Please return this paperwork to our office in person, by US Mail, or confidential fax:
Focus-MD Adult
3173-A Dauphin Street
Mobile, AL 36606
Phone: 251-301-8276
Fax: 877-515-5250

Patient Information

First:_______________________________ Middle: __________________ Last Name: __________________________
Nickname:_________________________ DOB: ___________________ Sex: F/M SS#______________________
Mailing Address: ____City/State/Zip:_______________________________
Preferred Email: ____
☐ *Ok to send me emails regarding appointment reminders, healthcare news, or practice notices.*
School/Employer: ____
Preferred Phone Number: ____________________ May we send text reminders to this number? ☐ Yes ☐ No
Alternate Phone Number: ____________________ May we send text reminders to this number? ☐ Yes ☐ No
How did you hear about Focus-MD? ☐ Friend/Relative ☐ Doctor Referral: ________________________
☐ Facebook ☐ Internet Search/Google ☐ Internet Ad ☐ Sign/Drive by

Guarantor Information:

Name: __________________________________ Cell #: ____________________
Relationship to patient: _______________________________ Social Security #: ____________________________
Is Mailing Address same as patient address? ☐ Yes ☐ No If not, please provide address below:
Mailing Address: _________________________________ City: ____________________ State: ____ Zip: _________
Is the person named above responsible for patient account? ☐ Yes ☐ No If not, please list below:
Responsible party: _____________________________ SS # _____________________ Date of Birth: ___________
Mailing Address: ________________________________City: ____________________ State: ____ Zip: _________

Insurance Information

Insurance Carrier: ____ ID #: _______________________
Group #: _______________________________ Policy Holder's Name: _____________________________________
Policy Holder's Date of Birth: __________________ Relationship to patient: ______________________________

Secondary Insurance Information

Insurance Carrier: ____ ID #: _______________________
Group #: _______________________________ Policy Holder's Name: _____________________________________
Policy Holder's Date of Birth: __________________ Relationship to patient: ________________________________

Primary Care Physician

Name: ______________________________________ Phone: ____________________ Fax: _____________________
Address: ____ City/St/Zip: ___________________________

Name of Referring Medical Professional (If applicable – referral not required to schedule an appointment)

Name: ______________________________________ Phone: ____________________ Fax: _____________________
Address: ____ City/St/Zip: ___________________________

Preferred Pharmacy

Name: ______________________________________ Phone: ____________________ Fax: _____________________
Address: ____ City/St/Zip: ___________________________

focusMD

Patient Name: ___________________________

ALLERGIES:

Do you have any drug allergies? ☐ Yes ☐ No
If so, please name and describe the reaction: ______________________________________
The reaction is ☐ Mild ☐ Moderate ☐ Severe

Do you have any food allergies? ☐ Yes ☐ No
If so, please name and describe the reaction: ______________________________________
The reaction is ☐ Mild ☐ Moderate ☐ Severe

CURRENT ADHD MEDICATIONS: ☐ **None**

Medication Name	***Dosage***	***Frequency***	***Duration***
	_____ mg _____# tabs Time taken: ______ am/pm	☐ Almost if not every day ☐ School/work days ☐ Less than 5 days a week	☐ < 6 hours ☐ 6-8 hours ☐ 8-10 hours ☐ 10-12 hours ☐ Adequate ☐ Not Adequate
Is this medication effective? ☐ Not effective ☐ Somewhat effective ☐ Effective ☐ Very Effective *Any side effects?* ☐ No ☐ If yes, please describe:			
	_____ mg _____# tabs Time taken: ______ am/pm	☐ Almost if not every day ☐ School/work days ☐ Less than 5 days a week	☐ < 6 hours ☐ 6-8 hours ☐ 8-10 hours ☐ 10-12 hours ☐ Adequate ☐ Not Adequate
Is this medication effective? ☐ Not effective ☐ Somewhat effective ☐ Effective ☐ Very Effective *Any side effects?* ☐ No ☐ If yes, please describe:			

CURRENT OCD/ANXIETY/MOOD MEDICATIONS: ☐ **None**

Medication Name	***Dosage***	***Frequency***	***Duration***
	_____ mg _____# tabs Time taken: ______ am/pm	☐ Almost if not every day ☐ School/work days ☐ Less than 5 days a week	☐ < 6 hours ☐ 6-8 hours ☐ 8-10 hours ☐ 10-12 hours ☐ Adequate ☐ Not Adequate
Is this medication effective? ☐ Not effective ☐ Somewhat effective ☐ Effective ☐ Very Effective *Any side effects?* ☐ No ☐ If yes, please describe:			

OTHER CURRENT MEDICATIONS: ____

PAST ADHD MEDICATIONS IN LAST 2 YEARS:

Medication Name: ___________________________ Dose: _____mg _______ mg _______ mg
Side Effects (if any): ____
How effective was this medication? ☐ Not effective ☐ somewhat effective ☐ effective ☐ very effective

Medication Name: ___________________________ Dose: _____mg _______ mg _______ mg
Side Effects (if any): ____
How effective was this medication? ☐ not effective ☐ somewhat effective ☐ effective ☐ very effective

Medication Name: ___________________________ Dose: _____mg _______ mg ________ mg
Side Effects (if any): ____
How effective was this medication? ☐ not effective ☐ somewhat effective ☐ effective ☐ very effective

Financial Policy

This financial policy contains important information about payment for our professional services. It is intended to help us provide the best possible medical care while also controlling administrative costs. It outlines our responsibilities, and those of our patients, with regard to payment for services.

Please note: the party that brings the child to the office will be responsible for the visit's copay AND will also be the final responsible party on record. We will not be involved in parental court cases. Whoever brings the child to the office for a visit will be authorized to receive financial and medical information. Information regarding a visit will be available on the portal.

It is the patient's responsibility to make payment at the time of service for all services rendered if it is determined that the patient's insurance policy may not cover our services. You must report ALL insurance coverage correctly. Failure to do so is considered insurance fraud. This will also result in full patient responsibility of your bill. The contract with your insurance company mandates that we collect copays at this time. If a patient finds that they will be unable to pay in full upon check-out, they will be responsible for determining a payment plan agreed upon by Focus-MD *prior to the scheduled appointment*.

Additional Fees

No Show/Late Cancellation Extended Appointments	$100	Extensive Accommodation Requests	$25
No Show/Late Cancellation Follow-Up Appointments	$50	Medical Records $5 search fee. $1/page up to 25 pages. $.50/page 26+ pages	
Returned Check	$35		

We require 24 advance notice for cancellations or reschedule. Less than 24 hours is considered "Late". As a courtesy, you may receive a reminder of your upcoming appointment by e-mail or text message. You are still responsible for honoring your appointment even if you do not receive a reminder. Unless other arrangements are made the parent or guardian of patients less than 18 years of age responsible for payment according to the terms described above.

Students, 18 years old and above, who are covered under the insurance policy of the parent or guardian, must designate whether responsibility for payment will fall upon the parent / guardian or themselves. For those students whose parent / guardian(s) will maintain responsibility for payment, an authorization for services must be signed by that parent or guardian. As a convenience, the parent / guardian may provide a credit card number and authorize that the co-pay be billed to that card at each visit.

You, the patient, have a contract with your insurance carrier. Our services may or may not be covered by your particular policy. It is your responsibility to contact your carrier to determine if these are covered services under your contract ***prior*** to the date of service. A referral may be required by your insurance company for services to be paid. It is the ***patient's responsibility*** to obtain the required referral for treatment prior to the visit.

Our staff is happy to help with general questions relating to a claim or to provide additional information requested by your insurance carrier in order for the claim to be processed. However, patients should direct questions about coverage for specific procedures to a representative of their insurance company's member services department by calling the number on the back of the card.

For each visit please bring:
Current insurance card and Driver's License
Co-pay/Deductible for the day's visit (this is an estimate from our billing dept.)
Cash, check, or credit card for paying any balance from previous billing.

______________________________ ______________________________

Parent/Guardian/Patient Signature (if over 18) **Patient Name (Please Print)**

______________________________ ______________________________

Date **Patient DOB:**

Patient Acknowledgement of Privacy, Financial, and Practice Policies

Financial Policies

_____ (initial) I acknowledge I have received the Focus-MD Financial Policy

- Patient/guarantor is responsible for providing accurate insurance information
- Patient/guarantor is responsible for any authorization required by insurance companies
- Patient/guarantor understands additional fees may incur as described in policy

_____ (initial) I acknowledge I have received the Focus-MD Non-Covered Service Agreement

- Some services are not covered by insurance
- Any services not covered are the responsibility of the patient/guarantor

_____ (initial) Our Cancellation Policy

Our provider's time is reserved for you. We do not double book our patients in order to provide adequate time for each individual. We strive for exceptional care through individual attention.

- Any appointment cancelled *less than 24 hours in advance* is considered a No Show.
- A No Show on a new or extended patient appointment will result in a $100 fee that is not covered by insurance.
- A No Show on an established patient appointment will result in a fee of $50 that is not covered by insurance
- Exceptions to this policy will be reserved for verifiable emergencies only and will be at the sole discretion of management.
- Repeated No Show appointments will result in unconditional discharge from care at this facility.

Privacy Polices

_____ (initial) I acknowledge I have received the Focus-MD's Notice of Privacy Practices

- Our Notice of Privacy Practices provides information about how we use and disclose your PHI

_____ (initial) I acknowledge I have received the Consent of Use or Disclosure of PHI

We will not discuss your or your child's care with family or friend unless authorized in writing.

Please complete the following so that the individuals you specify can have access to your information.

I consent to disclosure of the following protected health information about my child/me to the following family member(s) or person(s) involved in the care or payment for my child's/my care:

Name: _________________________________ Relationship: _______________________ Phone: _______________

Name: _________________________________ Relationship: _______________________ Phone: _______________

- In accordance with the law, your protected health information may be disclosed by us to effectively treat you, to get paid by your insurance company for your care, and to effectively operate our office.
- To effectively operate our office we may leave appointment reminders or other health care information via phone messages, email, text, and US mail.

_____ (initial) To ensure privacy, I agree to use the patient portal for questions pertaining to medical management and discussion of symptoms/side effects. I understand that this communication is a part of the patient's permanent medical record.

_____ (initial) I authorize Focus-MD to access my prescription history (including dosage and refills) from the pharmacy database.

_____ (initial) I authorize Focus-MD to correspond with and/or release my medical records to my Primary Care Physician and Referring Provider

I have read and understand the above policies and procedures.

____ ______________________________________

Parent/Guardian/Patient Signature (if over 18) **Patient Name (Please Print)**

____ ______________________________________

Date **Patient DOB:**

Non-Covered Service Policy

As our patients, we want to provide you the best care possible. There may be certain services that we feel are necessary that are not covered by some insurance carriers.

- You will be expected to pay for those services in full at the time they are provided.
- Policy holders of insurance carriers other than those currently contracted with our Providers will be expected to pay in full at the time of service.

These procedures are frequently used by Focus-MD providers and may or may not be covered under your insurance policy.

New Patient Testing (May or may not be covered under insurance or subject to deductible)	**Provider: Dr. Richard Fuhler**
• TOVA	96132 & 96138
• Clinicom	96103
• Vanderbilt Assessment, NeuroPsych Questionnaire, Adult ADHD Self-Report Scale, ADHD Rating Scale IV	96127
• Diagnosis Code:	F90.2

I have read and understand that charges for services not covered by my insurance plan will be my responsibility to pay in full the day the services are rendered.

Attention Humana and Coventry Patients:

One or more of the following Focus-MD testing procedures is not being covered by Humana nor Coventry. At this time, Humana and Coventry do not pay for any type of neuropsychological testing for ADHD or related disorders. Focus-MD has contacted Humana and Coventry in an effort to educate them on the value and evidence base for the testing we provide. Unfortunately, Humana and Coventry require providers to have this waiver signed each time the testing is performed. If you have questions or concerns about Humana and Coventry's policy please call the customer service number listed on your insurance card. Initials:____

Attention Uninsured Patients:

Focus-MD accepts patients who are uninsured. Patients without insurance will be seen as "Self Pay". Current Self-Pay rates are as follow and are subject to change annually: Initials ________:

- New Patient Office Visit w/testing $350
- Follow Up Office Visit w/testing $300
- Follow Up Office Visit no testing $130

____
Parent/Guardian/Patient Signature (if over 18)

____
Patient Name (Please Print)

____
Date

____
Patient DOB: