HAMDANI

PSYCHIATRY

Acceptance of Policies

Dr. Hamdani is committed to providing professional services of the highest quality and standards. In order to serve her patients efficiently and responsibly, she requires agreements be made as to the policies stated above. Patients/guardians are encouraged to ask any questions related to this document before signing.

I have read the policies, understand, and agree with them.

Patient Name: _____
Patient Signature (if an adult): _____
Guardian's Name (if applicable): _____
Guardian's Signature (if applicable): _____
Date: _____

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PSYCHIATRY

Statement of Party Responsible for Payment

Office of Najma Hamdani, MD | Najma Hamdani MD Psychiatric services, PLLC

Statement of Party Responsible for Payment

I, the undersigned, understand that payment is due according to the terms detailed in Dr. Hamdani's Practice Policies. I understand that I will receive a receipt electronically, which will record the payee as "Najma Hamdani MD Psychiatric services, PLLC". That receipt will include the information needed for me to collect out of network benefits, if applicable, from my insurance company. All payments are due at the time of service. All previous balances have to be paid in order to make another appointment. I agree that regardless of any insurance coverage, I am financially responsible for all charges generated for this patient. I understand that unpaid balances over 30 days past due may carry a late fee equivalent to 1.5% per month of the outstanding balance. I understand that unpaid balances over 90 days past due may be referred to a collection agency.

All returned personal checks will be charged a return fee of $30. Any fraudulent or suspicious check writing activity will be handed over to the appropriate DA's office, as it is against the law in Oklahoma to write such checks under the OK Stat. 21 &1541.4

I understand the fee charges for later than 48 business hour cancellations/No show for follow up/New patient appointments.

Party Responsible for Payment

First and Last Name (if someone other than the patient, identify relationship to patient):

_____

Physical Address: _____

Primary Phone and Email Address: _____

Signature of Responsible Party _____

Date _____

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PSYCHIATRY

Dr. Hamdani's practice, Hamdani Psychiatry, operates under the company Najma Hamdani MD Psychiatric services, PLLC. Payment is required at the time of services. To expedite the billing process, we ask for a credit card to be kept on file through our secure payment processing system, within the electronic medical record CHARM. At the time of your intake appointment, we will ask for the card you would like to have kept on file. The following section is the consent for using the file on card for fees.

Credit/Debit Card Payment Consent

I authorize Najma Hamdani MD Psychiatric services, PLLC, to charge the credit card that is provided to be kept on file for professional services as outlined in the Policies. I will notify Najma Hamdani MD Psychiatric services, PLLC, in writing 30 days in advance, if I no longer want my credit / debit card used and will provide a different credit card/debit card.

I also authorize Najma Hamdani MD Psychiatric services, PLLC, to bill the debit/credit card when I do not give 48 business hour advance notice for a late-cancellation or no-show, as per the policies.

_____

Signature of cardholder/Date

_____

Cardholder's name

HAMDANI

PSYCHIATRY

Notice of Health Information 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.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information is often referred to as your health or medical record. Under federal law, we are permitted to use and disclose personal health information without authorization for treatment, payment or health care options.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment. For example: Information obtained by the physician will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his expectations of the treatment. In that way the physician will know how you are responding to treatment.

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, procedures and supplies used.

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information, obtain a paper copy of the notice of information practices upon request, inspect your health record, and revoke your authorization to use or disclose health information except to the extent that action has already been taken.

This organization is required to: maintain the privacy of your health information, provide you with a 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 alternative means or at alternative locations.

For additional information about our health information practices or to report a problem, you may contact Dr. Hamdani at her office phone number. A full copy of this notice is available at https://www.hamdani-psychiatry.com/. If you believe your privacy rights have been violated, you can file a complaint with Dr. Hamdani or with the Secretary of Health and Human Services.

My signature below indicates that I have read the notice of privacy practices.

Patient Name:_____

Signature: _____ Date: _____

HAMDANI

PSYCHIATRY

AUTHORIZATION TO USE OR RELEASE PERSONAL HEALTH INFORMATION

Patient Name_____ DOB_____

1.I hereby authorize the health care information described below to release to:

Name _____

Entity _____

Address_____

2. This request and authorization applies to only the following health information:

List each purpose or reason for the use or release of the protected health information:

_____

_____

3. This authorization shall remain in full force and effect until_____

4. I understand that,except with respect to action already taken in reliance on this authorization, I may revoke this authorization in writing at any time by delivering or sending written notification to Najma F.Hamdani, MD.

5. I understand that Dr.Hamdani may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is related to the research project.

6. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

7. I understand that I have the right to receive a copy of this authorization after I have signed it. I understand that a copy of this authorization will be maintained in the patient record.

8. I understand that I have the right to refuse to sign this authorization.

_____

Signature of Patient or Patient's Personal Representative Date

_____

Name of Patient or Patient's Personal Representative Date