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ALTAPOINTE HEALTH
STATEMENT OF UNDERSTANDING AND CONSENTS

CONSUMER NAME: _____

Review and initial each applicable area:

All Programs

_____ **Treatment/ Psychiatric Care:** I hereby authorize AltaPointe to provide me with treatment services, and if it is my child or ward, I hereby give consent for treatment:
Services may include the prescription of psychoactive medications and the administration of those medications by approved program staff. Emergency medications may be given to the consumer (by mouth or injection) to prevent harm to themselves or others.
Children and adolescent inpatient consumers will receive educational services on site as appropriate. Classrooms may consist of students receiving special and/or regular educational services. Due to our emphasis on treatment of emotional and behavioral difficulties consumers will not be eligible to receive the same number of credits as they would on a public school campus.

_____ **Consent for Follow-up contact:** I consent to AltaPointe staff members contacting **__myself ___other contact** by letter, questionnaire or telephone for establishing my current condition. I understand this information will be held in confidence and will not be disclosed without my written consent. I further understand this consent for follow-up will remain valid for a period of **ONE** year following my discharge from the program. I understand that I may revoke this consent at any time in writing. ☐ **I do not want to be contacted.**
Name: _____Address: _____ Phone#: _____

_____ **Health Information Exchange (HIE):** AltaPointe participates in a HIE called Care Quality. I understand that any physician or hospital that participates in the Care Quality HIE either directly or indirectly may request for the purpose of my continuity of care the following limited set of records regarding my care: Allergies, Demographics, Labs, Immunizations Medications, and Problem Lists. You many chose to Opt-Out of allowing your health information to be shared through the Care Quality HIE by requesting an Opt-out form.
All other releases will follow the practices explained in Your Notice of Privacy Practices.

_____ **Payment Agreement:** For and in consideration of services rendered by AltaPointe, consumer (responsible person) herby agrees to and guarantees payment of all AltaPointe charges incurred for the account of the consumer from the date of admission until discharge. I understand that if an agency or company is responsible for payment of services, that agency or company will have the right to review the services I receive at AltaPointe. If the Probate Court placed me at AltaPointe, I understand that my insurance along with contract fees will be used to pay for services rendered while I am receiving services at AltaPointe.

I also understand that that I may be charged a fee or co-payment for services and that it is expected, if I am responsible for the payment of these services, to pay for them as they are received. I further understand I should contact AltaPointe if there are any changes to my insurance. A no-show fee may be charged if applicable.

Methods of Payment – Our office accepts the following payment methods: Cash, Personal Check, Credit Cards and Money Orders.
There will be a $25.00 NSF charge for all returned checks.

_____ **Fee Schedule:** I understand that I am responsible for payment for services rendered by AltaPointe Health, Inc. at its standard rates provided to me on the fee schedule.

_____ **Self-Pay –** I agree to pay AltaPointe in full for services rendered.

_____ **Medicaid:** Consumer certified that the information given in applying for payment under Title XIX (19) of the Social Security Act is correct. Consumer authorizes any holder of medical or other information about Consumer to release to the respective State Medicaid Agency or its intermediaries or carries any information needed for this or a related Medical claim. Consumer requests that payment of authorized benefits be made on his/her behalf.

_____ **Medicare:** Consumer certified that the information given in applying for payment under Title XVIII (18) of the Social Security Act is correct. Consumer authorizes any holder of medical or other information about Consumer to release to the Social Security Administration or its intermediaries or carries any information needed for this or a related Medical claim. Consumer requests that payment of authorized benefits be made on his/her behalf.

_____ **Assignment of Insurance Benefits and Agreement to Pay Any Balance**: Consumer (responsible party) irrevocably assigns and transfers to AltaPointe all right, title and interest to medical reimbursement benefits under any and all applicable medical insurance policies covering consumer, for the payment of treatment and medical care being provided. Consumer (responsible party) authorizes payment directly to AltaPointe Health of said medical reimbursement benefits. Consumer (responsible party) is responsible for and co-payments, co-insurance, deductibles, and/or other amounts specified by my insurance. In the event the said medical insurance coverage is not sufficient to satisfy the AltaPointe charge in full, consumer (responsible party) acknowledges that the resulting balance is not covered by this assignment and agrees to be fully responsible for the payment. I understand that my agreement with my insurance carrier is a private one, and that AltaPointe does not routinely research why my insurance carrier has not paid or why it paid less than anticipated for care.

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AltaPointe Health Statement of Understanding and Consents pg. 2

_____ **Integrated Healthcare Pharmacy Services**: As a consumer at AltaPointe Health my prescriptions may, but are not required, to be filled at the Integrated Healthcare Pharmacy located at Gordon Smith Drive. AltaPointe Health has an ownership interest in Integrated Healthcare Pharmacy and offers the on-site pharmacy services for the convenience of the consumer. It is the consumer's decision as to where he/she chooses to fill their prescription.

_____ **Consent for Residents, Interns, and Medical and Nursing Students to Participate in my Treatment**: I am aware that, residents, interns, medical and nursing students, could be present for educational purposes. I understand that in the educational process they may observe or participate in my or my child's treatment and/or review my or my child's medical record.

_____ **Family Involvement**: Family involvement is an integral part of treatment especially when treating children and adolescents. I agree to make every reasonable effort to assist my or my child's therapist in scheduling a convenient time for this family therapy session. I do understand that failure to meet this requirement can result in denials of insurance payment related to non-compliance with treatment.

_____ **Responsibility for Destruction of Property**: The undersigned understands that consumers are responsible for any damage to or destruction of AltaPointe property, or property belonging to others which may be located at AltaPointe. The undersigned and/or legal guardian agree to accept liability of, and reimburse AltaPointe or other owners of property which the consumer may damage or destroy.

_____ **Confidentiality of Information and Group Participation**: I understand that any information which is disclosed to me while I am a consumer at this facility is confidential and that this information is protected by Federal law. I understand that this means that I will respect the rights of other participants by not talking with others outside the facility about what is said in treatment groups.

_____ **Consumer Rights Statement**: I understand that AltaPointe subscribes to a Consumer Rights Statement, which has been made available to me. I have had the opportunity to have the Consumer Rights Statement explained to me.

_____ **Grievance Process**: I have been furnished with a copy of the Grievance process and had it explained to me.

_____ **Procedure to Review Records**: I have been furnished with a copy of the Procedure to Review my health record and had it explained to me.

_____ **Notice of Privacy Practices**: I have been furnished a copy of the Notice of Privacy Practices and have had it explained to me. I understand that the information concerning the treatment of _____ will be held in confidence by the AltaPointe staff unless I give specific written consent for the release of information. In case of emergency AltaPointe is authorized to request or release that information which is essential to handle the emergency.

Also, AltaPointe staff will not release any information except as required by law or Court Order under compelling disclosure, or in a situation deemed potentially life-threatening, and in the following instances: Suspected Child Abuse, threats of physical harm to self and/or others, espionage or sabotage.

The confidentiality of your participation may also be protected by federal and state laws and regulations. The violation of federal requirements is a crime, and suspected violations may be reported. Federal regulations do not protect from disclosure of information related to a consumer's commission of a crime against AltaPointe property or personnel, or reports under state law of suspected child abuse or neglect (See 42 U.S.C. 290 ee 3 for federal laws 42 CFR Part 2 for federal regulations).

_____ **Special Equipment**: I understand that special equipment, in the form of cameras, may be utilized at the facility for the safety of the consumers.

_____ **Rehabilitation Act:** It is the policy of AltaPointe, in compliance with Section 504 of the Rehabilitation Act of 1973, to afford qualified handicapped persons an opportunity to receive benefits or services that are equal to that offered non-handicapped persons. Any person who feels he/she has not received treatment in accordance with this policy may submit a compliant with the Consumer Needs Specialist, AltaPointe Health, 5750-A Southland Drive., Mobile, Al. 36693.

_____ **Consent to Photographs:** I consent to have my photograph taken by the staff at AltaPointe as part of the admission process. I understand that this photograph will be placed in my individual medical record in keeping with this facility's system of consumer identification, and will be used for identification purposes only when necessary during the course of my treatment.

_____ **Consent to Search**: I do hereby give my willing and informed consent to AltaPointe to search my personal belongings in my presence. **This consent is given to ensure that neither I nor anyone else in this facility has any prohibited items (dangerous objects, medications, contraband, or any other prohibited items)**. I do understand that this search would also be performed in the event of my leaving the facility by the appropriate clinical staff member as AltaPointe deems necessary. I do also understand that this search is to include socks and underwear.

_____ **Responsibility for Personal Articles**: Consumer (responsible person) acknowledges and agrees that AltaPointe does not assume responsibility for any personal possessions. Consumer and/or legal guardian acknowledges and agrees to accept responsibility for any personal possessions. Consumer acknowledges and agrees to accept responsibility for clothing and/or personal effects including dentures, eye glasses, hearing devices, etc.

_____ **Psychiatric Advance Directives:** ***(All Adult Programs)*** ___ I have a psychiatric advance directive and have provided a copy to AltaPointe. ___ I do not have a psychiatric advance directive, and have been provided information by AltaPointe

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Children's Outpatient Programs

_____ **Children's Outpatient Program Admission Agreement**: I have been furnished with a copy of the admission agreement and it has been explained to me.

Residential / Hospital Program

_____ **Seclusion & Restraint: The Last Resort**: I understand that AltaPointe's policy is to use Seclusion and Restraint only as a last resort. I have been given a copy of their policy and had the opportunity to ask questions. Physical restraint and/or seclusion may be used only in an emergency to protect the consumer or others from imminent risk of harming self or others. This procedure has been explained to me. I understand that this is not used as punishment, but only as an emergency procedure. I understand that an attempt will be made to contact:
Name _____ Relationship: _____
Phone Number: _____.

_____ **Consent for Participating in and Transport to Off-Ground Activities and therapies**: I give permission for me or my child to participate in off-ground activities such as movie, skating, museums, bowling, plays, etc., as approved by the attending physician. I understand that AltaPointe will provide reasonable supervision and will take reasonable precautions to provide for the safety and well-being of me and/or my child.

_____ **Adult Residential Services and Transitional Age Residential Financial/Medical/Dental Responsibility Agreement:** As a resident of a residential care home, I understand that (1) I am charged up to 75% of my monthly income or up to $750 for room and board. (2) My room, board charges may be changed if my income changes. I am responsible for up to 75% of all my income for room and board for those months for which I am eligible. (3) I will reimburse the program for all personal expenses incurred while a resident at AltaPointe Health to include, but is not limited to, any property damage personally created. (4) I understand that AltaPointe provides no routine medical and dental care. The provision of payment for routine and major medical costs must be made prior to admission through consumer resources, acceptable third party, or warranty by the sponsoring agent. I understand that I will be responsible for all my medical and dental care. If my relative/guardian/sponsor accepts responsibility for my medical and dental care, the signature is affixed below.

_____ **Child/Adolescent 24 Hour Care Program Elopement Report Permission**: I hereby give my permission as parent/legal guardian for the staff at AltaPointe to notify local law enforcement (police and/or sheriff's departments) of my child's full identity in the event of his/her unauthorized elopement from AltaPointe and/or the grounds. Identifying information may include name, birth-date, name(s) of parent(s), home address, and any other identifying information deemed potentially helpful in such a report.

_____ **Emergency Medical/Surgical Services**: I authorize and give my consent to AltaPointe staff to seek and obtain emergency medical/surgical treatment or dental treatment services as needed.

_____ **Medical Advance Directives:** ___I have a medical advance directive and have provided a copy to AltaPointe. ___ I do not have a medical advanced directive, and have been provided information by AltaPointe.

_____ **Consent for Sex education**: State and National Guidelines for child/adolescent treatment facilities require that the consumers be offered the chance to participate in sex education classes. AltaPointe will offer these classes on an informational level to those consumers who are of age to make their own informed decision or whose parents/guardians wish to have them enrolled. I give consent for my child to participate in informational sex education classes.

_____ **Consent to Attend Church-Related Activities**: I agree or give permission for my child to attend church-related activities while a consumer at AltaPointe. **(24 hour care programs)**

_____
Print Consumer's Name Consumer's Signature Date

_____ _____
Parent/Legal Guardian Signature Date Witness Signature/Credentials Date

_____
Witness Signature/Credentials **(required when signed with a mark)**

If consumer signature is not present mark reason:

_____ Consumer Unable to Sign

_____ Consumer refused to Sign (Show multiple attempts)
Date: _____
Date: _____
Date: _____
Date: _____
Date: _____

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ALTAPOINTE HEALTH SYSTEMS, INC.
INFORMED CONSENT FOR
VERBAL / EMAIL EXCHANGE OF INFORMATION

I, _____ hereby consent to the verbal/ email exchange of information between
(Print consumer name)

AltaPointe Health Systems and: _____
(Name of person or organization or email address information will be discussed with)

regarding_____
(Information that will be discussed)

For admission of _____ and for the following purpose:
(Date of admission)

☐ Facilitate Evaluation and Treatment
☐ Participate in treatment
☐ Other
Specify: _____

I understand that this consent will expire on _____ (Two year from the signature date) **or** at the time of my discharge from this program, whichever comes first. I understand that I may revoke this consent at anytime. The revocation may be given *verbally or in writing*, and it will not apply to information that was discussed prior to my revocation of this consent.

I have been informed that copies of my medical record can only be released by my signing an authorization giving my permission to do so.

_____ _____
Consumer Signature Date

_____ _____
Guardian/ Legal Representative Signature Date

_____ _____
Witness Signature Date

_____ _____
Witness Signature (if appropriate) Date

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AltaPointe Health

Date Released: _____
HIM Staff Initials: _____/_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

5750-A Southland Drive Mobile, Alabama 36693
Health Information Management (HIM) Department – Phone: (251)450-4352; Fax: (251)450-1396

Please allow up to fifteen (15) days for processing.
Failure to complete EACH section will render this authorization invalid, and therefore it will not be processed.

Name _____ **Date of Birth** _____/_____/_____
Address _____ **Social Security # (last 4 digits)** _____
City, State, Zip Code _____ **Phone Number** _____

I hereby authorize: _____

To release to: _____
Name

_____
Address and Fax Number

This consent and authorization may include, but is not limited to, release of medical, psychological, psychiatric, alcohol, drug abuse, STD and HIV/AIDS information.

Purpose of Disclosure: ▫Personal ▫Attorney ▫Insurance ▫Disability/SSI ▫Continued Care ▫Other _____

The specific information to be released is:

▫ Biopsychosocial	▫ Psychological Testing	▫ Psychiatric Evaluation
▫ Medication Records	▫ Treatment Plan	▫ History/Physical
▫ Progress Notes _____	▫ Laboratory Reports	▫ Discharge Summary
▫ Diagnosis	▫ Physician Orders	▫ Entire Record

▫ Other: _____

Date(s) of Service Requested: _____

Delivery Format: ▫ Paper ▫ CD/DVD ▫ Electronic Transfer

I understand that this consent is revocable, except to the extent that action has already been taken in reliance thereon. Request for revocation of this authorization must be in writing. This authorization will expire (i) one year, (ii) after the disclosure is made, or (iii) the date specified here: _____, to accomplish the purpose of the disclosure stated above. I understand that I will receive a copy of this Authorization form after I sign it.

_____	_____	_____
Signature of Patient/ Representative	Relationship to Patient	Date
_____		_____
Signature of Witness		Date
_____		_____
Signature of Witness (If appropriate)		Date

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected under Title 45, CFR. AltaPointe Health may not condition treatment or payment on whether you sign this authorization, unless this authorization is for the provision of research-related treatment or for the creation of health information for disclosure to a third party.
Created: 5/16/19 NB 152

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ALTAPOINTE HEALTH

INFORMED CONSENT FOR PSYCHIATRIC TELEHEALTH SERVICES

Patient Name: _____

Healthcare Practitioner: AltaPointe Health Credentialed Provider

Introduction

Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual consumer health information for the purpose of improving consumer care. **This consent is valid for twelve months.** The information obtained may be used for diagnosis, therapy, follow-up, referral, and/or consultation, and may include one or both of the following:

- Live two-way audio and video
- Output data from medical devices and sound and video files

The interactive tele-video equipment and telecommunication lines used are HIPAA approved for consumer security and privacy.

Expected Benefits

- Improved access to psychiatric care by enabling a consumer to have a session with a psychiatrist while remaining at a remote site,
- More efficient medical evaluation and management.

Possible Risks

There are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment,
- In very rare instances, security protocols could fail, causing a breach of privacy of personal health information.

By signing this form, I understand the following:

1. The laws that protect privacy and the confidentiality of psychiatric information also apply to telehealth, and that no information obtained in the use of telehealth, which identifies me, will be disclosed to other entities without my written or verbal consent.
2. I have the right to withhold or withdraw my consent (either written or verbally) to the use of telehealth in the course of my care at any time.
3. I understand that the health care provider is off site at a remote location.
4. I understand that none of the teleconference will be recorded or photographed.
5. I understand that in the event of technical difficulties an employee of the IT department, as well as additional staff, may be present during my session.
6. I may have to travel to see a health care practitioner in-person if I decline the telemedicine service.
7. If I decline the telemedicine services, the other options/alternatives available for me, including in person services, are as follows:_____
8. The information from the telehealth service (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my **additional** written consent.
9. I will be informed of all people who will be present at all sites during my telemedicine service.
10. I may exclude anyone from any site during my telehealth service.
11. I may see an appropriately trained staff person, or employee, in-person, immediately after the telemedicine service if an urgent need arises. **OR,** I will be told ahead of time that this is not available.
12. I may contact the healthcare provider at phone number _____ for any questions I have related to medical services received through a telemedicine provider/site.

I understand that this consent will expire on _____ (Twelve months from the signature date) **or** at the time of my discharge from this program, whichever comes first.

I have read this document carefully, and my questions have been answered to my satisfaction.

Printed Name of Patient: _____

Signature of Patient: _____ Date: _____

OR Signature of Parent or Legal Representative: _____ Date: _____

Signature of Witness & Credentials/ Title Obtaining Telemedicine Consent: _____ Date: _____

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ALTAPOINTE HEALTH SYSTEMS

SECLUSION & RESTRAINT: The Last Resort

AltaPointe Health Systems creates and promotes a safe environment for all consumers. All consumers have a right to be free from seclusion and restraint. The use of seclusion and restraint is implemented only as an emergency safety measure when a consumer is at risk of harming themselves or others.

Upon each admission or intake, staff obtains information about the individual from the family member/legal guardian that is used to assist in minimizing the use of seclusion and restraint. Seclusion and restraint is never used to punish a consumer or for staff convenience. It is never meant to cause intentional physical discomfort, harm or pain to the consumer.

A consumer is placed in seclusion or restraint only when approved by a qualified individual (a physician, nurse practitioner or registered nurse). The use of nonphysical interventions are the first choice before seclusion and restraint are used and may include verbal interventions, removal of the consumer from the situation, one to one supervision by staff, or supervision by a family member or significant other to assist in calming the individual.

In the event of a seclusion and restraint episode, the staff will notify the family member/legal guardian of the occurrence as agreed on at intake. The staff discusses with the consumer and family member/legal guardian the circumstances leading to the incident and explores ways that future seclusion and restraint episodes can be avoided.

AltaPointe staff will preserve the consumer's safety, dignity and rights when seclusion and restraint is used. All consumers will be respected as an individual and their modesty and privacy will be safeguarded.

_____ _____

Signature of consumer/guardian Date

_____ _____

Witness Date

Revised: 3/6/12
BC 91018

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AltaPointe Health

Procedure for Review of Records

Any consumer or legal representative of a consumer may request an opportunity to review his/her records to obtain information from his/her records at AltaPointe Health. Such a request must be submitted in writing on a facility provided *Release of Authorization to Disclose Protected Health Information* form.

Upon receipt of this request, the Health Information Department shall forward the consumer's request and medical record to the clinician for determination if release of information would be detrimental to the consumer.

If after review the clinician determines the information may be released, the requested information will be copied and released to the consumer.

The copying fee for such requested records is:

On disc: $6.50 disk fee
On paper: $5.00 labor fee, $1.00 per page for the first 25 pages, $0.50 per page thereafter
$15.00 Certification fee if requested

Requests for Release of Health Information not completed and witnessed at one of our facilities require a notarized validation of identity of the requestor.

Appeal Process

Step 1: You may report any complaint/grievance to any employee of AltaPointe. All complaints received will be reported to the Consumer Needs Specialist. You will receive a response with possible solutions to your complaint within 10 working days from the Consumer Needs Specialist.

Step 2: If you are not satisfied with the solution you may request that your complaint be reviewed by the Consumer Needs Committee. You will receive a response with a possible solution from the Consumer Needs Committee within 10 working days.

Step 3: If you are not satisfied with the solution offered by the Consumer Needs Committee you may request that your complaint be reviewed by the CEO of AltaPointe Health. You will receive a response from the CEO within 30 days.

At any time you may contact the following agencies regarding your complaint/grievance:

Department of Mental Health – Mental Retardation Office of Advocacy Services
1-800-367-0955

Alabama Disabilities Advocacy Program
1-800-826-1675

Consumer Needs Specialist
(251) 450-4303

Department of Human Resources
(251) 450-9100 (Children) or (251) 450-1800 (Adult)

You may contact the Joint Commission's Office of Quality Monitoring to report any concerns or register complaints about ALTAPOINTE by either calling 1-800-994-6610 or e-mailing complaint@jointcommission.org.

AltaPointe Health
NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We have a legal duty to safeguard your (PHI) Protected Health Information. This PHI includes information that can be used to identify you that we have created or reviewed about your past, present or future health conditions. It contains what healthcare we have provided to you, or the payment history on healthcare related accounts. We must provide you with notice about our privacy practices and explain how, when and why we use and disclose your PHI.

We will not use or disclose your health information without your authorization, except as described in this notice or otherwise required by law. We are legally required to follow the privacy practices that are described in this notice.

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE RECORDS:

The confidentiality of alcohol and drug abuse records maintained by this organization is protected by federal law and regulations. Generally, the program may not communicate to a person outside the program that you attend the program, or disclose any information identifying you as an alcohol or drug abuser unless one of the following conditions is met:

* you consent to it in writing
* the disclosure is allowed by a court order
* the disclosure is made to medical personnel in a medical emergency or to qualified personnel for program

Violations of federal laws and regulations by a program are a crime. Suspected violations may be reported to the appropriate authorities in accordance with federal regulations.

Federal laws and regulations do not protect any information about a crime committed by you either at the program or against any person(s) who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

YOUR HEALTH INFORMATION RIGHTS:

Although your medical record is the physical property of AltaPointe Health, the information belongs to you. You have the right to:

* request in writing a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
* request in writing to obtain a paper copy of your health record as provided for in 45 CFR 164.524
* request in writing to amend your health record as provided in 45 CFR 164.526
* obtain a paper copy of the notice of information practices upon request
* request in writing to obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
* request in writing communication of your health information by alternative (other) means or at other locations
* revoke in writing your authorization to use and disclose health information except to the extent that action has already been taken
* obtain notice following any breach of your unsecured protected health information as provided in 45 CFR 164.520(b)(1)(v)(A)

OUR RESPONSIBILITIES:

AltaPointe Health is required to:

* maintain the privacy of your health information
* provide you with notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
* abide by the terms of this notice
* notify you if we are unable to agree to a requested restriction
* accommodate reasonable requests you may have to communicate health information by other means or at other locations
* train our personnel concerning privacy and confidentiality; implement a sanction policy to discipline those who breach privacy or confidentiality of our policy

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our Information practices change; the revised notice will be available through your therapist and in the lobby of the facility.

We will not use or disclose your health information without your authorization, except as described in this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have questions and would like additional information, you may contact the Consumer Needs Specialist at 251-450-4303.
If you believe your privacy rights have been violated you can file a complaint with the Consumer Needs Specialist at AltaPointe Health or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Your written statement to AltaPointe Health and/or the Office of Civil Rights must include your name; address; telephone number; your signature; how, why, and when you believe you were discriminated against; name and address of institution or agency you believe discriminated against you; and any other relevant information.

You may submit in writing a request for review of any discrepancy or complaint under HIPAA to any of the following:

Director
Office of Civil Rights
U.S. Department of Health & Human Service
61 Forsyth St., SW – Suite 31370
Atlanta, GA 30323
(404) 562-7858 or 562-7884

Consumer Needs Department
AltaPointe Health
5750-B Southland Drive
Mobile, AL 36693
(251) 450-4303

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS:

We will use your health information for treatment (fox example):
Information obtained by a, doctor, nurse or other mental health professional will be recorded in your record and used to determine the course of treatment that will work best for you. Any service provided to you will be documented in the record.

We will use your health information for payment (for example):
A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis. You may request restrictions on such uses only if the request relates to services paid of out-of-pocket and the request is for nondisclosure to a health plan related solely to such services as provided in 45 CFR164.520(v)(1)(iv)(a) and 164.522(a)(1)(vi)

We will use your health information for regular health operations (for example):
Members of the medical staff, the risk or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it.

Business Associates:
We provide some services through contracts with business associates. (Example: certain diagnostic tests).

Directory:
We do not have a directory that provides any information concerning your treatment here.

Notification:
We will not disclose any information to anyone about you without your written consent/authorization. Examples of uses or disclosures requiring your authorization include most disclosures of psychotherapy notes as provided in 45 CFR 164.520(b)(1)(ii)(E)

Communication with Family:
Only with your written authorization/consent will we disclose to a family member, another relative, a close friend, or any other person that you identify; health information relevant to that person's involvement in your care or payment related to your care.

Research:
We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Funeral Directors:
We may disclose health information to funeral directors consistent with applicable law to enable them to carry out their duties.

Marketing/continuity of care:
We may contact you to provide appointment reminders or information about treatment alternatives that may be of interest to you.

Fund raising:
We will not contact you concerning any fund raising activities.

Food and Drug Administration (FDA):
We may disclose to the FDA health information relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or postmarking surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation:
We may disclose information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health:
We may disclose your health information as required by law.

Correctional institution:
If you are an inmate of a correctional institution, we may disclose to the institution health information necessary for your health and the health and safety of other individuals.

Law Enforcement
We may disclose your health information for law enforcement purposes as required by law or in response to a court order.

Health Oversight Agencies & Public Health Authorities:
By Federal law provisions your health information may be released provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more consumers, workers or the public.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (MEDICAL RECORDS) THAT WE MAINTAIN. IF WE CHANGE OUR INFORMATION PRACTICES, WE WILL HAVE THE REVISED NOTICE AVAILABLE IN THE THERAPIST'S OFFICE AS WELL AS HAVE A SUPPLY AVAILABLE IN THE LOBBY OF THE FACILITY.

EFFECTIVE DATE: **04/14/03**
Revised 4/23/2018
NB- 30

AltaPointe Health

WHAT TO DO IF YOU HAVE A PROBLEM

1. If you don't like something that happens to you here, tell a grown up right away, Your parents can do this for you too.

   We have someone called a Consumer Needs Specialist who will talk to you and maybe your parents. She/he will try to find a way to fix the problem. She/he will tell you about her/his ideas in about 10 days.

2. If you don't like what she/he says you can ask the Consumer Needs Committee for help. They will try to come up with other ideas. They will let you know in about 10 days.

3. If you don't like what they say you can ask our Executive Director for help. He will let you know what he thinks in about 30 days.

You can always call someone at these numbers too:

Department of Mental Health - Mental Retardation Office of Advocacy Services
(800) 367-0955

Alabama Disabilities Advocacy Program
(800) 826-1675

Consumer Needs Specialist
(251) 450-4303

Department of Human Resources
(251) 450-9100 (Children) or (251) 450-1800 (Adult)

You may contact the Joint Commission's Office of Quality Monitoring to report any concerns or register complaints about AltaPointe by either calling 1-800-994-6610 or e-mailing complaint@jointcommission.org.

YOUR RIGHTS AT ALTAPOINTE HEALTH

At AltaPointe, we want to make sure you get the best care. So, if you are to get good care, there should be trust and respect between you and the people who give that care.

No consumer shall be refused services based upon their inability to pay.

WHEN YOU ARE A CONSUMER AT ALTAPOINTE, YOU HAVE THE RIGHT TO:

- Be treated with respect
- Be treated in a safe place
- Know how we will help you
- Get help from others, like your priest, pastor, preacher, or rabbi

FACTS ABOUT YOUR CARE . . . YOU HAVE THE RIGHT TO:

- Know why you are here and what the doctor thinks is the best way to help you
- Know how long you have to come here
- Not to be secluded or restrained unless a doctor says so

ABOUT YOUR MEDICINE . . . YOU HAVE THE RIGHT TO:

- Take medicine only if the doctor says you should
- Know about your medicine and how it can make you feel better
- Not take the medicine unless a judge says you have to

MAKING DECISIONS ABOUT YOUR CARE . . . YOU HAVE THE RIGHT TO:

- See your record
- Help plan your treatment
- Get your treatment in the place that least restricts you
- Not have any treatment unless the judge says you have to

ABOUT YOUR TREATMENT . . . YOU HAVE THE RIGHT TO:

- Be safe from harm while you are here
- Have your record kept private unless there is an emergency

IF YOU ARE GETTING CARE IN A RESIDENTIAL SETTING, YOU ALSO HAVE THE RIGHT TO:

- Get healthy meals
- Have your own things and your own clothes
- Not do any work that otherwise we'd have to pay for
- Go to public school every day
- Pray if you want to. We cannot make you pray.
- See a doctor or a dentist if you need to
- Have visitors, send mail, and make phone calls in private

YOU HAVE DUTIES TOO. YOU SHOULD:

- Respect other people
- Talk to your staff
- Not touch other people in the wrong way
- Not run away
- Not break things
- Take your medicine
- Not hurt other people or fight
- Go to school
- Follow the rules
- Join in activities
- Do your chores

REMEMBER! YOUR RIGHTS *CANNOT* BE TAKEN AWAY FROM YOU WITHOUT A VERY GOOD REASON!

If you feel that any of your rights have been stepped on or you have a complaint, there are 5 places you can call:

1. **Department of Mental Health Advocacy Office at 1-800-367-0955**
2. **Department of Human Resources at (251) 450-9100**
3. **Alabama Disabilities Advocacy Program at 1-800-826-1675**
4. **AltaPointe Consumer Needs Department at 1-251-450-4303**
5. **You may contact the Joint Commission's Office of Quality Monitoring to report any concerns or register complaints about AltaPointe by either Calling 1-800-994-6610 or emailing complaint@jointcommission.org.**

PSYCHIATRIC ADVANCE DIRECTIVES
INFORMATION FOR CONSUMERS

What is a psychiatric advance directive? A psychiatric advance directive (PAD) is a written document that describes your directions and preferences for treatment and care during times when you are having difficulty communicating and making decisions. It can inform others about what treatment you want or don't want, and it can identify a person called and "agent" who you trust to make decisions and act on your behalf.

Should I have an agent? You have the option of naming an agent:

- Who is at least 19 years old
- Who knows you and knows what you want when you are doing well

Can I write a legally-binding psychiatric advance directive? Yes. The Alabama Durable Power of Attorney Act allows you to appoint an "agent" to make healthcare decisions about mental health. The statutes include a form called "Advance Directive for Health Care". It is not mandatory for you to use that form, but it is advisable to do so.

You would include "other directions" on your form, which could include directions about mental health treatment. If you wish to write advance instructions about psychiatric medications and/or hospitalization, it is advisable to set out your wishes clearly in the "Mental Health Advance Directive" form. This form will still be valid even if you leave the end of life section blank.

Will everything in my psychiatric advance directive be followed? Your mental healthcare providers could decline to follow your instructions or those of your agent if the instructions concerned one of the excluded types of treatment, or if you were hospitalized or medicated under Alabama involuntary treatment laws.

Who should get a copy of my psychiatric advance directive? I you have named an agent, that person must be given a copy. After that, it is up to you who you give a copy to. You should think about giving one to your current mental health provider. Any treatment provider who gets a copy is required to make it part of your medical record.

How long does my psychiatric advance directive remain valid? The document appointing your agent is valid until you revoke it. It may be revoked in writing by you or someone else directed by you. If you destroy or deface it, it will also be assumed to be revoked. If you appoint your spouse as you agent and you divorce or legally separate after you wrote the document, your spouse would no longer be a valid agent. Be sure to notify everyone who has a copy if you revoke it or make any changes.

PSYCHIATRIC ADVANCE DIRECTIVE

Consumer Name_____ **MR #** _____

If you are hospitalized for mental health care in the future and aren't able to make decisions about your treatment, an advance directive will make your treatment preferences known. It is important that you decide **NOW** what types of treatment you want, and appoint a friend or family member to carry out your mental health care choices.

Read each section of the form carefully and discuss your choices with your treatment staff or other trusted person.

You can change your advance directive at anytime you are competent to do so. Your advance directive will not take effect unless a physician decides that you are incompetent to make your own treatment decisions. It is a good practice to carry a copy of the advance directive with you when you travel.

****

I, _____, being of sound mind, willing and voluntarily, execute this psychiatric advance directive to insure that if I should be found incompetent to consent to my own mental health treatment, my choices regarding my treatment will be carried out despite my inability to make informed decision for myself.

If a guardian or other decision-maker is appointed by a court to make health care or mental health decisions for me, I intend this document to take precedence over all other means of determining my intent while competent. This document represents my wishes and it should be given the greatest possible legal weight and respect. If the agent(s) named in this directive are not available, my wishes shall be binding on whoever is appointed to make such decisions.

If I become incompetent to make decisions about my own mental health treatment, I have authorized a mental health care agent to make certain treatment decisions for me. My agent is also authorized to apply for public benefits to defray the cost of my mental health care, to release information to appropriate persons, and to authorize my transfer from a health care facility.

This power of attorney shall become effective upon the disability, incompetency or incapacity of the Principal.

My mental health care agent is:

Name: _____

Address: _____

Telephone #: _____

Comments:_____

_____

_____

_____

_____

_____

_____

_____

_____

PSYCHIATRIC ADVANCE DIRECTIVE page2

Consumer Name_____ **MR #** _____

I, _____, mental health care agent

designated by _____, hereby accept the designation.

_____

Signature of Mental Health care agent Date

_____

Complete the following and initial in the blank marked yes or no:

A. If I become incompetent to give consent to mental health treatment, I give my mental health agent full power and authority to make mental health care decisions for me. This includes, the right to consent, refuse consent, or withdraw consent to any mental health are, treatment, service, or procedure, consistent with any instructions and/or limitations I have state in this advanced directive. If I have not expressed a choice in this advance directive, I authorize my agent to make the decision my agent determines is the decision I would make if I were competent to do so:
_____ YES _____ No

B. My choice of treatment facilities are as follows:

1. In the event my psychiatric condition is serious enough to require 24-hour care, I would prefer to receive this care in this/these facilities:
   Facility: _____
   Facility: _____

2. I do not wish to be placed in the following facilities for psychiatric care:
   Facility: _____
   Facility: _____

C. My choice of a treating physician is:

First choice of physician: _____
Second choice of physician: _____

I do not wish to be treated by the following physicians:

Name of Physician: _____

D. My wishes regarding confidentiality of my admission to a facility and my treatment while there are as follows:

1._____ My representative may be notified of my involuntary admission. ____ yes ____ no
2._____ Any person who seeks to contact me while I am in a facility may be told I am there. ____ yes ____ no
3_____ I consent to release of information about my condition and my treatment plan. ____ yes ____ no
To the following person: _____

4_____ I do not consent to the release of information about my admission or treatment to anyone unless I give specific consent at the time of the request or as otherwise allowed by law. ____ yes ____ no

E. If I am not competent to consent to my own treatment or to refuse medications relating to my mental health, I have initials one of the following, which represents my wishes:

1._____ I consent to the medications that Dr. _____ recommends.
2._____ I consent to the medications agreed to by my mental health care surrogate, after consulting with my treating physician and any other individuals my surrogate may think appropriate, with the exceptions found in # 3 below.
3._____ I specifically do not consent and I do not authorize my mental health care surrogate to consent to the administration of the following medications or their respective brand name, trade name, or generic equivalents: (list name of drug and reason for refusal).

_____

_____

4._____ I am willing to take the medications excluded in #3 above if my only reason for excluding them is their side effects and the dosage can be adjusted to eliminate those side effects.
5. _____ I have the follow other preferences about psychiatric medications: _____

Consumer Name_____ **MR #** _____

F. My wishes regarding Electroconvulsive Therapy (ECT) are as follows:

1. _____ My agent may not consent to ECT without express court approval.
2. _____ I authorize my agent to consent to ECT.
3. _____ Other instructions and wishes regarding ECT are as follows: _____

_____

G. If, during a stay in a psychiatric facility my behavior requires an emergency intervention, my wishes regarding which form of emergency interventions should be made in the following order as indicated by the number.. If an intervention you prefer is not listed, write it in after "other" and give it a number.

___ Seclusion
___ Physical restraints
___ Both seclusion & restraints
___ Other: _____

___ Medication in pill form
___ Medication in liquid form
___ Medication by injection

H. If I am incompetent to give consent, I want staff to immediately notify the following persons that I have been admitted to a psychiatric facility.

Name: _____ Relationship: _____
Address: _____
Telephone #: _____

Name: _____ Relationship: _____
Address: _____
Telephone #: _____

By signing here I indicate that I fully understand that this advance directive will permit my mental health agent to make decisions and to provide, withhold, or withdraw consent for my mental health treatment.

Printed Name: (Consumer): _____

Signature: _____ Date: ____/____/____

I am witnessing this form because I believe this person to be of sound mind. I did not sign the person's signature, and I am not the agent. I am not related to the person by blood, adoption, or marriage. I am at least 19 years of age and am not directly responsible for paying for his or her care.

Name of first witness: _____

Signature: _____Date: ____/____/____

Name of second witness: _____

Signature: _____Date: ____/____/____

YOUR RIGHT TO MAKE YOUR OWN DECISIONS ABOUT MEDICAL CARE

A Summary of the Law in Alabama

1. UNDER CURRENT ALABAMA LAW, DO I HAVE THE RIGHT TO MAKE MY OWN DECISIONS ABOUT MEDICAL CARE?

Yes. If you are nineteen (19) years old and are reasonably alert and mentally capable of understanding the consequences of your own decisions, Alabama and Federal laws give you the right to decide whether medical procedures or treatment will be provided to you. This right applies whether these are lifesaving emergency treatments, life-sustaining treatments, or the provision of food and liquids by artificial means. Examples of lifesaving treatments include CPR, cardiac defibrillation (a procedure where electric current is applied to your chest), mechanical ventilators to assist in breathing, dialysis machines to assist kidneys, administration of medications, foods, and liquids which can be administered through intravenous (IV) needles, or a tube inserted in your nose and down your throat, or through a tube which has been surgically placed directly into your stomach.

If you are unable to make your wishes known and have previously made your wishes known in a written document you signed when you were nineteen (19) years of age or older and were reasonably alert and mentally capable of understanding the consequences of your own decisions, then the Supreme Court of Alabama has recognized your right to have your wishes followed. These written documents are called Advance Directives and include: Living Wills, Durable Powers of Attorney, Health Proxies and other written expressions of your wishes regarding healthcare. If you are at all uncertain what your wishes are or that your wishes will not be followed, you should discuss your wishes with your physician and with as many of your family members as possible so that there will not be any question what your wishes are. If you are in an accident or suffer from a serious illness you may become permanently unconscious because you are in a Persistive Vegetative State. If you have not made your wishes known your family may be called upon to make health care decisions on your behalf.

2. AM I PERMITTED TO DECIDE WHAT TREATMENT I WANT OR DO NOT WANT TO HAVE?

Yes. Every Alabama citizen has the right to refuse unwanted medical treatments. If you are nineteen (19) years of age or older, reasonably alert, and able to understand the consequences of your own decisions, you have the right to refuse any medical treatment, including life-saving and life-sustaining treatments.

3. HOW CAN I MAKE IT KNOWN THAT I DO NOT WANT CERTAIN MEDICAL TREATMENTS?

You should simply tell your physician and other health care providers, such as the hospital or nursing home to which you have been admitted, exactly what treatments you do or do not want. It is clear that your wishes will be honored so long as you remain conscious and reasonable alert. If you are not sure what treatments may be offered to you, you should ask your physician.

4. CAN I DO ANYTHING NOW SO THAT MY WISHES WILL BE HONORED IF I LATER BECOME UNCONSCIOUS OR UNABLE TO COMMUNICATE?

There are three things you should do to make sure your wishes are honored even if you later become unable to speak for yourself.

First you may wish to consider creating a Living Will. This document will permit you to express your wishes in advance about certain medical treatments that are commonly offered to patients whose lives are in danger. It will only take effect if you later become unable to express your wishes about medical treatments at the time they are offered. If the document is properly filled out, it should be honored by the physicians, nurses, hospitals, nursing homes, and home health agencies. Some health care providers object to withholding artificially provided food and liquids. But even those health care providers may not give you treatments that you specify you do not want in your living will. Such a facility may, however, choose to transfer you to another facility where your wishes will be honored without objection.

Second, you may designate another person to make decisions on your behalf. Such a person may be known as a health care proxy or an attorney-in-fact. Don't be confused by the term, attorney-in-fact, however. The person you select to make decisions on your behalf need only to be a competent adult, and does not have to be a lawyer. This person will have the power to make decisions and grant consents on your behalf concerning your health care and treatment.

Third, you should in all cases discuss your wishes in advance about various kinds of medical treatment with your close family members so that they won't give conflicting instructions.

5. WILL I BE TREATED ANY DIFFERENTLY IF I DECIDE NOT TO CREATE A LIVING WILL OR HEALTH CARE PROXY?

Absolutely not. It is unlawful for health care providers to discriminate in the treatments and services offered based on a patient's decision about a Living Will or other form that specifies the patient's health care wishes.

6. HOW CAN I CREATE A LIVING WILL OR HEALTH CARE PROXY?

There is a form included in this pamphlet which has been specifically designed by Alabama attorneys representing the State Medicaid Agency, the State Department of Public Health, the State Medical Association, the State Hospital Association, the State Nursing Home Association and the State Bar Association. This form includes both a Living Will and a durable power of attorney for health care, or health care proxy. (Of course, you may also choose not to create a living will or health care proxy.) The Living Will form contains a number of options where you may choose which medical treatments you want given and which ones you want withheld. You may also want to contact your own attorney who may have another form that he or she prefers to use.

In any case, you will want to discuss your decisions about creating a Living Will or a health care proxy, and about the treatments you want and do not want with family members, close friends, and perhaps with a clergyman or other counselor.

If you decide to create a Living Will or health care proxy, it is most important that you give a copy to your physician and to any hospital or nursing home which you are admitted.

7. CAN A HEALTH CARE PROXY APPOINTED UNDER THE FORM INCLUDED IN THIS PAMPHLET HAVE ACCESS TO MY PROPERTY?

No. Your health care proxy appointed under the form included in this pamphlet can make only decisions concerning your health care. If you wish for that person to have access to your property to use for your benefit, you should consult an attorney for advice.

7. HOW DO I REVOKE (TAKE BACK) A WRITTEN ADVANCE DIRECTIVE?

You may revoke your Advance Directive by means of: 1) a signed, dated, written document which explicitly revokes the Advance Directive; 2) physically canceling or destroying the Advance Directive (you may do this on your own or have someone else do this in your presence); 3) by means of an oral expression of an intent to revoke the Advance Directive to your health care provider; or 4) a new Advance Directive which is materially different from the prior Advance Directive.

Such revocations will not be effective unless communicated to your attending physician and to the provider where you are receiving treatment. No health care provider has responsibility for failure to act upon a revocation, unless he/she has actual knowledge of the revocation.

9. SHOULD I ASK MY PHYSICIAN ABUT HIS OR HER POSITION IN REGARDS TO MY RIGHT TO **REFUSE MEDICAL TREATMENT?**

Yes. You should discuss with your physician your wishes in regards to medical treatment you may want or not want, so that both of you are clear exactly what your wishes are. Also, some physicians may have moral or ethical reasons that they are unable to assist patients in such situations. If this is the case with your physician you need to know this so that you may make other arrangements.

10. DO I NEED TO MEET WITH MY ATTORNEY PRIOR TO SIGNING ANY ADVANCE DIRECTIVE?

You may want to meet with your attorney prior to signing any Advance Directive. Alabama statutes currently provide a form for Living Wills; however, the printed language does not provide for all situations. For instance, the form only applies to persons who have a terminal condition and whose death is eminent and as such does not apply to persons who are in what is known as a "persisted vegetative state". The statutes do allow persons to include other specific directions in a Living Will. Alabama also has a statute allowing people to create Durable Powers of Attorney. An attorney can assist you in creating a document whereby you could designate someone as your attorney-in-fact to make health care decisions on your behalf or you may use the form attached to the pamphlet.

11. DO HOSPITALS, NURSING HOMES AND HOME HEALTH AGENCIES HAVE TO ASK PATIENTS ABOUT ADVANCE DIRECTIVES?

Yes. Under a Federal law passed in 1990 providers must ask about the existence of Advance-Directives, they must inform patients of their written policies and procedures about Advance Directives, and they must inform patients that care provided at the institution cannot be conditioned on completing an Advance Directives. This is why you have been given this document. If the provider cannot honor a request based on religious or moral grounds, the provider is obligated to help arrange transfer so that the patient's wishes can be followed.

NOTE: The attached Declaration is only a suggested form that may be used if you wish to create a Living Will and/or appoint a health care proxy. You cannot be required to do so, and you do not need to sign anything unless you DO want to create a Living Will and/or appoint a health care proxy.

DEFINITIONS

For the purpose of the provided declaration the following terms shall have the meanings ascribed to them:

1. Life-Sustaining Procedures. Any medical treatment, procedure, or intervention that, in the judgment of the attending physician, when applied to me, would serve only to prolong the dying process. These procedures shall include, but are not limited to, assisted ventilation, renal dialysis, surgical procedures, blood transfusions, and the administration of drugs and antibiotics. Life-sustaining treatment shall not include the administration of medication or the performance of any medical treatment where, in the opinion of the attending physician, the medication or treatment is necessary to provide comfort or to alleviate pain.

2. Artificially Provided Nutrition and Hydration. The supplying of food and water through a conduit, such as a tube or intravenous line, where the recipient is not required to chew or swallow voluntarily, including, but not limited to, nasogastric tubes, gastrostomies, jejunostomies, and intravenous infusions. Artificially provided nutrition and hydration does not include assisted feeding, such as spoon feeding or bottle feeding.

3. Attending Physician. The physician selected by or assigned to me and who has primary responsibility for my treatment and care.

4. Terminal Condition or injury. An illness or injury for which there is no reasonable prospect of cure or recovery, death is imminent, and the application of life-sustaining procedure would only prolong the dying process.

5. Persistive Vegetative State. A condition, to a reasonable degree of medical certainty:

   a. Which will last permanently, without improvement

   b. In which the thought, sensation, purposeful action, social interaction, and awareness of self and environment are absent; and

   c. Which has existed for 30 days since diagnosis as persistive vegetative state.

Medical Advance Directive

DECLARATION

Declaration made this_____ day of_____.

I, _____being of sound mind, willfully and voluntarily making known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

I. TERMINAL CONDITION

If at any time my attending physician determines that I am unable to direct my care and I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

II. MY OTHER SPECIFIC DIRECTIONS

My other specific directions are as follows (initial only those provisions you want applied):

1. Terminal Illness or injury. If my attending physician and another physician determine that I have an incurable terminal illness or injury which will lead to my death within six months or less, my wishes and respect to artificially provided nutrition and hydration are as indicated by my initials (initial only one):

_____ Initials (a) I do NOT want artificially provided nutrition and hydration provided to me even if withholding or withdrawing it causes me pain

_____ Initials (b) I do NOT want artificially provided nutrition and hydration provided to me but only if withholding or withdrawing it, in the judgment of my attending physician, would not cause me undue pain.

_____ Initials (c) In all cases I DO want artificially provided nutrition and hydration provided to me.

2. Persistive Vegetative State. If in the judgment of my attending physician, am in a condition of persistive vegetative state:

A. My wishes with respect to life-sustaining treatment are as indicated by my initials (initial only one).

_____ Initials (1) I do NOT want life-sustaining treatment which would only maintain me in a condition of persistive vegetative state without curing me.

_____ Initials (2)I DO want life-sustaining treatment which would only maintain me in a condition of persistive vegetative state without curing me.

B.. My wishes with respect My wishes with respect to artificially provided nutrition and hydration are as indicated by my initials (initial only one).

_____ Initials (1) I do NOT want artificially provided nutrition and hydration provided to me even withholding or withdrawing it causes me pain.

_____ Initials (2) I do NOT want artificially provided nutrition and hydration provided to me but only if withholding or withdrawing it, in the judgment of my attending physician, would not cause me undue pain.

_____ Initials (3) In all cases I DO want artificially provided nutrition and hydration provided to me.

Medical Advance Directive

DECLARATION

3. Other Specific Directions (if none, state "none")
_____ Initials

III. APPOINTMENT OF MY HEALTH CARE PROXY

I understand that my health care proxy is a person whom I may chooses here to make medical treatment decisions for me as described below.

1. I do NOT want to appoint a health care proxy. _____ Initials

2. I DO want to appoint a health care proxy. If my attending physician determines that I am no longer able to give directions to my health care providers regarding my medical treatment, I direct my attending physician and other health care providers to follow the instructions of _____,
(address)_____
(telephone)_____
Whom I appoint as my health care proxy.
If my health care proxy is unable to serve, I appoint _____,
(address)_____
(telephone)_____as
my alternate health care proxy with the same authority My health care proxy is authorized to make whatever medical treatment decisions I could make if I were able, including decisions regarding the withholding or withdrawing of life-sustaining treatment.

(a) This appointment of my health care proxy shall become effective upon my disability, incompetency or incapacity. My disability, incompetency, or incapacity shall be defined as a physical or mental condition, which renders incapable of giving directions to my health care providers regarding my medical treatment, as determined by the sole opinion of my attending physician . If or when I recover from any disability, incompetency or incapacity which activated this power of attorney, the powers granted hereby shall be terminated, until such time as my attending physician again determines that I suffer from disability, incompetency or incapacity. The determination as to whether or not I have recovered from my disability, incompetency or incapacity shall be made by and within the sole discretion of my attending physician.

(b) Durable Power of Attorney, i intend this appointment to be the creation of a durable power of attorney under the Alabama durable Power of Attorney Act, Section 26-1-2, Code of Alabama 1975, as the same should be amended from time to time, for my health care proxy to make decisions set forth above and to become effective upon my attending physician's determination that I am no longer able to direct my health care because of my disability, incapacity, or incompetency.

Medical Advance Directive

DECLARATION

(c) My health care proxy is authorized, subject to the provisions of Section III.2.(e) and (f) below, to make whatever medical treatment decisions I could make if I were able, including without limitation decisions regarding the giving or withholding or withdrawing of life-sustaining procedures, health treatment, medical procedures, health procedures, health care, or diagnostic procedures; to talk with health care personnel, obtain information and sign forms necessary to carry out such decisions, as well as to execute authorizations for medical treatment and for the administration of drugs, therapy, testing, radiological testing, anesthetic drugs and devices, surgery, cosmetic surgery, reconstructive surgery, blood transfusions, and in general for any type of medical treatment administered by any practitioner of the healing arts (including but without limitation medical doctors, registered nurses, licensed practical. I understand that if I do not initial either of the above, then my health care proxy will make the decision.

IV. APPLICABILITY

In the absence of my ability to give directions regarding the use of such life-sustaining procedures and artificially provided nutrition and hydration, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

The provisions of this declaration are severable. If any part of this declaration is determined invalid or unconstitutional, that determination shall not affect the part that remains.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration. I understand I may revoke this declaration at any time.

Signed: _____ City: _____

County: _____

Date: _____ State: _____

The declarant has been personally known to me and I believe him or her to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not related to the declarant, by blood or marriage, appointed as a health care proxy herein, entitled to any portion of the estate of the declarant according to the laws of interstate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care.

_____

Witness Address

_____

Date Address

_____

Witness Address

_____

Date Address

MR#: | | | | | | | EP: | | Date: | | | – | | | – | | | | |
M M D D Y Y Y Y

ALTAPOINTE HEALTH

CONSENT FOR PET THERAPY

I, _____, give consent for
(Guardian/ Legal Representative Name)

_____, to participate in the Pet
(Consumer Name)

Therapy program at _____and verify that he/she does not

have any pet allergies.

_____ _____
Consumer Signature Date

_____ _____
Guardian/ Legal Representative Signature Date

_____ _____
Witness Signature Date

10/21/13 Revised 4/19/2018
BC 92077

92077

Health Insurance Portability and Accessibility Act (H.I.P.P.A.)

We are committed to protecting your health information in compliance with the law. We are required by law to give you a copy of this notice and obtain your written acknowledgment that you have received a copy of this notice.

Patient Acknowledgement of Receipt

I, _____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

_____

Print Patient's Name

_____ _____

Signature **Date**

People that are allowed to give information to:

_____

Child Consent

Consent for Services

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the Mobile Bay Dental & Vision of any changes in my child's medical status and new medications. I authorize the dentist/ optometrist to release any information including the diagnosis and records of any treatment of examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist/optometrist or dental group, insurance benefits otherwise payable to me. I understand that my child's insurance may pay less than the actual bill for services. I grant my permission to you or your assignee, to telephone me at my home or at my work to discuss related matters to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient:_____
Signature or patient, parent or guardian

Authorization

I authorize my insurance company to pay Mobile Bay Dental & Vision all insurance benefits otherwise payable to my child for services rendered. I authorize the use of this signature to all business submissions. I authorize Mobile Bay Dental & Vision to release all information necessary to secure the payment benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. By signing this document, I make this a legal binding document.

Signature of responsible party

_____

Date_____

*** PLEASE TURN OVER TO COMPLETE BACK***

Adding Collection Fees to Account Balances

Agreement to pay: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.

Signature of responsible party

_____

Date_____

Consent to Contact Debtors on Their Cell Phones

Express prior consent to contact consumer by cell phone:
You, agree, in order for us to service your account or to collect monies you may owe, Mobile Bay Dental & Vison and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Mobile Bay Dental & Vision, its employees and/or agents may contact me/us as described above.

Signature of responsible party

_____

Date_____

Please LIST below your CURRENT address & phone number.

_____

_____

Phone#

_____

Mobile Bay Dental & VISION

Financial Policy and Patient Responsibility

Patient's Name: _____

Mobile Bay Dental provides many different types of dental services including exams, emergency treatment, fillings, crowns, sedation, bridges, extractions, root canals, periodontal treatment and all forms of general dentistry. Although most insurance companies cover a percentage of most services, there are some insurance companies that DO NOT cover certain types of procedures. Our staff makes every effort to assist you in understanding your dental health benefits. However, it is ***impossible*** for us to know all the many different insurance benefits from one insurance company to the next. Therefore, we are providing this notice to inform you of the following responsibilities as they relate to benefit coverage and payment responsibilities by the patient and Mobile Bay Dental.

Patient's Responsibility:

Patients should know their insurance policy. Patients should be aware of their benefit coverage including which Dentists are contracted with their plan, covered and non-covered benefits, authorization requirements, and costs share information such as deductibles, co-insurance, and co pays. If you are not familiar with you plan coverage, we recommend you ***contact your carrier directly. Any non-covered services are the financial responsibility of the patient.*** To pay their co pay at the time of service. To promptly pay any patient responsibility indicated by their insurance carrier. To facilitate in claims payment by contacting their insurance carrier when claims have not been paid. The patient is ultimately responsible for payment for all services rendered by Mobile Bay Dental at the time of treatment, and the patient ***MUST*** pay for any services not covered by the patient's insurance company.

Mobile Bay Dental Responsibility:

Mobile Bay Dental is ***NOT*** responsible for knowing what services are covered by the patient's insurance plan and is ***NOT*** responsible for informing the patient whether a particular service is covered. Mobile Bay Dental will assist the patient in obtaining payment from his/her insurance company by submitting the necessary insurance claims.

By signing below, I hereby acknowledge and understand my responsibilities as a patient of Mobile Bay Dental and accept that Mobile Bay Dental is ***NOT*** responsible for knowing my dental insurance benefits for services provided.
I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered. I understand that payments can be made by cash, MasterCard or Visa. I agree that if my account is referred to a collection agency or attorney I will be responsible for all costs of collection on my account including attorney's fees, and any interest on money due.

_____

Signature of Responsible Party

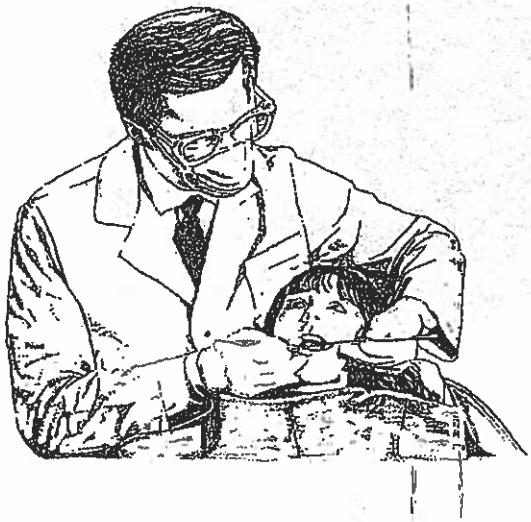
_____

Date

Your Rights and Duties as a dental patient

Read this to find out what you need to know!

Having healthy teeth is an important part of your good health. Medicaid's dental program is set up to help you get good dental care. In order for you to get good dental care, there should be respect and trust between you and your dentist.



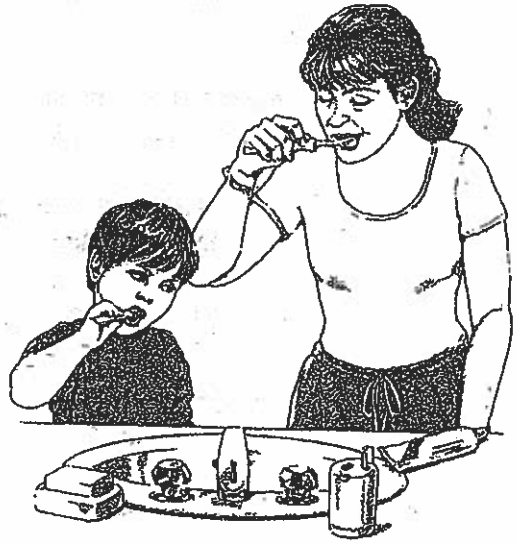
When you signed up for Medicaid, you agreed to be a part of Medicaid and to follow Medicaid's rules. This also means you have the following rights and duties when you go for dental care on the Medicaid program:

You have the right:

- To be told what your dental problem is, if you have one, and what the dentist thinks is the best way to treat it;
- To decide about your dental care and to give your permission before the start of any treatment;
- To have the personal information in your dental records kept private;
- To report to Medicaid any complaint or grievance about your doctor or your medical care; and
- To be treated with respect, dignity and privacy.

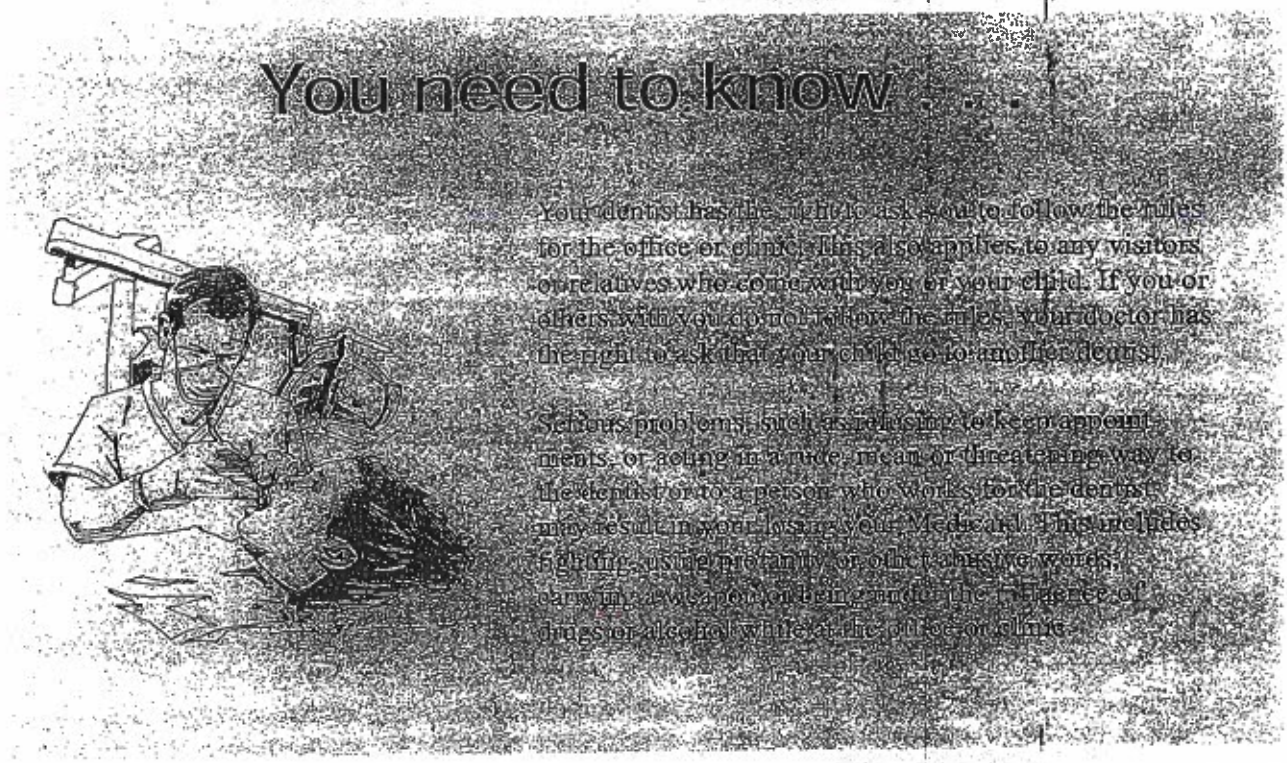
You have the duty:

- To follow the rules for Medicaid;
- To give as many facts as you can to help your dentist or other health care provider take care of you;
- To call your dentist or clinic and let them know if you cannot come to an appointment;
- To limit the number of people who come with you to the child who has the appointment and one adult
- To come for any appointment with a clean body and teeth that have been brushed.
- To follow the instructions you get from your dentist or clinic;
- To ask questions about anything you do not understand; and
- To follow the rules set up by your personal doctor for his or her office or clinic.



(OVER)

Rev. 2/01



To be signed by the patient:

I have been told about my rights and duties as a Medicaid dental patient. I have been told what the rules are for my dentist's office or clinic. I have been given the chance to ask questions about any rules I do not understand.

I have been told that if I miss appointments, do not follow the dentist's directions or do not follow the rules for Medicaid, my dentist can ask that my child go to another dentist.

I understand that if I or someone who comes with me acts in a rude, mean or threatening way to the dentist, employees of the office or clinic and/or other patients and visitors, I can lose my Medicaid.

I have been told that I have a right to complain to Medicaid and get an answer to my complaint.

Signed: _____ Date: _____

If you have questions about Medicaid,
call 1-800-362-1504 for help. This is a free call.

(OVER)

Playground Consent Form

I, _____(parent or legal guardian) for my child(ren) agree to all the following:

1. I understand that there is an additional waiting room away from the playground that I can chose to sit in if I do not wish for my child(ren) to play on the playground.
2. I wish for my child(ren) to play on the Mobile Bay Dental & Vision's Playground.
3. I realize that I will have to be present while my child(ren) actively participate in their activities while they are at the Mobile Bay Dental & Vision's playground.
4. I agree to follow any instructions or rules established by Mobile Bay Dental & Vision's Playground with regard to my child(ren)'s activities, weather written or orally given by the Mobile Bay Dental & Vision's Playground personnel. I understand and agree that at anytime, the Mobile Bay Dental & Vision's reserves the right to require me to remove my child(ren)from any activity for any reason.
5. I agree not to hold Mobile Bay Dental & Vision responsible for any injuries suffered by my child(ren) while involved in playground activities.

I HAVE READ THIS DOCUMENT AND AGREE TO ALL OF ITS TERMS.

Signature_____Date_____

Print Name_____Date_____

Child(ren) Name(s): _____

_____

_____

_____

_____

Medical History Today's Date:_____

Patient Name:_____ D.O.B. _____ SSN:_____
(If Minor)
Parent/Guardian Name: _____ D.O.B_____ SSN:_____

Insurance Company:_____ Policy Holder's Name:_____
D.O.B._____ SSN:_____

Secondary Insurance Company:_____ Policy Holder's Name:_____
D.O.B._____ SSN:_____

ALL OF THE QUESTIONS ASKED ON THIS FORM CAN AFFECT YOUR DENTAL TREATMENT IT IS EXTREMELY IMPORTANT THAT YOU ANSWER TRUTHFULLY.

Do you have a history of, are currently being treated for, or ever experienced any of the following:
Please check ALL that apply.

- o High Blood Pressure
- o Pacemaker Of Implanted Defibrillator
- o Heart Murmur
- o Blood Disorder
- o Seizures/Epilepsy
- o Chest Pain
- o Arrhythmia
- o Heart Failure
- o Bruise Easily
- o Dizziness
- o ADHD
- o Autism
- o Tuberculosis
- o Trouble Breathing
- o Gastric/Acid Reflux
- o HIV/AIDS
- o Cancer
- o Blood Borne Disease
- o Osteoporosis
- o Stomach/Intestinal Ulcers
- o Heart Attack
- o Stroke
- o Swollen Feet/Ankles
- o Glaucoma
- o Headaches/Migraines
- o Cerebral Palsy
- o Asthma
- o Shortness of Breath
- o Sinus Problems
- o Kidney Disorder
- o Liver Disorder
- o Tumors
- o White Blood Cell Disorder
- o Genetic Disorder
- o Immune Disorder
- o Dementia/Alzheimer's
- o Developmental Disability
- o COPD/Chronic Bronchitis/Emphysema
- o Sleep Apnea
- o Diabetes
- o Hepatitis (If so, type_____)
- o Alcohol/Drug Dependency
- o Sexually Transmitted Disease
- o Radiation or Chemotherapy
- o Colon/Rectal Problems
- o Thyroid, Adrenal, Metabolic Disorder

If unsure please note below & we will be happy to answer any questions you may have.
If not applicable put NA

Do you have any medical conditions past or present that was not listed? _____**Yes** _____**No**
_____
_____
Please Explain all illnesses checked: _____

Are you allergic to anything (including drugs & medicines)? _____**Yes** _____**No** *(If Yes, please list all)*
_____ _____ _____
_____ _____ _____
Are you or any possibility that you may be Pregnant? **Yes**_____ **No**_____ Nursing? **Yes**_____ **No**_____

Are you currently taking any medications? _____**Yes** _____**No** *(If yes, please list all)*
Include OVER THE COUNTER MEDICATIONS AND HERBAL SUPPLEMENTS.

_____ _____ _____
_____ _____ _____

you taking any of the following?
_____**Immunosuppressive** ***(such as steroids)*** _____ **Anticoagulant/Blood Thinners** ***(including aspirin)***

Please Turn to Reverse Side to Complete Medical History →

Have you ever taken or are you considering taking any drugs for osteoporosis or bone cancer or any drug that would affect bone density? *(Examples: Bisphosphonates, Boniva, Reclast, Prolia, Zometa, Fosamax)* _____**Yes** _____**No**

Do you or anyone in your family have angioedema or have history of unexplained swelling of the head or neck? _____**Yes** _____**No**

Approximately, when was your last visit to a primary care physician or have you ever seen a primary care physician?
If so, please list name of Doctor, approximates date, & reason for visit _____
_____

Please list any past surgeries or hospitalizations with the approximate dates starting with the most recent.
_____ _____ _____
_____ _____ _____

Do you use or have you used Tobacco products? _____**Yes** _____**No** *(If Yes, please fill out the following)*
Years used: _____ Type: _____ Amount per day:_____

Do you use or have used alcohol? _____**Yes** _____**No** *If yes, Please estimate drinks per day/week/month.*
_____
_____

Do you use or have used in the past any recreational drugs prescribed or otherwise? _____**Yes** _____**No** *(If yes, please list all)*
(We only ask to make sure any medications used/prescribed do not have negative interactions)
_____
_____

Dental History

Do you have fear or anxiety at the dentist?	Y____ N___
Would you be interested in sedation dentistry or to discuss options if you are anxious or phobic of dental treatment?	Y____ N___
Are you interested in straighter teeth?	Y____ N___
Are you interested in a whiter smile?	Y____ N___
Do you have missing teeth that you may be interested in replacing?	Y____ N___
Is there anything about your facial profile, your lips, or facial appearance that you may not like?	Y____ N___
Would you be interested in a custom mouth guard for sports?	Y____ N___
Do you grind or clench your teeth?	Y____ N___
Do you have dry mouth?	Y____ N___
Do you have any jaw pain, clicking, popping, or pain from jaw joint (TM disorder/TMD)?	Y____ N___
Have you had any trauma to the face or jaws?	Y____ N___
Are you interested in Botox or to improve facial contours & correct wrinkles for functional & cosmetic concerns?	Y____ N___

To the best of my knowledge all the information I have provide is correct and currently up to date:

_____ _____
Signature **Date**

Emergency Contact Name(s) _____

Emergency Contact Phone#_____ ***Relationship To Patient***_____

DO NOT SIGN BELOW IF MEDICAL HISTORY WAS FILLED OUT TODAY.
Bottom portion is to be signed on returning visits with in 1 year of completion or unless something has changed which in case a new medical history will need to be filled out.

By signing below, I am agreeing that the above information, previously filled out at a prior date, is correct and that I understand that it is my responsibility to inform Mobile Bay Dental, LLC if any changes to my child's or my medical history.

Signature:_____ Date:_____

Name: _____ Mobile Bay Dental & Vision
first last Height: _____
Birthday: ____/____/_____ Weight: _____

Visual and Health Information

Hello and welcome to our practice! We are excited to work with you today. Please take a few minutes to fill out this questionnaire to the best of your ability. This is information we need to know in order to determine a proper diagnosis.

Please **circle** if you are here for: **ANNUAL EXAM** or **I HAVE A PROBLEM**
OTHER: _____

When was your last eye exam? _____
Do you wear glasses? **YES NO** If so, how old are they? _____
Do you wear contacts? **YES NO** If so, how old are they? _____
Have you had corrective eye surgery in the past? **YES NO**
If so, what kind? _____ and when? _____

BIRTH INFORMATION:
Birth weight: _____ Weeks gestation: _____ Birth defects? **YES NO** on oxygen? **YES NO**

PLACE A "✓" BY YOUR SYMPTOMS:

___ Blurred Vision at a Distance	___ Surgery	___ Itching	___Dry Eye
___ Blurred Vision at Nearness	___ Injury	___ Headache	___Glaucoma
___ Flashes	___ Redness	___ Double Vision	___ Macular Degen
___ Floaters	___ Eye Pain	___ Lazy Eye	___ Other

If **"Other"** please list: _____

HAS THE PATIENT EVER HAD:

___ Major Surgeries or Hospitalizations	___ Arthritis
___ Currently Pregnant or Nursing	___ Cancer
___ Immune System Problems (HIV/LUPUS)	___ Diabetes
___ Bleeding/Clotting Disorders (Sickle-Cell)	___ Heart Problems
___ High Cholesterol	___ High Blood Pressure
___ Stroke	___ Asthma/COPD

Other: _____

CIRCLE YES OR NO:

Recently, have you had trouble with weight gain or weight loss? **YES NO**
Are you feeling tired or sick today? **YES NO**
Are your eyes, ears, nose or throat giving you trouble today? **YES NO**
If so which one and how is it bothering you? _____
Are you currently feeling any anxiety, depression or symptoms of ADHD? **YES NO**
Recently, have you experienced racing or irregular heart beats, heart murmurs, dizzy spells or chest pains? **YES NO**
Do you have trouble urinating or urinate frequently? **YES NO**
Currently, are you experiencing skin problems such as acne, skin rashes, sores, eczema, psoriasis, etc.? **YES NO**
Do you have problems with joints (knee, hip, etc.), body aches or arthritis? **YES NO**
Are you experiencing wheezing, shortness of breath or other respiratory issues? **YES NO**
Currently, are you feeling numbness or tingling sensations, dizziness, or inability to move one side of your body? **YES NO**
Are you experiencing nausea, heartburn, diarrhea, constipation, bloating or stomach pains? **YES NO**

PLEASE COMPLETE THE BACK SIDE OF THIS QUESTIONNAIRE

Do you smoke? **YES NO** (✓) ___ Cigarettes, ___ Cigars, ___ Other
How many per day? _____ For how long? _____

Do you drink? **YES NO** (✓) ___ Beer, ___ Liquor, ___ Wine
How many per day? _____ For how long? _____

Occupation: _____

Hobbies: _____

FAMILY MEDICAL HISTORY
PLACE A "✓" BY ALL THAT APPLY TO THE FAMILY'S PAST MEDICAL HISTORY:
(OCULAR-Strictly eye medical history)

___ Glaucoma ___ Blindness ___ Color Vision Problems ___Retinitis Pigmentosa
___ Cataract ___ Lazy Eye ___ Macular Degeneration ___ Retinal Detachment
___ Other: _____

(MEDICAL-Strictly personal health history)

___ High Blood Pressure If so, who? _____
___ Immune Disorders If so, who? _____
___ Sickle-Cell Anemia If so, who? _____
___ Asthma/COPD If so, who? _____
___ Stroke If so, who? _____
___ Cancer If so, who? _____
___ Heart Problems If so, who? _____
___ Diabetes If so, who? _____
___ Arthritis If so, who? _____
___ High Cholesterol If so, who? _____
___ Gastro Intestinal Problems If so, who? _____
___ Other _____ If so, who? _____

ALLERGIES AND MEDICATIONS:
Please list any and all allergies and medications pertaining to the patient.

Allergies:
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Do we have permission to dilate the patient today?

Yes or No

Medications:
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Mobile Bay Vision
Patient Demographic

PATIENT NAME _____

ADDRESS _____

CITY_____ STATE_____ ZIP_____

DATE OF BIRTH __/___/_____

EMAIL ADDRESS_____

EMPLOYER OR SCHOOL _____

PHONE NUMBER CELL/HOME _____-_____-_____

MAY WE TEXT YOU IF THIS IS A CELL YES/NO (CIRCLE)

MEDICAL INSURED'S INFORMATION

NAME _____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

PHONE NUMBER CELL/HOME _____-_____-_____

INSURED'S SOCIAL SECURITY NUMBER _____-_____-_____

INSURED'S DATE OF BIRTH ____/_____/_____

MEDICAL INSURANCE COMPANY_____

INSURANCE POLICY NUMBER _____

TURN OVER TO BACKSIDE

VISION INSURANCE COMPANY _____

VISION INSURANCE POLICY NUMBER _____

VISION CARE PLANS ONLY COVER ROUTINE VISION EXAM, MATERIALS, AND BASIC SCREENING FOR EYE DISEASE. THEY DO NOT COVER DIAGNOSIS MANAGEMNET, OR TREATMENT OF EYE DISEASES. MEDICAL INSURNACE MUST BE USED IF YOU HAVE ANY EYE HEALTH PROBLEMS OR SYSTEMIC HEALTH PROBLEMS THAT HAVE OCULAR COMPLICATIONS. IT MAY BE NECESSARY FOR US TO BILL SOME SERVICES TO ONE PLAN AND OTHER SERVICES TO THE OTHER. WE WILL BILL YOUR INSURANCE PLAN FOR SERVICES IF WE ARE A PARTICIPATING PROVIDER FOR THAT PLAN. WE WILL TRY TO OBTAIN BENEFITS SO WE CAN TELL YOU WHAT IS COVERED. IF SOME FEES ARE NOT PAID BY YOUR PLAN, WE WILL BILL YOU FOR ANY UNPAID DEDUCTIBLES, COPAYS, OR NON-COVERED SERVICES AS ALLOWED BY THE INSURANCE CONTRACT.

PLEASE SIGN _____

ARE YOU HERE TODAY FOR CONTACTS OR GLASSES EXAM?

_____