Mitchell A. Barber, D.P.M., LLC

PATIENT INFORMATION

Patient Name: ____ **Date of Birth**: _____________

Address: ________________________________ **City/State**:_____________________ **Zip**: _________

Home Phone: ___________________ **Work Phone**: _______________ **Cell Phone**: _______________

E-Mail Address: ____

Insurance: ___________________________________ **ID#** ____________________________________

Family Physician: _____________________________________**Phone**: _________________________

Pharmacy: ____ **Location**: ________________________

Do you have any Allergies? ___ No ___ Yes. **If Yes, Please List**: ______________________________

Prescription Medications (Including Dosage): ____

____

PLEASE INDICATE BY CIRCLING THOSE THAT APPLY TO YOUR MEDICAL HISOTRY

Anemia	YES	NO	Kidney Problems	YES	NO	Thyroid Disease	YES	NO
Arthritis	YES	NO	Liver Problems	YES	NO	Tuberculosis	YES	NO
Asthma	YES	NO	Multiple Sclerosis	YES	NO	Vision Trouble	YES	NO
Cancer	YES	NO	Nervous Condition	YES	NO	Poor Circulation	YES	NO
Diabetes	YES	NO	Pacemaker	YES	NO	Numbness in Feet or Legs	YES	NO
Epilepsy	YES	NO	Pneumonia	YES	NO	Pain in Feet or Legs at Night	YES	NO
Gout	YES	NO	Rheumatic Fever	YES	NO	Pain in Feet or Legs as you Walk	YES	NO
Heart Problems	YES	NO	Skin Problems	YES	NO	Venereal Disease	YES	NO
High Blood Pressure	YES	NO	Stroke, TIA, Brain Attack	YES	NO	HIV+, AIDS, ARC	YES	NO
High Cholesterol	YES	NO	Stomach Ulcers	YES	NO	Other:		

Have you had any surgical operations? ___ No ___ Yes. **If Yes please list**: ______________________

____

Family History:
Arthritis - Asthma - Cancer - Diabetes - Foot/Ankle Pain - Heart Problems - High Blood Pressure
High Cholesterol - Kidney Disease - Stoke/TIA

Do you currently Smoke? _ No _ Yes. **How much**: __ **Do you currently consume alcohol**? _No _ Yes.

Do you currently use drugs? (Illegal, narcotics, etc) __ No __ Yes. **If yes, please list**: ______________.

Current Height: ______________ **Current Weight**: _______________ **Shoe Size**: ______________.

Last Blood Pressure Reading: ____________________

Patient Printed Name: ____

Patient Signature: ____ **Date**: __________

Mitchell A. Barber, D.P.M., LLC

SUMMARY NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a questions, concern or complaint regarding out privacy practices, please contact Cristina Liso, at 301-490-2216.

I, ______________________________, acknowledge that I was provided a copy of the Notice of Privacy Practices
(name of patient)
and that I have read or had the opportunity to read if I so chose and understood the Notice. By signing below, I hereby authorize Dr. Mitchell A. Barber, D.P.M., LLC to obtain Medication History related to the patient above, from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

In addition, I authorize the following, ______________________ access to my personal health information upon request.

____ ______________________________
Signature of patient or legal representative Date

FINANCIAL POLICY

❖ Payment in full is due at time of service unless prior arrangements have been made.

- Office visit co-payments for our participating HMO/PPO insurances are due at time of service. For insurance plans with DEDUCTIBLES and CO-INSURANCE obligations, applicable amounts due for services rendered are also due at the time of service.

- If we are a participating provider with your primary health insurance, we are happy to file a claim on your behalf. However, once the insurance company is billed we allow 60 days for the balance to be paid by your insurance carrier. If the insurance company does not remit payment within 60 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance, we will gladly issue a refund overpayment to you within 30 days, providing that you do not have any outstanding accounts with our office.

- An HMO/PPO claim denial due to no referral or authorization is the patient's responsibility. Office staff will notify and assist you in referral/pre-certification procedures, but final responsibility lies with the patient to comply with their specific insurance's requirements. All referral must be presented to our office before seeing the doctor.

- Please present your most recent insurance card each time you visit if we participate with your plan to insure proper filing of information to submit claims, Otherwise your visit may not be covered and you will be responsible for payment. A **$15 service fee** will be assessed for the refiling of insurance claims due to incomplete or incorrect information given at the time of the appointment.

- There is a $25.00 fee for all returned checks.

- All unpaid balances are subject to a 1.5% interest charge after 30 days. On balances that remain unpaid after 90 days, we will take the appropriate collection actions including registering the amount past due with the EQUIFAX credit rating service. If your account must be forwarded to a collection service and/or attorney because of non-payment, you will be responsible for all collection and/or attorney fees charged by these services.

- Please be on time for your appointment. Barber Podiatry, LLC reserves the right to charge a **fee of $60.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice.** "No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice. If you are 10 minutes late or more for your appointment, you may be asked to reschedule.

- If you are scheduled for an outpatient surgery, there will be a $150.00 fee for rescheduling or canceling the surgery.

ASSIGNMENT OF BENEFITS

I understand, certify that I (or my dependent) have coverage with ______________________________
And assign directly to Mitchell A. Barber, DPM, LLC all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of my deductibles, co-payments, and/or non-covered services. I herby authorize the doctor to release all information necessary to secure payment of benefits. I authorize release of medical information to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. By my signature I acknowledge receipt of a copy of this policy and hereby agree to its terms.

Patient Name: ____
Signature: ____ Date: ___________________