BARBEE™
PRIMARY + CARE

PATIENT INFORMATION

Date _____ / _____ / _____

First Name _____ Middle Initial _____ Last Name _____

Date of Birth _____ / _____ / _____ Social Security Number _____ - _____ - _____ Gender □ Male □ Female

Marital Status □ Married □ Single □ Divorced □ Separated □ Widowed

Email address:_____

Address _____ Apartment/Suite _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Race: _____ Ethnicity:_____ Primary Language:_____

Employment Status □ Employed □ Self Employed □ Unemployed □ Disabled □ Retired □ Student

Occupation _____ Employer _____

Emergency Contact _____ Relation _____ Phone _____

Previous Primary Care Doctor_____ Phone_____

Spouse/Partner/Parent/Guardian _____ Phone _____

Who may we thank for referring you?_____

Primary Insurance Information

Name of Insurance Company _____ Phone _____

ID/Subscriber Number _____ Group or Plan # _____

Subscriber Name _____ Relationship to Patient _____

Subscriber SSN _____ - _____ - _____ Subscriber Date of Birth ____ / _____ / _____ Subscriber Gender □ Male □ Female

Additional Insurance Information (if applicable)

Name of Insurance Company _____ Phone _____

ID/Subscriber Number _____ Group or Plan # _____

Subscriber Name _____ Relationship to Patient _____ Subscriber SSN

_____ - _____ - _____ Subscriber Date of Birth ____ / _____ / ____ Subscriber Gender □ Male □ Female

We are required to gather Pharmacy information in order to use electronic prescriptions and exchange information with your Pharmacy. By providing us with the crossroads to your Pharmacy, we will be able to send and receive refill authorizations in a more HIPPA compliant and timely manner. We will also be able to receive current medication information directly from your Pharmacy, which will eliminate your need to bring us lists or try to remember what medication and dosages you are currently taking.

Please look up on your smart phone while waiting.

Pharmacy name, address with zip code and x-streets:_____

Consent to allow electronic exchange between your pharmacy and Barbee Primary Care:

Signature:_____

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OFFICE POLICIES

Insurance Billing
As one of your insurance company's network providers, it is our obligation to require your co-payment prior to your appointment. You will be asked to present your insurance card at each visit. Please inform our staff of any insurance changes immediately. We will bill your insurance for your visit; deductibles, co-insurance, and any non-covered services are your responsibility. Our billing company will send monthly statements to collect these balances after all attempts to collect payment from your insurance company have been made. Failure to pay your responsibility will result in reporting your account to our collections agency.

_____
(Patient Initials)

Office Co-pays, Co ins and Guarantor Balances
Payment is required in advance of your visit for co-pays, co ins and guarantor balances. If you do not have your co-pay or co ins you may be asked to reschedule your appointment. If you have a guarantor balance and you have not already established and maintained a current payment plan with our billing office, you will be asked to make a payment towards this balance in addition to your co-payment. For your convenience, we accept cash, debit, Visa, Master Card, Discover, and American Express as a form of payment in our office.

_____
(Patient Initials)

Returned Checks
There will be a fee assessment of at least $25 for all returned checks for non-sufficient funds, stop payments and account closures. Your account will be flagged for failure to pay and checks will no longer be accepted as a form of payment for your account.

_____
(Patient Initials)

Delinquent Accounts
Delinquent accounts will be reported to our collection agency, Kenneth Eisen & Associates, after normal collection procedures. Contact our billing office at 800-594-8043, temporary financial problems will affect timely payment of your account or if a payment plan is required to prevent your account from going to collections. An additional fee of 23% of the outstanding balance will be applied to all balances reported to our collection agency.

_____
(Patient Initials)

No Show
I understand that a $25.00 fee assessment will be applied to my account upon my second occurrence of neglecting to cancel my appointment 24 hours prior to my scheduled appointment for an office visit. I understand that no additional appointments will be scheduled until this fee is paid.

_____
(Patient Initials)

Fee for Forms
There will be a $35 charge for the completion of any requested forms. Payment will be collected in advance of documents being submitted to Dr.

_____
(Patients Initials)

Patient Printed Name _____

Patient Signature _____Date _____

Notice of Privacy 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.

Barbee Primary care is dedicated to maintaining the privacy of your personal health information. Each time a patient visits this office a record is made that describes the treatments and services provided. Federal law outlines specific privacy protections and individual rights related t the information we maintain that identifies you as a patient. Protected information includes demographic data and facts about your past, present, or future physical or mental health. Our office has put in a place policies and procedures to help protect our health information. We are required to provide this notice outlining you legal duties and responsibilities related to the use and disclosure of patient identifiable health information, Privacy Practices, and examples of how your information may be used or disclosed.

Practice will abide by the terms of this notice. We may revise this notice at any time. The new notice will be posted in our office in a prominent location. You can request a copy of our most current notice at any time. Revisions to the notice will be effective for all health care information this office maintains: past, present, or future.

Practice may use your individually identifiable health information for the following purposes without your authorization:

1. Treatment: We may use and disclose your identifiable health information to treat you and assist others in your treatment. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition, or we may disclose information to others who take part in your care, such as your spouse, children, or parents.
2. Payment: We may use your health information to bill and collect payment for services provided. This may include providing your insurance company with the details of your treatment, sharing you payment information with other treatment providers, your insurance company with the details of your treatment, sharing your payment information with other treatment providers, contacting you over the phone or through the mail about balances, or sending unpaid balances to a collection agency.
3. Health Care Operations: We may use and disclose your health information to operate our business. For example, your health information may be used to evaluate the quality of care we provide, for state licensing, or to identify you by name when you visit the office.
4. Appointment Reminders: We may use and disclose your information to inform to remind you of appointments. We may also mail you a reminder for follow-up visits.
5. Treatment Options: We may use your health information to inform you of treatment options or other health-related services we offer that may be of interest to you.
6. Business Associates: We may share your health information with other individuals or companies that perform various activities for, or on behalf of, our office such as after-hour telephone answering, billing, or quality assurance. Our Business Associates agree to protect the privacy of your information.

Practice may disclose your health information without your authorization when permitted or required to by law, including:

- For public health activities including reporting of certain communicable diseases.
- For workers' compensation or similar programs as required by law.
- To authorities when we suspect abuse, neglect, or domestic violence.
- To health oversight agencies.
- For certain judicial and administrative proceedings pursuant to an administrative order.
- For law enforcement purposes.
- To a medical examiner, coroner, or funeral director.
- For the facilitation of organ, eye, or tissue donation if you are an organ donor.
- For research purposes under strictly limited circumstances.
- To avert a serious threat to your health and safety or that of others.
- For governmental purposes such as military service or for national security.
- In the event of an emergency or for disaster relief.
- In any other instance required by law.

Practice may also disclose your information to family members and/or other persons involved in your care or payment for your care. Practice may leave messages for you at home or work about your visits or test results. If you do not want us to do so, please inform us in writing.

All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time except to the extent that we have already acted on it. Should you require your records to be released, Practice will provide you with n authorization form to complete and return to the address listed on it.

YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF PRACTICE. THE INFORMATION CONTAINED IN IT BELONGS TO YOU. BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

1. Restrictions on Use and Disclosure: You have the right to request restrictions on how we use and disclose your health information. This includes requests to restrict discloser of your health information to only certain individuals, or entities, involved in your care such as family members and insurance companies. We are not required to agree with your request. If we agree, we are bound to the agreement unless discloser is otherwise required or authorized by law.
2. Confidential Communications: You have the right to request that we communicate with you in a particular manner or at a certain location. For example, you may request that we only contact you at home. We will accommodate reasonable requests.
3. Access: You have the right to inspect or request a copy of records used to make decisions about your health care, including your medical chart and billing records. This office will schedule appointments for record inspection. We may charge a fee for providing you copies of your records. Under special circumstances, we may deny your request to inspect and/or copy your records. You may request a review of this denial.
4. Record Amendment: You have the right to request amendments to your health records created by and for this Practice if you feel that are incorrect or incomplete. We may accept or deny your request. If we deny your request, you have the right to provide a statement of disagreement.
5. Accounting of Disclosures: You have the right to receive an accounting of disclosures. This means you may request a list of certain disclosures Practice has made of your records. Upon your request, we will provide this information to you one time free during each twelve (12) month period. There may be a fee for additional copies.
6. Copy of Notice: You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.

_____ _____

Printed Patient Name Name/Relationship if Signed by Individual Other than Patient

_____ _____

Signature Date

_____

Primary Phone

☐ Ok to leave message with detailed medical information. (Extended)
☐ Leave message with call-back number only (Brief)

Please list who you want to have access to your pertinent medical information, (i.e.: family member, spouse, or guardian):

1. Name and relationship to you:_____

Information we may share: ☐ Medical ☐Billing ☐Other (be specific): _____

Best number to contact them: _____

May we leave a message? ☐ Yes ☐ No