

PATIENT DEMOGRAPHIC FORM

How were you referred to our office? : _____ Date: _____

Patient Name: _____ SS#: _____
Last First MI

Date of Birth (DOB): _____ Age: _____ Gender: _____ Marital Status: _____
MM/DD/YYYY S M W D LP

Address: _____ Home Phone: _____
PO Box or Street if no PO Box City State Zip

Daytime Phone: _____ Cell Phone: _____ e-mail _____

Patient's Employer (if applicable): _____

INSURED'S Address & Phone (if different from above): _____

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____ Name of Insured: _____

Insured's Employer: _____

Insured's SS#: _____ Insured's DOB: _____ Insured's Gender: _____

Ins. Effective Date: _____ Insured's Relationship to Patient: _____

Insurance ID#: _____ Insurance Group#: _____ Co-pay Amt: \$ _____

SECONDARY INSURANCE INFORMATION:

Insurance Company: _____ Name of Insured: _____

Insured's Employer: _____

Insured's SS#: _____ Insured's DOB: _____ Insured's Gender: _____

Ins. Effective Date: _____ Insured's Relationship to Patient: _____

Insurance ID#: _____ Insurance Group#: _____ Co-pay Amt: \$ _____

Emergency Contact (someone not living in the same household) _____
Name and Daytime Phone number

Signature on File: _____ Year: 2009 2010 2011 2012



BOWLING GREEN FAMILY PHYSICIANS, INC.

Elizabeth Horrigan, M.D., F.A.A.F.P.

Sean Machanda, M.D.,

**Patricia Noble, C.N.P., Kelly Blickensderfer, C.N.P.,
& Diane Fouts, C.N.P.**

1215 Ridgewood Dr., Suite B

Bowling Green, OH 43402

Phone: 419-352-9071 Fax: 419-352-9073

bgfamilyphysicians.com

PATIENT INFORMATION, MEDICAL INFORMATION RELEASE, AND HIPAA AUTHORIZATION

Patient Name: _____ Date of Birth: _____

RELEASE OF INFORMATION

Please tell us how you wish to be contacted. Check all that apply.

Oral/Written Communication:

____ Home
() _____

____ OK to leave message with detailed information
____ Leave message with call back number/name only
____ OK to mail correspondence to home
____ OK to send E-mails to address below

____ Work
() _____

____ OK to leave message with detailed information
____ Leave message with call back number/name only

E-mail address: _____

Please tell us with whom we are allowed to discuss and/or disclose your Personal Health Information.

Circle all that apply: **Myself only Spouse Adult Children Parents Sibling(s) Personal Representative**

Employer ____ **OK to fax information to employer as needed, ie work releases**

Name(s) of above: _____

My signature below authorizes the release of medical information to any specialists I may be referred to and to process insurance claims/applications, prescriptions, and lab work.

In compliance with HIPPA regulations, we are required to have confirmation that you have been offered a written copy of Bowling Green Family Physicians, Inc Notice of Privacy Practices. My signature below indicates that I have been given an opportunity to review a copy of Bowling Green Family Physicians, Inc. Notice of Privacy Practices.

If at any time you wish to change the information provided on this form, please ask for a new form prior to your appointment so your chart can be updated. Please do not hesitate to ask if you have any questions regarding the HIPPA regulations.

Patient/Responsible Party Signature **Date**

The patient information included on this form is true to the best of my knowledge. I herein authorize payment of medical benefits by my insurance carrier to the physician for services rendered when an assigned claim is filed. **(TO FILE INSURANCE, YOUR SIGNATURE IS REQUIRED).**

Patient/ Responsible Party Signature **Date**

Bowling Green Family Physicians, Inc.

Financial Policy

Patient and insurance responsibility for services rendered, we have been advised to develop this financial policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance- We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and deductibles- All co-payments and deductibles must be paid at the time of service. Failure to pay at the time of service will result in a \$10.00 fee. This arrangement is part of *your* contract with *your* insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Non-covered services- Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or medically necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

Proof of insurance- All patients must complete our patient demographic form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims submission- We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage changes- If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 60 days, the balance will automatically be billed to you.

Nonpayment- Unpaid balances will incur a 2% finance charge 24% APR. If your account is over 90 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physicians will only be able to treat you on an emergency basis.

Bankruptcy- If you file bankruptcy and include this office as a creditor, you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physicians will only be able to treat you on an emergency basis.

Non-Sufficient Funds- If a check is returned to our office unpaid there will be a \$30.00 fee assessed to your account. After a second check has been returned unpaid, your account will be considered as “CASH ONLY” and we will only accept cash or credit card as payment.

Missed appointments- Our policy is to charge \$20.00 for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Auto Accidents- If you have Medicare, Medicaid or Paramount health insurance, claims will be sent to these insurance companies. You will be responsible for any balances the insurance company does not cover due to an auto accident. All other health insurance plans will be required to pay in full at the time of service. We will provide you the necessary documentation to file with the auto insurance company.

Worker’s Compensation- We do not see Worker’s Compensation patients in the office. Any work related injury will be referred elsewhere.

Miscellaneous Forms- Our policy is to charge \$10.00 to fill out miscellaneous forms that are not completed during an office visit.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date

Print patient name

BOWLING GREEN FAMILY PHYSICIANS, INC.

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 - HIPAA

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

**Michelle Crook
1215 Ridgewood Dr. Suite B
Bowling Green, OH 43402
419-352-9071**

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

- 1. Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.
- 2. Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.
- 3. Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.
- 4. Disclosures Required By Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

- 1. Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
 - maintaining vital records, such as births and deaths
 - reporting child abuse or neglect
 - preventing or controlling disease, injury or disability
 - notifying a person regarding potential exposure to a communicable disease
 - notifying a person regarding a potential risk for spreading or contracting a disease or condition

- reporting reactions to drugs or problems with products or devices
 - notifying individuals if a product or device they may be using has been recalled
 - notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
 - notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
- 2. Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
- 3. Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
- 4. Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:
- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
 - Concerning a death we believe has resulted from criminal conduct
 - Regarding criminal conduct at our offices
 - In response to a warrant, summons, court order, subpoena or similar legal process
 - To identify/locate a suspect, material witness, fugitive or missing person
 - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)
- 5. Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
- 6. Military.** Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- 7. National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
- 8. Inmates.** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
- 9. Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

- 1. Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Michelle Crook 419-352-9071** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.
- 2. Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **Michelle Crook 419-352-9071**. Your request must describe in a clear and concise fashion:
- (a) the information you wish restricted;
 - (b) whether you are requesting to limit our practice's use, disclosure or both; and
 - (c) with whom you want the limits to apply.
- 3. Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Michelle Crook 419-352-9071** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
- 4. Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Michelle Crook 419-352-9071**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
- 5. Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Michelle Crook 419-352-9071**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
- 6. Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Michelle Crook 419-352-9071**.
- 7. Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Michelle Crook 419-352-9071**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Michelle Crook 419-352-9071**