OMNIA
MEDICAL GROUP

Patient Information

First Name	Middle Name	Last Name

◯ Male ◯ Female	/ /	
Gender	Date of Birth	Social Security Number

Street		
City	State	Zip

Email	Mobile Phone	Home Phone

Pharmacy	Ethnicity	Language	Race

Emergency Contact

First Name	Middle Name	Last Name

Relationship	Street	
City	State	Zip

Email	Mobile Phone	Home Phone

Health History

Please explain the reason for your visit today:	
Please list any medications you are taking:	
Please list any allergies to any medications:	
Do you use any of the following (check all that apply)? ☐ **Tobacco** ☐ **Alcohol** ☐ **Illicit Drugs**	

(FOR OFFICE USE ONLY)

HT:	WT:	BP:	P:	RR:	O2:
PMH	**PSH**	**FH**	**SH**	**SPECIALISTS**	**PLAN**

Authorization and Release

By signing this consent form, I acknowledge that I have read, understand, voluntarily consent to, and authorize the following:

Authorization of Treatment:

I authorize the administration and cost of all medical procedures, x-ray and medication for myself and dependents.

Patient Financial Agreement

____ (Initial) Patient Payment: All copayments and/or deductibles are to be paid at the time of service. This arrangement is part of your contract with your insurance company.

____ (Initial) Insurance: We participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit.

____ (Initial) Registration: All patients must complete our patient information forms, which will be entered into our computer to maintain accurate information for proper billing. We **must obtain a copy of your driver's license (or valid state ID)** and **current valid insurance card** to provide proof of insurance. If you fail to provide us with the correct insurance information or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have time filing restrictions; if a claim is not received within 30 days of the date of service, it can be rendered ineligible for payment, and you will be responsible for the remaining balance.

____ (Initial) Forms: **Filling out paperwork that is outside of the normal standard of care may be associated with a fee. The fee schedule is outlined in Appendix A (available upon request).** This includes disability paperwork, handicap/parking placard requests, transportation forms, government forms, emotional support animal letters (NOT SERVICE ANIMALS), FMLA (Family Medical Leave Act) or LOA (Leave of Absence/sick leave) forms. Service fees cover cost(s) associated with copying, printing, mailing and/or faxing the requested forms to the designated department outlined within the form(s) as well as the cost of labor/time required to complete forms by the healthcare employee.

Guarantee of Payment:

____ (Initial) Self Pay: I elect to pay for all services rendered in full today. I understand that my insurance will not be billed by Omnia Medical Group.

____ (Initial) Insurance - Assignment of Benefits: I authorize direct payment to Omnia Medical Group for all benefits otherwise payable to me. I understand that I am financially responsible for all charges not covered by insurance. I authorize Omnia Medical Group to submit claims to my insurance carrier as well as medical records required to evaluate these claims for payment. I understand that if my employer is responsible for all or part of this claim, they will receive the necessary medical information required to evaluate these claims for payment.

Receipt of Privacy Practices:

By signing this consent form, I acknowledge that a copy of the notice of Privacy Practices of Omnia Medical Group has been offered/is available to me upon request.

Patient Signature _____ Date_____

Responsible Party _____ Date_____

Release of Medical Records:

I authorize Omnia Medical Group to release verbally, electronically and or in writing confidential medical information obtained during the course of my examination and/or treatment to any person or entity including my insurance carrier, employer (if treatment is related to employment), and/or other healthcare provider(s) for purpose of treatment, payment of charges, quality assurance and utilization review. I understand that should I choose not to release my medical records to a specific entity and/or person(s) I must specifically state so in writing for inclusion in my medical record.

Patient Signature _____ Date_____

INFORMED CONSENT TO PARTICIPATE IN A TELEMEDICINE VISIT

NAME: _____ DOB: _____ DATE: _____

1. I understand that my health care provider may wish me to engage in a telemedicine visit with me.

2. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider(s) or myself can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

3. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider. The abovementioned people will all maintain confidentiality of the information obtained.

4. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.

5. I have read this document carefully and understand the risks and benefits of the telemedicine visit and have had my questions regarding the procedure explained and I hereby consent to participate in a telemedicine visit under the terms described herein.

SIGNATURE: _____ DATE: _____

65 Highview Blvd STE 101A | Columbus, OH 43207 | Phone (614) 587-7778 | Fax (740) 212-8808

OMNIA
MEDICAL GROUP

CONSENT TO TEXT AND/OR VOICE MESSAGING

Omnia Medical Group now has the ability to send patients appointment confirmation messages and reminders by text and/or voice message. If you wish to receive these messages, we require your consent per compliance with the Telephone Consumer Protection Act (TCPA).

SMS Text/Voice Call Appointment Reminder
If an SMS text is the preferred method of communication selected, a sample of the language and information included in the text message is pictured on the left-hand side of this page.

If a voice call is the preferred method of communication selected for a particular patient, below is a sample of the language and information included in the call:

"Hello, this is Omnia Medical Group reminding [Patient Name] that you have an appointment on [Day, Date] at [Time] scheduled with [Provider Name] at Omnia Medical Group. Press "1" to confirm your appointment. Please contact us 24 hours in advance at 614-850-7450 if you need to cancel or reschedule your appointment. Press "2" to unsubscribe from these telephonic reminders."

Please read the following disclaimer and complete this form as directed. Once complete, return this form to Omnia Medical Group. Your consent will be kept as a confidential document in your permanent medical record.

• Omnia Medical Group may revoke or disable this option at any given time and for any given circumstance or reason without warning to the patient or other members of the practice.

• You can opt out of SMS text or voice messaging at any time by replying "STOP" to the text or voice message.

By signing this document, you agree to the following statement:
I acknowledge that appointment reminders by text/voice messaging are an additional service and that these may not take place on all occasions. I understand that the responsibility of attending appointments or cancelling them still rests with me, the patient. I understand that I can cancel the text/voice messages at any time. I understand that text/voice messages are generated using a secure facility and that they are transmitted over a public network onto a personal telephone and as such may not be secure. However, Omnia Medical Group will not transmit any information which would enable an individual patient's personal protected health information to be revealed or identified. I understand that it is my responsibility to provide the correct mobile phone number to Omnia Medical Group and that any inability to do so is at no fault of Omnia Medical Group. I agree to advise Omnia Medical Group if my mobile number changes or is no longer in my possession.

☐ I consent to text/voice messaging.

☐ I DO NOT consent to text/voice messaging.

Name_____ DOB_____

Signature_____ Date_____

Mobile Number_____

Patient Informed Consent

Notice:

Before we proceed with your appointment, I want to inform you about an important aspect of how we document our consultations. We utilize a note taking tool called Heidi to accurately and efficiently capture the details of our discussions and the outcomes of our appointments. Heidi ensures that we can focus more on our conversation and less on manual note taking, enhancing the quality of care you receive.

Your consent is crucial for us to use this technology. Please understand that your information will be handled with the utmost care, and Heidi's use is aimed solely at improving your healthcare experience.

By signing this consent form, you are agreeing to allow your clinician to use Heidi during your consultation.

Name: _____

Date: _____ **Signature:** _____

OMNIA MEDICAL GROUP, LLC

HIPAA CONSENT – PRIVACY POLICY

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your provider, our office staff, and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your provider's practice.

Following are examples of the types of uses and disclosures of your protected health information that your provider's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. We will also disclose protected health information to other providers who may be treating you. For example, your protected health information may be provided to a provider to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another provider or health care provider(s) (e.g., a specialist or laboratory) who, at the request of your provider, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your provider(s).

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services, we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of the Company. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required by Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury, or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or

company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.

Research: We may disclose your protected health 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 protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization:

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please

understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object:

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your provider and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If your provider does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your provider.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this

accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your provider amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

The CLIENT MUST sign the consent if they are able to do so. The only exceptions are if the client is a minor, or has a legal document giving permission for someone else to sign on their behalf.

_____

Signature of patient or personal representative

_____

Printed name of patient or personal representative and his or her relationship to patient

Date:_____