes" **skip to next section.**

If "No" relationship to Patient: _____

First Name: _____ Last Name: _____

Street Address: _____

City: _____State: _____ Zip: _____

Home #: _____Cell #: _____Work #: _____

IN CASE OF EMERGENCY

Name of a local friend or relative: _____

Relationship to Patient: _____

Home Phone #_____ Mobile Phone # _____

Patient/ Guardian signature: _____ Date: _____

NAPA
NORTH ALABAMA
PSYCHIATRIC ASSOCIATES, P.C.

Heath Penland, MD
Heidi Hollinger, CRNP, PMHNP
James Taylor, LPC
953 Jeff Rd. NW Huntsville, AL. 35806
(P) 256-322-6272* (F) 256-322-4987

AUTHORIZATION/PERMISSION TO CONTACT PATIENT

Should a circumstance arise when it becomes necessary for the office to call you for any reason (such as to verify or change your appointment or insurance issues), every effort will be made to notify you in a timely manner. Please indicate your preference for being contacted.

1. Telephone my home ☐ Yes ☐ No home# _____

2. Telephone my place of employment ☐ Yes ☐ No work #_____

3. Email Contact ☐ Yes ☐ No email _____

4. Text message ☐ Yes ☐ No cell # _____

5. Cell Phone Carrier _____

After 2 unsuccessful attempts to contact you in the manner indicated above, we will write a letter addressed to you asking that you contact the doctor's office.

******Also please make note that NAPA no longer provides the after hours on call answering services. If you have any type of emergency after our office has closed, please call 911 or seek your nearest Emergency Room******

_____ _____
Patient Signature Date

_____
Patient Printed Name

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Printed Name

NAPA
NORTH ALABAMA
PSYCHIATRIC ASSOCIATES, P.C.

Heath Penland, MD
Heidi Hollinger, CRNP, PMHNP
James Taylor, LPC
953 Jeff Rd. NW Huntsville, AL. 35806
(P) 256-322-6272* (F) 256-322-4987

FINANCIAL AND POLICY HOLDER INFORMATION

Primary Insurance Information:

Insurance Company: _____ Contract #: _____ Group #: _____

Effective Date: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Date of Birth: _____ Relationship to Patient: _____

Policy Holder Street Address: _____

City: _____State: _____Zip: _____

Policy Holder Phone #: _____ Sex: ☐ Male ☐Female ☐Other

Secondary Insurance Information: We DO NOT file secondary insurance at this location. We are very limited to what we can try to file on any Secondary Claims

Insurance Company: _____ Contract #: _____ Group #: _____

Effective Date: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Date of Birth: _____ Relationship to Patient: _____

Policy Holder Street Address: _____

City: _____State: _____Zip: _____

Policy Holder Phone #: _____ Sex: ☐ Male ☐Female ☐Other

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician/provider. I understand that I am financially responsible for any balance due. I also authorize North Alabama Psychiatric Associates or insurance company to release any information required to process my claims.

Patient/ Guardian signature_____ **Date** _____

NAPA
NORTH ALABAMA
PSYCHIATRIC ASSOCIATES, P.C.

Heath Penland, MD
Heidi Hollinger, CRNP, PMHNP
James Taylor, LPC
953 Jeff Rd. NW Huntsville, AL. 35806
(P) 256-322-6272* (F) 256-322-4987

NORTH ALABAMA PSYCHIATRIC ASSOCIATES
PRIVACY OF PROTECTED HEALTH INFORMATION

I consent to the use of disclosure of my protected health information by North Alabama Psychiatric Associates (hereinafter referred to as "NAPA") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct healthcare operations of NAPA.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations. The practice of NAPA is not required to agree to the restrictions that I may request. However, if NAPA agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that NAPA has taken action in reliance on this consent.

My protected health information means health information, including my demographic information collected from me and created or received by my physician, another healthcare provider, health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, and future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review NAPA's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of NAPA. The Notice of Privacy Practices also describes my rights and NAPA's duties with respect to my protected health information.

If you have asked us to file health insurance for you, we send only the minimum information required to obtain payment from your insurance company. We do not release any information to anyone about your treatment nor do we acknowledge that you are a patient here (even to your immediate family or other healthcare providers) without your expressed written consent. If you wish us to communicate with anyone about your treatment, please ask for a release of information form.

I understand that although NAPA providers are independent, I may be seen by more than one provider at NAPA for various clinical purposes. Clinical providers at NAPA, involved, or anticipated to be involved, in my care may share Protected Health Information for the purpose of coordinating care.

NAPA reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent by email or asking for one at the time of my appointment.

NAPA
NORTH ALABAMA
PSYCHIATRIC ASSOCIATES, P.C.

Heath Penland, MD
Heidi Hollinger, CRNP, PMHNP
James Taylor, LPC
953 Jeff Rd. NW Huntsville, AL. 35806
(P) 256-322-6272* (F) 256-322-4987

EXCEPTION TO PRIVACY, PRIVILEGED COMMUNICATIONS AND CONFIDENTIALITY

Any unusual circumstances information that the client discloses may be released without consent to the appropriate parties involved if:

- There exists a danger of harm to the client or someone else
- The client needs to be involuntarily hospitalized due to the debilitating effects of mental illness or substance abuse
- The client is required to undergo a court-ordered examination
- The client discloses information about reportable abuse, neglect, or exploitation of a minor
- The client discloses information about reportable abuse, neglect, or exploitation of an aged or disabled adult
- The client's mental or emotional condition is used as a legal defense
- A civil, criminal, or disciplinary action arises from a complaint filed on behalf of the client against a mental health professional in which case the disclosure and release of information shall be limited to that action

I hereby give my consent for service to be provided under these conditions.

INFORMED CONSENT FOR TREATMENT

- I understand the concepts and conditions of informed consent, privacy and confidentiality.
- I understand that I have the opportunity to discuss these concepts and conditions and to ask for clarification of parts which I am concerned about or do not fully understand.
- I understand that I will be informed of the goals, expectations, procedures, benefits, and possible risks involved in the evaluation and counseling/treatment.
- I understand that the process of counseling, psychotherapy, and evaluation is an interview process requiring self-disclosure, self-exploration, and responsible action. It has the overall purpose of promoting understanding and change. Sometimes this process can be stressful and emotionally uncomfortable. At other times, it can be very fulfilling. I also understand that there are no guarantees of positive outcome for the therapy/treatment.
- I have the right to refuse or withdraw from any counseling, psychotherapy, or evaluation procedure unless otherwise specified by law.
- I have the right to question any procedure, intervention, rationale, or discussion that is unclear or that I do not understand.
- I understand that all communication will be private, legally privileged, and confidential unless otherwise specified by the specific laws presented below or unless I provide my written consent with a specified release of information. I understand that if my provider is a resident or intern, then the treatment will be discussed with a supervising professional.
- I understand that this consent may be withdrawn by me at any time without prejudice and has to be completed in writing.
- I understand this consent will be valid for any psychiatrist, psychologist, nurse practitioner, and/or counselor I see during the course of treatment.

NAPA
NORTH ALABAMA
PSYCHIATRIC ASSOCIATES, P.C.

Heath Penland, MD
Heidi Hollinger, CRNP, PMHNP
James Taylor, LPC
953 Jeff Rd. NW Huntsville, AL. 35806
(P) 256-322-6272* (F) 256-322-4987

NORTH ALABAMA PSYCHIATRIC ASSOCIATES
FINANCIAL AND PAYMENT POLICIES

Our policy is full payment at the time services are rendered. We accept most forms of payment. There will be a $40 service charge for NSF or returned check.

We require a **24-Hour notice for cancellation.** We will attempt to make a reminder call or text the business day before your appointment.

_____ For REFILL's outside of the scheduled appointment, **$50.00 will be charged**
(Initials)

_____ For late cancellations, **you will be charged $50.00**
(Initials)

_____ For No Shows, **you will be charged $75.00**
(Initials)

_____ For ALL fee's due at time of services rendered, some providers may require a
(Initials) credit card be put on file in your confidential EMR for all copays or balances due.

Authorization for Credit Card on File YES or NO

Name on Credit Card: _____

Credit Card Number: _____

Expiration Date: _____/_____

Security Code (3 Digits for Visa, 4 Digits for AMEX): _____ Zip code: _____

Your insurance card(s) may be copied each time you are seen. We must verify correct insurance information at each visit.

Benefits quoted by your insurance company are NOT a guarantee of payment. **You will be required to pay any charges not paid by your insurance company.**

We bill your insurance as a courtesy. If you disagree with any amount your insurance pays or they do not pay, you are responsible for the terms of that agreement.

Your insurance contract is an agreement between you and the insurance company and as the subscriber, you are responsible for the terms of that agreement.

You are responsible for confirming with your insurance company that the providers you are seeing are in your network. **This office does not file out- of -network claims at this time.**

NAPA
NORTH ALABAMA
PSYCHIATRIC ASSOCIATES, P.C.

Heath Penland, MD
Heidi Hollinger, CRNP, PMHNP
James Taylor, LPC
953 Jeff Rd. NW Huntsville, AL. 35806
(P) 256-322-6272* (F) 256-322-4987

This office is not a Medicare/Medicaid Provider at this time, nor do we ever plan to become one. We will not guarantee your reimbursement payment or be able to help with the necessary forms to file to MCR. Sorry for any inconvenience this may cause

*You may be billed for letters or forms completed by your provider. Fees may vary.
*You will be billed for lost prescriptions, prescriptions not requested at the time of your visit, and for prescriptions that have to be mailed. These services may be provided at the discretion of your provider.

We will gladly file your primary insurance for you; however, we will provide you with a completely itemized statement in order for you to file your secondary insurance.

It is understood that, regardless of amounts reimbursed by your insurance company, you as the patient/responsible party will be responsible for full amounts charged. If your account is turned over to an attorney or collection agency for nonpayment, you will also be responsible for

additional attorney or collection fees. If you are covered by managed care you may be exempt from payment of charges not fully covered by your insurance.

I authorize NAPA to file insurance for me and to provide the insurance company any information necessary. I further authorize payment to be made directly to my provider at NAPA.

I have read and understand the policies above and agree to abide by them. I understand that I am financially responsible for payment for all services at the time services are rendered. I agree to be liable for any costs incurred in the collection of any unpaid balance, including any and all reasonable attorney fees.

I authorize my provider at NAPA to release any medical and/or psychiatric information acquired in the course of my examination or treatment to my health insurance company to facilitate payment for medical services rendered. I authorize payment of medical benefits to my provider at NAPA.

INFORMATION FOR OUR CLIENTS

Our Practice

We are a group of licensed mental health professionals in private practice. Our office is open Monday from 8:00 AM to 5:00 PM Friday from 8:00 AM to 12:00 PM. We see clients by appointment only. Appointments are scheduled according to the individual PROVIDERS recommendation. If there is an emergency during office hours, which requires immediate attention, please contact the office by phone.

If an appointment cannot be kept, please contact the OFFICE at least 24 hours in advance. There will be a $50.00 fee for late cancellations and a $75.00 fee for no shows.

NAPA
NORTH ALABAMA
PSYCHIATRIC ASSOCIATES, P.C.

Heath Penland, MD
Heidi Hollinger, CRNP, PMHNP
James Taylor, LPC
953 Jeff Rd. NW Huntsville, AL. 35806
(P) 256-322-6272* (F) 256-322-4987

Confidentiality

Communications between the provider and the patient are strictly confidential and protected under Alabama Law and by the ethics of our profession. In order to communicate with others about your case, your provider must have permission in writing. Our registration forms and our Notice of Privacy Practices explain the limits of confidentiality (you can obtain a copy in our lobby).

After Hour Emergencies

Our office number is **256-322-NAPA**. If you need to speak with your doctor or therapist, please try to make your calls brief if it's after normal business hours. Calls of more than 5 minutes will be billed at the provider's hourly rate. Calls are accepted during business hours daily and 24 hours each day, 7 days a week by voicemail. After office hours, you can leave a message on the voice mail; or in an emergency; PLEASE call 911. You will be billed for after office hours calls to your provider. If immediate services are required, please again call 911, or go to your nearest emergency department.

Fees All fees are subject to change and may be adjusted reasonably at the discretion of your provider, depending on clinical needs and time required.

ADDITIONAL OFFICE POLICIES AND FEES

Appointments:

- Appointment cancellations require **24-hour** advance notice.
- Repeated late cancellations or no-shows may lead to termination of care at the discretion of your provider.
- Late, or same-day, cancellations: $**50.00**
- No show to scheduled appointment: **$75.00**

Many services are not covered by regular insurance, and our office may provide such services for additional fees.

Paperwork and letters:

- Charges will be determined at the discretion of your provider and depend on the time required for chart review and completion, as well as complexity.
- A typical hourly rate can be $300 per hour.
- Each provider reserves the right to not complete requested paperwork or compose letters.

Requests for direct calls, or telephone consultations, from your provider:

- Depending on the schedule and policies of your provider, this service may not always be available.
- Please attempt to schedule an appointment with your provider. However, if your provider is able to return your request for a call, please note that fees may be charged, depending on time requirement and complexity.
- A typical hourly rate can be **$300 per hour**.

For patients of Dr. Penland and Heidi Hollinger, CRNP all after hours calls are for urgencies only:

NAPA
NORTH ALABAMA
PSYCHIATRIC ASSOCIATES, P.C.
Heath Penland, MD
Heidi Hollinger, CRNP, PMHNP
James Taylor, LPC
953 Jeff Rd. NW Huntsville, AL. 35806
(P) 256-322-6272* (F) 256-322-4987

- **$50 and up**, depending on time and complexity.
- In the event of a true emergency, please call 911 or go to your nearest emergency room.

Medication requests, during office hours, and not during appointments:

- **$50 charge**, and up, depending on time and complexity
- After hours on-call services are not meant for routine medication refills. Refills called in for last minute cancelled appointments and after hours will incur a **$50 charge**, not covered by your insurance. The covering clinician may not always not have access to your complete record to verify your prescription needs. Please limit refill requests to your office visits, or routine office hours.
- Prescription requests require **advance notice of 48 to 72 hours** for processing.
- Prescriptions for certain controlled medications will only be provided during office hours.
- Each patient is responsible for maintaining the security of their prescriptions and medications. Reports of lost or stolen prescriptions are taken seriously and require additional time and resources to verify. Reports of lost or stolen prescriptions may be grounds for limitations of certain prescriptions, or for termination of care.

Prior Authorizations (PAs):

- At this time, there is no charge for PA's for medications and other treatments, though many medical offices do charge for this service.
- However, please be aware, as regular insurances continue to increase the burden of such requirements for both patients to receive care, and offices to provide routine care, a charge for this service may become necessary.
- We cannot guarantee that any prior authorization will be approved.

Worker's compensation claims are not done by providers in our office.

All fees subject to change without prior written notice.

Having read the above, I agree to abide by the policies and fees set by North Alabama Psychiatric Associates. My signature below confirms my reading and understanding ALL Office Policies, Procedures and Fees.

_____ _____
Patient Signature Date

_____
Patient Printed Name

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature (NAPA Staff) Date

NAPA
NORTH ALABAMA
PSYCHIATRIC ASSOCIATES, P.C.

Heath Penland, MD
Heidi Hollinger, CRNP, PMHNP
James Taylor, LPC
953 Jeff Rd. NW Huntsville, AL. 35806
(P) 256-322-6272* (F) 256-322-4987

TELEPSYCHIATRY PATIENT CONSENT FORM (1)

In order to receive telepsychiatry services from North Alabama Psychiatric Associates PC you must be an **Alabama State Resident**.

Telepsychiatry is the delivery of psychiatric services using the telephone and interactive audio and visual electronic systems between a provider and a patient that are not in the same physical location. These services may also include electronic prescribing, appointment scheduling, communication via email or electronic chat, electronic scheduling, and distribution of patient education materials.

The potential benefits of telepsychiatry are:

- Reduced the spread of COVID-19
- Reduced wait time to receive psychiatric care visits.
- Avoiding the need to travel to a psychiatrist/provider.

The potential risks of telepsychiatry include, but are not limited to:

- A telepsychiatry session will not be exactly the same and may not be as complete as a face-to-face service.
- There could be some technical problems (telephone or video quality, internet connection) that may affect the telepsychiatry session and affect the decision-making capability of the provider.
- The provider may not be able to provide medical treatment using interactive electronic equipment nor provide for or arrange for emergency care that you may require.
- A lack of access to all the information that might be available in a face to face visit, but not in a telepsychiatry session, may result in minimal decision making in some instances.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- North Alabama Psychiatric Associates PC utilizes technology and software that meets the recommended standards to protect the privacy and security of the telepsychiatry sessions. However, the service cannot guarantee total protection against hacking or tapping into the telepsychiatry session by outsiders. This risk is small, but it does exist.

Alternatives to the use of telepsychiatry:

- Traditional face-to-face sessions.

NAPA
NORTH ALABAMA
PSYCHIATRIC ASSOCIATES, P.C.

Heath Penland, MD
Heidi Hollinger, CRNP, PMHNP
James Taylor, LPC
953 Jeff Rd. NW Huntsville, AL. 35806
(P) 256-322-6272* (F) 256-322-4987

TELEPSYCHIATRY PATIENT CONSENT FORM (2)

I understand that I have the following rights with respect to telepsychiatry:

- (1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

- (2) The laws that protect the confidentiality of my medical information also apply to telepsychiatry. As such, I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

  I also understand that the dissemination of any personally identifiable images or information from the telepsychiatry interaction to researchers or other entities shall not occur without my written consent.
- (3) I understand that there are risks and consequences from telepsychiatry, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychiatrist/provider, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that telepsychiatry based services and care may not be as complete as face-to- face services. I also understand that if my psychiatrist believes I would be better served by another form of psychiatric services (e.g. face-to- face services) I will be referred to a psychiatrist/provider who can provide such services in my area if my current provider cannot provide the service at that time. Finally, I understand that there are potential risks and benefits associated with any form of psychiatry, and that despite my efforts and the efforts of my psychiatrist/provider, my condition may not be improve, and in some cases may even get worse.

- (4) I understand that I may benefit from telepsychiatry, but that results cannot be guaranteed or assured.

- (5) I understand that I have a right to access my medical information and copies of medical records in accordance with **Alabama** Law.

Patient's Responsibilities

- I will not record any telepsychiatry sessions without written consent from my provider. I understand that my provider will not record any of our telepsychiatry sessions without my written consent.

- I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins.

NAPA
NORTH ALABAMA
PSYCHIATRIC ASSOCIATES, P.C.

Heath Penland, MD
Heidi Hollinger, CRNP, PMHNP
James Taylor, LPC
953 Jeff Rd. NW Huntsville, AL. 35806
(P) 256-322-6272* (F) 256-322-4987

TELEPSYCHIATRY PATIENT CONSENT FORM (3)

- I understand that I, not my provider, am responsible for the configuration of any electronic equipment used on my computer that is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins. I understand that I must be a resident of the State of Alabama to be eligible for telepsychiatry services from North Alabama Psychiatric Associates PC.
- I understand that my psychiatrist/provider may determines whether or not the condition being diagnosed and/or treated is appropriate for a telepsychiatry encounter.
- I understand that if the telepsychiatry session does not achieve everything that is needed, then I will be given a choice about what to do next. This could include a follow up face-to- face visit, or a second telepsychiatry visit.
- I can change my mind and stop using telepsychiatry at any time, including in the middle of a video visit. This will not make any difference to my right to ask for and receive mental health care.

Patient Consent to the Use of Telepsychiatry:

I hereby consent to engaging in telepsychiatry with NORTH ALABAMA PSYCHIATRIC ASSOCIATES PC as part of my psychiatric evaluation and treatment. I understand that "telepsychiatry" includes the practice of mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I have read and understand the information provided above regarding telepsychiatry.

_____ Date: _____
Patient Signature

_____ _____
Parent/Patient Representative Signature (If Applicable) Printed Name and Relationship to Patient (If Applicable)

_____ Date: _____
Witness Signature

NAPA
NORTH ALABAMA
PSYCHIATRIC ASSOCIATES, P.C.
Heath Penland, MD
Heidi Hollinger, CRNP, PMHNP
James Taylor, LPC
953 Jeff Rd. NW Huntsville, AL. 35806
(P) 256-322-6272* (F) 256-322-4987

MEDICARE PATIENTS ONLY

Physician-Patient Private Contract ("Agreement") (Medicare Opt-Out)

Even though you, the patient, and I, the physician, are entering into a private agreement outside of Medicare, because I have opted out of Medicare, Medicare REQUIRES your agreement to the following terms MEDICARE HAS SPECIFIED, before we can proceed. This Agreement protects Medicare from payment responsibility for services you receive directly from me. If requested by Medicare, this Agreement will be provided to resolve any misunderstanding and clarify our intent. This Agreement must be signed before I can see you as a patient. Please review the following and sign this Agreement to confirm your acceptance of the terms of this Agreement:

The undersigned patient/Medicare beneficiary (or the Medicare beneficiary's legal representative) (either is referred to as "Medicare Beneficiary") is signing this Private Contract to evidence his or her understanding and agreement regarding payment for any services to be provided by **Heath R. Penland, MD, FAPA** ("Physician"). Physician's practice entity is known as **North Alabama Psychiatric Associates PC** (also referred to as "Physician").

Physician hereby certifies that Physician is not and has not been excluded from participation in the Medicare program under section 1128 or other applicable sections of the Social Security Act.

Physician further certifies that the effective date of Physician's opt-out is January 1, 2017, and the estimated date of expiration of the opt-out period for Heath Penland was January 1, 2019, provided that Physician may extend the opt-out period further, which we did extend it indefinitely, which now Medicare states unless we opt back in there is no date of expiration.

By executing this Private Contract, Medicare Beneficiary acknowledges and agrees as follows with respect to all items or services provided by Physician to Medicare beneficiary:

1. That Medicare Beneficiary **will not** submit a claim, or request Physician to submit a claim, for payment under Medicare, even if such items or services would otherwise be covered under Medicare.

2. That Medicare Beneficiary agrees to accept full responsibility for payment in full at the time of service, in accordance with Physician's current fee schedule, whether Medicare Beneficiary is reimbursed through private insurance or otherwise, for payment for all such items or services.

3. Medicare Beneficiary understands that **NO** reimbursement may be provided by Medicare for such items or services provided by Physician.

NAPA
NORTH ALABAMA
PSYCHIATRIC ASSOCIATES, P.C.
Heath Penland, MD
Heidi Hollinger, CRNP, PMHNP
James Taylor, LPC
953 Jeff Rd. NW Huntsville, AL. 35806
(P) 256-322-6272* (F) 256-322-4987

4. Acknowledge that physician is not limited by Medicare in the amount that he or she may charge Medicare Beneficiary for the items or services provided, and that Medicare Beneficiary will pay Physician's charges in full at time of service.

5. That Medigap plans do not make payment, and other Medicare supplemental insurance plans may choose not to make payment, for items or services furnished by Physician.

6. That Medicare Beneficiary has the right to have the items or services sought from Physician to be provided by other physicians or practitioners whose items or services would be covered by Medicare.

7. That Medicare Beneficiary is not in an emergency or urgent health care situation.

8. That Medicare Beneficiary agrees to reimburse Physician for any costs, collection fees, and reasonable attorney's fees that result from violation of this Agreement by Medicare Beneficiary.

9. That Medicare Beneficiary acknowledges a copy of this Agreement has been provided to Medicare Beneficiary.

10. That Medicare Beneficiary signs this Private Contract voluntarily and upon full understanding of its terms.

Do Not sign below this line until in the office with a Clinician to witness and sign

Patient/Medicare Beneficiary (or Legal Representative):

Printed Name: _____

Signature: _____

If Representative,
Print Name and Relationship: _____

Physician Printed Name: _____

Physician Signature: _____

Date: _____

NAPA
NORTH ALABAMA
PSYCHIATRIC ASSOCIATES, P.C.

Heath Penland, MD
Heidi Hollinger, CRNP, PMHNP
James Taylor, LPC
953 Jeff Rd. NW Huntsville, AL. 35806
(P) 256-322-6272* (F) 256-322-4987

Pharmacy Information Form/Current Medication List

Patient Name: _____ DOB: _____

Pharmacy Name: _____

Pharmacy Address: _____

City/ State: _____

Zip: _____

Pharmacy Phone #: _____

Any known Allergies: _____

_____

List Current Psychiatric Medications:

_____

_____

_____

_____

_____

_____

NAPA
NORTH ALABAMA
PSYCHIATRIC ASSOCIATES, P.C.

Heath Penland, MD
Heidi Hollinger, CRNP, PMHNP
James Taylor, LPC
953 Jeff Rd. NW Huntsville, AL. 35806
(P) 256-322-6272* (F) 256-322-4987

Patient Rights and Responsibilities

Patients have the right to:

- Be treated with respect and dignity.
- Have their cultural, psychosocial, spiritual, and personal values, beliefs, and preferences respected.
- Receive quality treatment from trained individuals, regardless of race, creed, sex, or national origin.
- Receive treatment in the least restrictive environment.
- Be informed about their diagnosis, treatment, prognosis, and any recommended treatments in terms that they can understand.
- Make informed decisions regarding their treatment.
- Refuse treatment.
- Receive treatment in an environment that is safe and secure.
- Privacy and confidentiality.
- Access information contained in their medical record, according to federal privacy laws, unless clinically contraindicated.
- Be informed of any rules and regulations governing NAPA which affect them.
- Access the Quality Improvement Officer to voice and receive aide in resolving concerns, conflicts, grievances, and/or complaints.
- File a complaint with the appropriate state regulatory agency.

Patients are responsible to:

- Inform their provider to the best of their knowledge, complete and accurate information regarding their medical history, including present symptoms, past illnesses, medications, both prescription and non-prescription, hospitalizations, etc., and to report any changes in their health or in the medication they take.
- Accept consequences should they refuse treatment or not follow the recommendations of the treating professional.
- Ask questions of their provider, or as applicable, NAPA staff when they are unclear about any aspect of their treatment.
- Be considerate of the rights of, and treat respectfully, other patients and staff.
- Take an active part in planning, implementing, and following through with their treatment program.
- Provide adequate notice in the event they are unable to attend a scheduled appointment.
- Notify their network provider if they choose to discontinue their treatment.
- Follow the rules of the program in which they are participating.
- Meet financial commitments agreed to with their network provider.
- Protect the confidentiality of other patients by not disclosing their names or any other information disclosed by other patients.

ACKNOWLEDGEMENT OF RECIEPT

Your signature acknowledges that you have received a copy of the Patient Rights & Responsibilities.

Patient Name: _____

Patient Signature or Patient Representative: _____

Relationship to patient: _____Date Signed: _____

NAPA
NORTH ALABAMA
PSYCHIATRIC ASSOCIATES, P.C.

Heath Penland, MD
Heidi Hollinger, CRNP, PMHNP
James Taylor, LPC
953 Jeff Rd. NW Huntsville, AL. 35806
(P) 256-322-6272* (F) 256-322-4987

Authorization for Release/Request of Protected Health Information

Name: _____ DOB: _____ Last 4 of SS#-_____

I hereby authorize the release of the following specific information (circle all items that apply):

YES **NO** 1. Medical History
YES **NO** 2. Psychological test/psychiatric evaluation/neurological workup
YES **NO** 3. Social History, including family, education, employment, arrest and drug use information
YES **NO** 4. Summary of previous mental health treatment
YES **NO** 5. Periodic reports of current treatment, including attendance, participation and urine drug screen results
YES **NO** 6. Other (Specify) _____

Date(s) of Treatment to be released: _____

To/From: Dr. Heath Penland Heidi Hollinger CRNP James Taylor LPC

Address: 953 Jeff Rd. NW, Huntsville AL. 35806
Phone: 256-322-6272 **Fax:** 256-322-4987

From/To: _____

Address: _____

Phone: _____ **Fax:** _____

I understand that this information will be used for the following specific purposes (Circle Yes or No)

YES **NO** 1. To develop a diagnosis, treatment, and rehabilitation plan
YES **NO** 2. To coordinate medical, psychological and social rehabilitative process
YES **NO** 3. To process insurance claims for services provided (diagnosis, number of visits, modalities, and expected length of treatment)
YES **NO** 4. Other (specify) **TO COORDINATE PATIENTS CARE or TRANSFER PATIENTS CARE**

I voluntarily allow the release of the above information. No threat or other measures have induced me to sign this consent form. I may revoke this at any time.

_____ Date: _____
Patient Signature

_____ _____
Parent/Patient Representative Signature (If Applicable) Printed Name and Relationship to Patient (If Applicable)

_____ Date: _____
Witness Signature

Unless otherwise noted, this authorization will expire on the following date 3 Years or upon Termination of Services. This authorization is valid for one year from the date listed above. You may revoke this authorization at any time by notifying **NAPA** in writing, but such revocation will have no effect on disclosures of information already made under this authorization prior to receipt of the revocation. This authorization is voluntary, and you may refuse to sign the authorization and the patients' treatment, or payment obligations will not be affected by this authorization unless (i) the treatment is related to research and the use and/or disclosure is related to such research, or (ii) the treatment is solely for the purpose of creating protected health information for disclosure to a third-party. Upon signature, you may receive a copy of this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by state or federal law. **NAPA** will not receive financial or in-kind compensation or remuneration in exchange for the use and/or disclosure of the patient's information unless an applicable legal exception applies. This authorization is continuing in nature and is to be given full force and ffect to release any and all of the foregoing information learned or determined after the date hereof until the expiration date. I hold **NAPA** its employees, associates, directors, officers, agents and representatives harmless from any and all damages which might result to myself, the patient, our representatives, heirs, and/or assigns from the disclosure of this information. A copy or facsimile of this authorization shall be valid and effective, just as the original.