NAPA
NORTH ALABAMA
PSYCHIATRIC ASSOCIATES, P.C.

DR. DANIEL LAEUPPLE, MD
953 JEFF ROAD N.W. BLDG#2 HUNTSVILLE, AL. 35806
www. northalabamapsych.com
(256)346-0126 Office (256) 255-2148 Fax

PATIENT REGISTRATION FORM

Patient Name: _____

Address: _____

City: _____

State: _____ ZIP Code: _____

Marital Status: Single/Married/Domestic Partnership/Divorced/Widowed/Separated

SS#: _____ Age: _____

Date of Birth: _____ Gender: _____

Home Phone: _____Work Phone: _____

Cell Phone: _____

Email Address: _____

Employer Name: _____

Employer Address: _____

City: _____ State: _____

ZIP Code: _____

Emergency Contact Name: _____ Phone: _____

Referred By: _____ Phone: _____

Family Physician: _____ Phone: _____

Have you had previous mental health treatment? YES or NO

***If yes, WHERE? WHEN?**

_____

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INSURANCE INFORMATION

(PLEASE ATTACH A COPY OF YOUR INSURANCE CARD)

Primary Insurance Carrier: _____

Policy #: _____

Insured's Name: _____ Insured's DOB: _____

Insured's SS#: _____Group #: _____

Patient's Relationship to the Insured: _____

Employer Name: _____

Secondary Insurance Carrier: _____

Policy #: _____

Insured's Name: _____ Insured's DOB: _____

Insured's SS#: _____Group #: _____

Patient's Relationship to the Insured: _____

ASSIGNMENT AND RELEASE

I the undersigned have insurance coverage with _____ and assign directly to **Dr Daniel Laeupple LL C**all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

I request that payment of authorized insurance benefits to me or on my behalf to **Dr Daniel Laeupple LLC** for any services furnished on me by that provider. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for the related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. My signature authorizes releasing of the information to the insurer or agency shown.

X_____

Signature of Insured and/or Guardian Date

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FINANCIAL AND PAYMENT POLICIES

1. I understand that I must pay my co-pay at the time of visit in full. ***Personal checks will not be accepted***.

2. After insurance has paid, I understand that if there is any additional amount due for the visit, I will be responsible for this amount.

3. Any outstanding balance that is not paid within 60 days of insurance remittance I understand that I will not be seen by **Dr. Daniel Laeupple MD** until the outstanding balance is paid in full.

4. If my check is returned, I understand that I will have to pay a $25.00 fee in addition to any bank charges.

5. If I do not give 48-hours' notice to cancel my initial appointment, I will be charged a $40.00 fee. If I do not give 24-hour notice for any follow-up appointment, I will be charged an $75.00 fee. This fee is not covered by insurance, and I will be responsible for payment in full before I am able to reschedule my appointment.

6. It is my responsibility to notify staff of any changes to my personal or insurance information.

7. If paperwork is completed for me in regard to Disability Determination, Leave from work forms, Letters, etc. I will be charged a fee for the doctor's time to complete the forms.

8. Lost or damaged prescriptions and messages left afterhours or services of non-emergency nature will also incur charges, refill fees, etc.

9. If I cancel or no show 3 appointments consecutively in a calendar year, I may be dismissed from the practice.

_____ For ALL fee's due at time of services rendered, this provider may require a
(Initials) credit card to be put on file in your EMR for all copays or balances that are 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: _____

X_____

Patient's Signature **Date**

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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:

_____

_____

_____

_____

_____

_____

_____

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SITUATIONS WHICH REQUIRE AUTHORIZATION

Other uses and disclosures of medical information will be made only with specific, written authorization. You have the right to revoke an authorization at any time except in the instance where entity has already taken action in reliance on this authorization.

NATIONAL SECURITY

Dr Daniel Laeupple LLC may disclose medical information to federal officials for intelligence and other national security agencies as required by law.

INMATES

If you are an inmate, **Dr Daniel Laeupple LLC** may disclose medical information about you to the institution or official to which you are assigned.

COMPLAINTS

If you have a question or complaint about the way your protected health information is handled; please contact the privacy officer whose name is listed below.

PRIVACY OFFICER

953 Jeff Rd NW Bldg#2 Huntsville, AL 35806 (256) 346-0126. You may also file complaints with the Secretary of the Federal Dept. of Human Services. You will not be penalized or suffer retaliation if you file a complaint regarding a known or suspected violation of your privacy rights.

REVISION OF NOTICE

This notice may be revised or updated from time to time. If the notice is revised or changed, you will be provided a copy of the revised notice. Any revision of the notice will apply to all protected health information that is maintained by **Dr Daniel Laeupple LLC**. We will also post any revised notice in the front office located at **953 Jeff Rd NW Bldg#2 Huntsville, AL. 35806.**

SITUATIONS WHICH DO NOT REQUIRE AUTHORIZATION

We are allowed to release medical information about you to the following without an authorization:

PUBLIC HEALTH ACTIVITIES

Dr Daniel Laeupple LLC may disclose medical information about you for public health activities such as control of disease, injury, or disability, reporting of child abuse or neglect, reporting of medication adverse events, and in situations related to defective medical products.

ORGAN TISSUE DONATION

Dr Daniel Laeupple LLC may disclose medical information to organizations that handle organ transplantation if you are an organ donor.

MILITARY AND VETERANS

Dr Daniel Laeupple LLC may release medical information about you to military authorities if you are a member of the armed forces for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Dept. of Veterans Affairs of your eligibility for benefits, or to foreign military authorities if you are a member of that foreign military service. We may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

WORKER'S COMPENSATION

Dr Daniel Laeupple LLC may disclose medical information about you for worker's compensation programs if you have a work-related injury.

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AVERTING SERIOUS THREAT TO HEALTH OR SAFETY

Dr Daniel Laeupple LLC is required to disclose medical information when necessary to prevent a serious threat to your health and safety of others.

HEALTH OVERSIGHT

Dr Daniel Laeupple LLC may disclose medical information to a health oversight agency such as audits, investigations, and inspections.

LAW ENFORCEMENT

Dr Daniel Laeupple LLC may disclose medical information to law enforcement officials to the extent that the law requires such use or disclosure.

CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS

Dr Daniel Laeupple LLC may disclose medical information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death.

TREATMENT

Dr Daniel Laeupple LLC shall from time to time provide information about you without requesting specific authorization for treatment, payment, and healthcare operations. This is not a complete listing, but is provided as example of how the information may be used:

Dr Daniel Laeupple LLC *may confer about your needs and will share pertinent information about you as needed for on* call coverage**. Dr Daniel Laeupple LLC** may share protected health information about you with hospitals or other healthcare providers.

PAYMENT

Information about your health will be shared with your insurance company to provide the information they require in order to pay your claim for the services rendered. We may also disclose medical information to your insurance company to obtain prior authorization for treatment and procedures. We may also disclose information about your health or medical billing information to third party billers or outside medical services.

HEALTH CARE OPERATIONS

Dr Daniel Laeupple LLC may use health information for operations and activities such as quality control, quality assurance, and financial planning that are necessary to provide efficient and quality care for our patients.

APPOINTMENT REMINDERS

Dr Daniel Laeupple LLC staff may contact you by phone to remind you of your scheduled appointments at any time if the automated reminders show that it did not go through. If you do not wish to have these reminders by phone, please contact the receptionist or the administration office at **953 Jeff Rd NW Bldg#2 Huntsville, AL 35806 (256) 346-0126**.

EFFECTIVE DATE

This notice is effective on January 1, 2022

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. Please review it carefully.

RIGHTS

Patients of **Dr Daniel Laeupple LLC** have the right to the following:

You have the right to request restrictions on certain uses and disclosures of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to any restriction and will advise you if this is the case.

You have the right to receive confidential communications of your protected health information and may request to receive information from us by alternative means or at alternate locations.

You have the right to inspect and copy protected health information about yourself. If you desire to review and inspect your medical record, a request to do so may be made in writing to the Privacy officer whose name and telephone number are listed below. You will receive information on the dates available for inspection of your record within 30 days of your request. If you desire to copy any part of all of your medical record, you may also make a request for copies to the Privacy Officer. The copies will be made and forwarded to you by mail within 30 days of receipt of your request. A charge of $50.00 plus $1.00 per page will be assessed to cover the costs of copying and reviewing the material.

You have the right to request amendments or revisions to your protected health information and to receive a response to your request for an amendment or revision. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of disclosures of protected health information that were provided without your written authorization. This accounting will be provided one time per year at no cost to you,

You have the right to obtain a paper copy of this notice if this form is provided electronically.

ACKNOWLEDGEMENT OF RECIEPT

Your signature acknowledges that you have received a copy of the

NOTICE OF PRIVACY PRACTICES.

Patient Name _____

Signature of Patient _____

Patient Representative (if applicable) _____

Relationship of Representative (if applicable) _____

Date Signed _____

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REFUND & Payment POLICY

It is the policy of Dr Daniel Laeupple LLC that payment is due at the time of service unless other financial arrangements are made in advance.

We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit.

At the conclusion of your visit with us you may be billed for any outstanding balances. If there is a credit balance, you will be provided a refund promptly.

***When your account is reviewed and a refund is approved, we will initiate the refund to your credit card on file (or the original method of payment). You will receive the credit within 7-10 business days, depending on your card issuer's policies.**

X _____ _____

Patient's Signature **Date**

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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. DANIEL LAEUPPLE, MD**
Address: 953 Jeff Rd. NW Bldg#2, Huntsville AL. 35806
Phone: 256-346-0126 **Fax:** 256-255-2148

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 **Dr Daniel Laeupple LLC** 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. **Dr Daniel Laeupple LLC** 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 **Dr Daniel Laeupple LLC** 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.