IM CLINIC
The Internal Medicine Clinic

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420 Lowell Dr. SE, Suite 105
Huntsville, AL 35801

Patient Authorizations, Consents, and Notifications

Name **Date of Birth** (mm/dd/yyyy)

Assignment of Benefits

Initial I hereby authorize Omer Iqbal, D.O. (IM Clinic LLC) to apply benefits on my behalf for the covered services rendered by the office or by the office's order. I request that payment from my insurance company be made directly to Omer Iqbal, D.O. or to the party who accepts assignment. I certify that the information I have reported about my insurance coverage is correct.

No Show Policy

Initial I agree that if I do not call the office at least 24 hours prior to my scheduled appointment to cancel or reschedule that I may be charged a $25.00 no show fee which will not be covered by insurance. After 3 no show appointments, I may be discharged from the practice for non-compliance.

Financial & Office Policies

Initial I certify and agree that I have read and agree to the IM Clinic financial and office policies. I have been directed to the website location of the most up-to-date version of this document at https://imclinic.org/forms/ .

Profile Photo

Initial I hereby authorize IM Clinic LLC to have my photograph for the purpose of attaching it to my medical profile either in the electronic health record and on the paper chart should one be used.

Notice of Privacy Practices

Initial I acknowledge I am aware of the "Notice of Privacy Practices Form 7.2" for IM Clinic LLC. I acknowledge I have either been given a copy for my own reading and records or I have been directed to the website location of this form at https://imclinic.org/forms/ .

HIPAA Privacy and Release of Information Authorization

Initial I hereby authorize IM Clinic LLC and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services. I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

Communicating Your Health

Initial If family members call requesting information about your personal healthcare information, who may we release this information to? ☐**No, don't release** ☐**Yes, release to the following people:**

Name **Relationship** **Phone**

May we leave personal health messages on your home telephone: ☐**Yes** ☐**No**
May we leave personal health messages at your office number: ☐**Yes** ☐**No**

These agreements will remain in effect as long as you are a patient at IM Clinic LLC, unless we are advised in writing of the need to make a change.

Signature **Date**

Please turn in this form in to the receptionist.