



Patient Information

Last Name: _____ First: _____ Middle: _____

Preferred Name: _____ Date of Birth: _____ Age: _____

Social Security Number: _____ Gender: (Circle One) Male / Female

Street Address: _____

Mailing Address(if different): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Cell Carrier: _____

Email: _____

Race: (Circle one): Caucasian Hispanic American Indian African American Asian Pacific Islander Other

Ethnicity: (Circle one): Hispanic or Latino Non-Hispanic or Latino

Employer: _____ Occupation: _____

Work phone number: _____ Marital Status (Circle one): Single Married Divorced Widowed

Parent/Guardian or Spouse Information

Name: _____ Social Security Number: _____

Date of Birth: _____ Cell Phone Number: _____ Work Number: _____

Employer: _____ Occupation: _____

Responsible Party/Insurance Carrier:

Name: _____ Relationship to patient: _____

Insurance Company: _____ Subscribers date of birth: _____

Insurance Policy/ID Number: _____ Insurance Group Number: _____

Employer Name: _____

Pharmacy Name: _____ Phone number: _____

Any employee of Divine Family Wellness has my permission to discuss my account and medical conditions which may include symptoms, treatment, diagnosis, test results, medications, or any other type of protected health information with the following persons to facilitate, coordinate my care, treatment, and payment:

Emergency Contact/Release of Information

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

I understand that authorizing this release of my information to the above individuals is voluntary and does not affect my access to treatment. I can revoke it by completing a new form at any time. This authorization will remain in effect until I change or revoke it in writing. I understand that if information is shared with the above individual(s), it may be subject to re-disclosure by the individual(s).

Patient/Guardian Signature: _____ Date: _____

FINANCIAL POLICY

BASIC POLICY Pay for service is due in full at the time service is provided in our office.

You will be sent 3 statements for any money owed to Divine Family Wellness, LLC. If the balance is left unpaid, you will receive a pre-collections letter. If the outstanding balance is still not paid, you will be sent to our collection’s agency. At this point, we will add an additional 25% to your outstanding balance.

I consent to allow Divine Family Wellness to add an additional 25% to my outstanding balance if sent to collections.

Initials: _____

FOR PATIENTS WITH INSURANCE We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

All copayments or deductibles are due and payable at the time service is provided.

NONCOVERED SERVICES Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

PERSONAL INJURY CASES This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.

WORKER’S COMPENSATION If your injury is work-related, we will need the case number and carrier name prior to your visits in order to bill the worker’s compensation insurance company.

YEARLY HEALTH CHECKS Periodic preventive health checks may or may not be covered under your health insurance policy.

MISSED APPOINTMENTS In fairness to other patients and the provider, we require at least 24-hour notice to cancel appointments.

*****A missed appointment with a no call and no show will result in a \$35 charge.**

After 3 consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

I understand the “no-show” policy of Divine Family Wellness and agree to pay for this service. Initials: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Divine Family Wellness, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Divine Family Wellness PO Box 522, Hamilton, AL 35570

With this consent, the Practice may call, text, use a secure App, call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory and procedure test results, among others.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I am consenting to allow the Practice to use and disclose my PHI to carry out TPO. Initials: _____

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

I have read, understood, and agreed to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all professional fees.

Patient/Guardian Signature: _____ Date: _____

Printed Name of Patient/Guardian: _____

Relationship to patient: _____



General Consent for Treatment

This consent provides Divine Family Wellness, LLC with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time.

You have the right to discuss the treatment plan with your provider about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a health care provider (Nurse Practitioner), and any other designees as deemed necessary, to perform reasonable and necessary medical examinations, testing, and treatment for the conditions that bring me to seek care at this practice.

I certify that I have read and fully understand the above statements and consent voluntarily to its contents.

Patient/Guardian Signature: _____ Date: _____

Printed Name of Patient/Guardian: _____

Relationship to patient: _____

**Only fill out this section if the patient is a minor (under age 18).

Please list anyone that is allowed to bring your child to their appointment. If a person's name is not listed, he/she will not be allowed to bring the child to any appointment.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please list anyone who is **NOT** allowed to bring your child to their appointment.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Guardian Signature: _____ Date: _____

Printed Name of Guardian: _____

Relationship to patient: _____



Authorization to Release Medical Records

Patient Name: _____ Phone: _____

Date of Birth: _____

Release Records To:

**Divine Family Wellness, LLC
Ashley Ozbirn, CRNP
PO Box 522
Hamilton, AL 35570
P: 205-921-2838
F: 205-430-2672**

Records Requested From:

Practice/Hospital Name: _____

Physician/CRNP Name: _____

Practice Phone #: _____

Practice Fax #: _____

Send the last 12 months of medical records; including labs, office notes, diagnostic testing

Send the last labs and office note only

Other: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation. I expressly request that the designated record custodian of all covered entities under HIPAA, identified above, to disclose full and complete protected medical information.

Patient/Guardian Signature: _____ Date: _____

Relationship to Patient: _____