Batesville Clinic

PATIENT INFORMATION FORM

(Please Print)

Today's Date ____/____/____

David A. Ball, M.D. Hilary B. Lott, FNP-C
E. Lee Linder, M.D. Magan L. Shipp, FNP

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Social Security #	Birth Date: / /	Age:	Sex: ☐ M ☐ F

Home Address	City	State	ZIP Code	Home Phone No. ( )
P.O. Box	City	State	ZIP Code	Cell Phone No. ( )

Occupation	Employer Name & Address	Employer Phone No. ( )
Spouse's Name	Address	Phone No.

Occupation	Employer	Employer Add. & Phone No.

(PLEASE GIVE YOUR INSURANCE CARD AND A VALID PHOTO ID TO THE RECEPTIONIST)

Person Responsible for Bill		Address (if different)	Home Phone No. ( )
Social Security #	Birth Date / /		Cell Phone No. ( )
Employer		Employer Address	Employer Phone No. ( )

Pharmacy ____________________

Are You Allergic to Any Drugs? Yes ___ No ___ If Yes Please List:

____________________ ____________________

____________________ ____________________

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

ALL CHARGES ARE DUE AT THE TIME OF SERVICE. CO-PAYS AND/OR PAYMENT WILL BE COLLECTED FROM PERSONNEL AT FRONT DESK BEFORE SEEING PHYSICIANS, UNLESS OTHER ARRANGEMENTS MADE WITH PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS, HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.

Insurance, Medicare and Medicaid Release of Information and Assignment

I authorize Batesville Clinic and/or my attending physician to release any medical information necessary to file my insurance claim. I authorize direct payment of benefits to Batesville Clinic and/or my attending physician.

I request that payment of authorized Medicare or Medicaid benefits for services, either for me or on my behalf, be made to the above named physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and/or Medicaid and its agents, any information needed to determine these benefits for related services. I understand if should Medicare or Medicaid declare any portion of my bill to be patient responsibility that I am financially responsible. If this account should be referred for collections, I am responsible for all collection expenses including attorney fees. (If patient is a child, parent's signature is required below.) No one under the age of 18 will be treated without a parent present.

X ____

PATIENT/GUARDIAN SIGNATURE DATE

senatobia print shop • 562-4652

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: ____________________ Signature: ________________________ Date: ____________

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. Moré so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

BATESVILLE CLINIC **PATIENT MEDICAL HISTORY**

NAME: ______________________________ **DATE:** ______________

Reason for your visit to Batesville Clinic: ______________________________

Is this visit work related?	**YES**	**NO**
Is this visit related to an auto accident?	**YES**	**NO**
Could you br pregnant?	**YES**	**NO**

Medications (LIST ALL): ______________________________

____

Have you ever been diagnosed with:

Diabetes	**YES**	**NO**
Heart Disease	**YES**	**NO**
High Blood Pressure	**YES**	**NO**
Heart Attack	**YES**	**NO**
Hepatitis	**YES**	**NO**
Kidney Disease	**YES**	**NO**
Liver Disease	**YES**	**NO**
Lung Disease	**YES**	**NO**
Mental Illness	**YES**	**NO**
HIV/AIDS	**YES**	**NO**
Stroke	**YES**	**NO**

Any other medical conditions: ______________________________

Have you ever had an allergic reaction to a medication? **YES** **NO**

Please List: ______________________________

Family History: ______________________________

____

Surgeries: ______________________________

Hospitalizations: ______________________________

Do you smoke or chew tobacco?	**YES**	**NO**	**How many** ________
Do you drink alcohol?	**YES**	**NO**	**How much** ________
Do you use recreational drugs?	**YES**	**NO**	**List** ________