Bowling Green Family Physicians • 1215 Ridgewood Dr, Suite B, Bowling Green Ohio 43402

PATIENT DEMOGRAPHIC FORM

How were you referred to our office? : ______________________________ Today's date: ________________

Patient Name: ____ SS#: ____________________
Last First MI

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

Address: ____ Primary Phone: ______________
PO Box or Street if no PO Box City State Zip

Cell/Other phone: ______________ Email ______________________

Race: ______________ Primary Language: ______________ Hispanic/Latino Heritage Y or N ______

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 person and phone number: ____

I acknowledge that the above information is accurate: ______________________________

Wood Health Company, LLC
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 INFORMAITON.

PLEASE REVIEW IT CAREFULLY.

Each time you visit a Wood Health Company office, we make a record of the information gathered during your visit. This information is used for a number of purposes. These uses are set forth below. Finally, we have certain responsibilities regarding our use of your information. Our responsibilities are set forth below.

USE AND DISCLOSURES OF HEALTH INFORMATION

We are permitted by law to use your health information to provide treatment to you. For example, we will provide your physician and other clinicians involved in your care and treatment with the information in our records to assist the physician in providing proper care to you. We will also provide this information to subsequent health care providers. These individuals may create additional information related to the care and treatment they provide to you.

We are permitted by law to use your health information to obtain payment for our services. For example, we may use your health information to assess the quality of care we provide in order to maintain our standards.

In addition to these disclosures, we may use your information to contact you to provide appointment reminders to you or to advise you of treatment alternatives available to you.

We are permitted, and in some cases required by law, to make certain other disclosures of health information without your consent. We may disclose your health information, if appropriate, to the following entities under the following circumstances:

- To public health agencies to satisfy certain reporting requirements, such as births and deaths, certain communicable diseases, child abuse, and other Public health issues;
- To health oversight agencies, such as governmental auditors, the Ohio Department of Health and other agencies when required;
- To any individual when ordered by the court or other legal process to do so;
- To law enforcement officials when necessary for law enforcement purposes and required by law;
- To law enforcement officials if you are an inmate to provide health care to you or for the safety and security of the institution;
- To Family and Friends that are involved in your care, or who assist in taking care of you;
- To a coroner or medical examiner when necessary to enable them to perform their duties;
- To organ procurement organizations, to enable them to make suitability determination in cases of emergency;
- To Workers' Compensation and similar programs;
- To researchers if their research has been approved by and institutional review board and they take certain steps to protect your privacy;
- To the military if you are a member of US or foreign military forces and if required by the appropriate authorities.

We will not use your information for any other purpose without your written authorization. You have the right to revoke any authorization you provide us.

YOUR INDIVIDUAL RIGHTS

You have certain rights regarding your health information. These rights include:

- 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 to keep communications confidential;
- The right to obtain a paper copy of this Notice;
- The right to inspect and copy your health information (copies are available for a reasonable fee.) You must submit your request in writing and schedule an appointment to do this. However, our practice may deny your request in certain limited circumstances.
- The right to request amendments to your health information you believe to be inaccurate. You must submit your request in writing to the Office Manager. You must provide us with a reason that supports your request. 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 individually identifiable health information kept by or for our practice; c) not part of the individually identifiable health information which you would be permitted to inspect and copy; d) not created by our practice, unless the individual or entity that created it is not available to amend the information.
- The right to obtain an accounting of our uses and disclosures of your health information, subject to certain exceptions. You are required to submit your request in writing to the Office Manager. 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 the disclosure, and may not include dates prior to April 14, 2003.
- The right to request restrictions on our permitted uses and disclosures of your information. We are not, however, legally obligated to honor this request.
- The right to request communications regarding your health information be sent by alternative means or at an alternative location.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your information in accordance with this notice. We are also required to provide you with this Notice, explaining our duties and practices regarding your health information. We are required to abide by the terms of this Notice.

We reserve the right to change the content of this Notice and to make new provisions regarding your protected health information. We will provide you a revised Notice during your visit after the revisions are effective. If you have any questions regarding this Notice, or wish to exercise any of your rights as described herein, you may contact the Administrator at (419) 353-7069. Any complaint regarding your rights or our practices, can be directed in writing to the attention of the Privacy Officer, 745 Haskins Road, Suite B, Bowling Green, OH 43402. Finally, you may submit a complaint to the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint.

STATEMENT OF RESPONSIBILITY - The patient is responsible for notifying our office of any changes in address, telephone number(s), or insurance information. If the office is unable to contact you because of outdated or incorrect information, we cannot take responsibility for your care.

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. Please remember that your insurance policy is a contract between you and your insurance carrier. Co-payments are due at the time of service. Patients without insurance are expected to pay at the time the service is rendered.

Co-pays are due at the time of your service. **Wood Health Company charges a $5.00 fee for co-pays not paid at the time of service.**

No Show Appointments - Our office reserves the right to charge a $50 No Show Fee if you fail to keep your appointment.

Returned Check (NSF) - If you present a check that is returned to Wood Health for non-sufficient funds, a $25.00 fee will be charged to your account.

If your visit is the result of an **auto-accident**, we will file the claim to your medical insurance carrier only. Wood Health Company does not get involved with third-party litigation. As with any balance, the responsibility resides with the guarantor of the account.

Work related injuries - are referred to Wood County Hospital Occupation Health department.

Minors - the responsibility for the balance remains with the parent and/or legal guardian that accompanied the patient to Wood Health Company.

Referrals - It is your responsibility to obtain a referral if required by your insurance plan. You must know and utilize the facility that is covered by your insurance carrier. We are not responsible for any charges incurred for not following the rules set forth by your insurance plan.

Authorization and Assignment of Benefits - I authorize treatment by the providers and staff of Wood Health Company. I further authorize release of all medical information necessary to process insurance claims on my behalf. I authorize the assignment of benefit payment to which I am entitled to Wood Health Company. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient or Responsible Party Signature:______________________________ Date:______________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have reviewed a copy of the Notice of Privacy Practices of Wood Health Company, and understand that my protected health information may be used by the Practice as described in the Notice.
Patient Signature:______________________________ Date:______________

Consent to Release of Information-Required if you would like us to discuss your healthcare with someone other than you.

The HIPAA Privacy Regulations require that we obtain your consent to discuss your healthcare or financial information related to your care. If you would like to grant this access, it must be requested in writing, and will remain in effect until revoked in writing, by you.

Spouse: Yes No Spouse Name:______________________________

Child Yes No Child/Children Names:________________________
____

Other: Yes No Name-Relationship___________________________

Patient Signature:______________________________ Date:______________

BOWLING GREEN FAMILY PHYSICIANS
Elizabeth Horrigan, M.D., F.A.A.F.P.
Sean Machanda, M.D.* Deanne Kiba, DO,
Kelly Blickensderfer C.N.P
1215 Ridgewood Dr., Suite B
Bowling Green, OH 43402
Phone: 419-352-9071 Fax: 419-352-9073
bgfamilyphysicians.com

RECORDS RELEASE/ TRANSFER FORM

Patient Name: ______________________________

Address: ______________________________ Date of Birth: ______________

______________________________ Phone Number: ______________________

I authorize the custodian of records of the above named to release/transfer the following information* (**check all applicable**):

☐ All records (Last 2 years will be released unless otherwise indicated) ____________________
☐ Progress Notes Last **2 years**
☐ Consultation Notes All **NOTES**
☐ Laboratory/pathology records **Last 3 Years**
☐ X-ray/radiology/ EKG's: **Last 5 Years**
☐ Other (describe specifically) ______________
☐ Immunization record

**Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, Drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

Physician/ Organization to **RELEASE** information	Physician/Organization to **RECEIVE** information
Name: ______________________	Name: ______________________
Address: ______________________	Address: ______________________
______________________	______________________
Phone: ______________	Phone: ______________
Fax: ______________	Fax: ______________

The information may be used/disclosed for each of the following purposes:
☐ At my request (only the patient can check this box)
☐ For my health care provider ☐ For employment purposes
☐ For payment/insurance ☐ Other: ____________

I would like the records to be delivered via (check one)
☐ I will personally pick up records ☐ Mailed to above address ☐ Faxed: ______________
Note: There may be a fee for release of records; records will be released once payment is received.

This authorization shall expire in 1 year from the date of signature and may be revoked at any time.
I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. 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 ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.
By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

______________________________ __________ ______________________________
Signature of Patient or representative Date Relationship to Patient

______________________________ ______________________________
Printed name of Patient and or Representative Witness

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to Bowling Green Family Physicians, 1215 Ridgewood Drive, Bowling Green OH 43402