LOUISIANA NOTICE FORM

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- *"Treatment, Payment, and Health Care Operations"*
  – *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my [office, clinic, practice group, etc.], such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have

relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse** – If I have cause to believe that a child's physical or mental health or welfare is endangered as a result of abuse or neglect or that abuse or neglect was a contributing factor in a child's death, I must report this belief to Louisiana Department of Social Services.

- **Adult and Domestic Abuse** – If I have cause to believe that an adult's physical or mental health or welfare has been or may be further adversely affected by abuse, neglect, or exploitation, I must report this belief to the appropriate authorities as required by law. Please note that the term "adult", for the purposes of this section, means any person sixty years of age or older, any disabled person eighteen years of age or older, or an emancipated minor.

- **Health Oversight Activities –** The Louisiana Board of Psychological Examiners may subpoena records from me relevant to its disciplinary proceedings and investigations.

- **Judicial and Administrative Proceedings** – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information without your written authorization, or a court order. In the event of your death, your legally-appointed representative will be given access if a suit is brought on behalf of the estate. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I will inform you in advance if this is the case.

- **Serious Threat to Health or Safety** – If you communicate to me a threat of physical violence, which I deem to be significant, against a clearly identified victim or victims, coupled with the apparent intent and ability to carry out such threat, I must take reasonable precautions to provide protection from the violent behavior. These precautions include communicating the threat to the potential victim(s) and notifying law enforcement.

  Worker's Compensation – If you file a worker's compensation claim and I have treated you relevant to that claim, I must disclose any requested medical information and records relative to your injury to your employer, to a licensed and approved vocational rehabilitation counselor assigned to your claim, another health care provider examining you, or the worker's compensation insurer.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will . . .[*Notice must also describe how the psychologist will provide individuals with a revised notice, e.g., by mail.*]

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact **Louisiana State Board of Examiners of Psychologists, 8706 Jefferson Hwy, Suite B 70809, (225) 925-6511**

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 20, 2005.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail.

Thomas C. Fain, Ph.D., M.P.A.P.
10641-1 Hillary Court
Baton Rouge, LA 70810
(225) 387-3325

Receipt of Notice of Privacy Practices

This is to certify that the HIPAA Notice of Privacy Practices has been made available to me regarding me as a patient or regarding my child, for whom I am a legal guardian.

_____
Signature of Patient or Authorized Party

_____
Date

_____
Witness

CONSENT FOR TREATMENT

I, _____, hereby consent to diagnosis and treatment of my minor child(ren),_____ by **Thomas C. Fain, Ph.D., F.A.C.P., M.P.A.P.** In entering into this agreement, I understand that all mental health care, diagnosis and treatment is provided by the licensed professional person named above and not by Psychological Evaluation & Treatment Services.

I accept responsibility for payment of all usual and customary professional fees charged, **or** insurance deductibles and copayments set by my insurance carrier, managed care company, or other third party administrator, **and** that I am responsible for any expenses incurred that are not covered by such other entities (i.e. un-authorized procedure, telephone comunications to third parties or yourself, filling out of forms or other documents, letters, reports or other written communications, etc.). I understand that payment is due at the time services are rendered, unless other arrangements have been made in advance.

I understand further that all communications shall be held in professional confidence except for those circumstances provided by law or when I have given permission in writing for release of information on my behalf to a third party. Examples (**not a complete list**) of legal exceptions to the patient's privilege of confidentiality include the following:

* When you have filed a lawsuit placing your mental status at issue;

* When you have signed an agreement with some other person or company, such as your insurer, authorizing release of information;

* When your condition poses a danger to yourself or someone else;

* When evidence of abuse is revealed.

Cancellation of sessions, and re-scheduling of sessions, must be done at least 24 hours in advance. *Answering service available 7 days a week, 24 hours a day.* ***If you do not cancel/reschedule at least 24 hours in advance, you will be billed $80 for that session. If you are going through an insurance company, you should know that they will not pay this cancellation fee; it will be an out-of-pocket expense for you.***

_____ _____

Date Signature

_____

Witness

THOMAS C. FAIN, PH.D., M.P.A.P.

Adolescent Client Information

****Please fill out entire form to the best of your ability****

Patient Name _____ **Today's Date** _____

Birthdate _____ **Age** _____ **Height** _____ **Weight** _____

Home/Mailing Address _____

_____ **Home Phone** (____)_____

SSN# _____-_____-_____ **Email** _____

School _____ **Present or Highest Grade** _____

Parents _____ **Marital Status** _____

Mother's Address (if different) _____

Home Phone (____)_____ **SSN#** _____-_____-_____ **Cell** (____)_____

Employer/Occupation _____ **Work Phone** (____)_____

Father's Address (if different) _____

Home Phone (____)_____ **SSN#** _____-_____-_____ **Cell** (____)_____

Employer/Occupation _____ **Work Phone** (____)_____

Brothers/Sisters (names and ages) _____

_____

Circle All That Apply:

Pregnancy: normal threatened miscarriage mother sick; comment_____

Delivery: normal premature complicated C-section; comment_____

Infant: normal irritable handicapped sickly; comment_____

Development: normal delayed; comment_____

PLEASE FILL OUT THE FOLLOWING COMPLETELY:

Chief Complaint _____

_____

_____

Previous Evaluation/Treatment (where, when, who) _____

_____

Medications (Current/Past) _____

_____

Referred by _____

Primary Care Physician _____

CHILD/ADOLESCENT SYMPTOM CHECKLIST

In order to assist your clinician in the assessment process, please check any of the following symptoms that your child has experienced within the last month.

School Difficulties:

_____ Reading problems
_____ Writing problems
_____ Arithmetic problems
_____ Clumsy, awkward
_____ Won't obey at school
_____ Problem speaking
_____ Won't go to school
_____ Won't try in school
_____ Poor work habits
_____ Difficulty following directions
_____ Doesn't care
_____ Runs away from school
_____ Slow learner
_____ Tries hard but fails
_____ Fights at school
_____ Plays sick when not
_____ Daydreams ("In another world")
_____ Fidgety, hyperactive, can't sit still
_____ Talks out of turn
_____ Disturbs others when working

Everyday Situations:

_____ Shy
_____ Keeps to self
_____ Doesn't make friends
_____ Cries too much
_____ Hurts self
_____ Jealousy
_____ Worries too much
_____ Complains too much
_____ Poor loser
_____ No confidence
_____ Depressed/Unhappy
_____ Asks for too much help
_____ Won't take help
_____ Won't sit still
_____ Forgets things learned
_____ Won't keep at one thing
_____ Feelings hurt too easily
_____ Unable to express feelings
_____ Overactive
_____ Nervous
_____ Runs away from home
_____ Fights
_____ Hurts others
_____ Lies
_____ Steals
_____ Sets fires
_____ Temper fits
_____ Bad language
_____ Says strange things
_____ Does strange things
_____ Bed-wetting
_____ Clothes-wetting
_____ Soiling (stool in pants)
_____ Too neat
_____ Works too hard
_____ Thumb-sucking
_____ Many bad dreams
_____ No friends
_____ Friends younger mostly
_____ Friends older mostly
_____ Bossy
_____ Tattles, tells on others
_____ Keeps bad company
_____ Poor grooming
_____ Motor coordination problems
_____ Fears of _____

Name:_____ Date:_____

Thomas C. Fain, Ph.D., M.P.A.P.
10641-1 Hillary Court
Baton Rouge, LA 70810
(225) 387-3325

HEALTH REVIEW

NAME _____ DATE _____

DATE OF BIRTH _____ PRIMARY CARE PHYSICIAN _____

HAVE YOU EVER HAD OR HAVE ANY OF THE FOLLOWING PROBLEMS (PLEASE CIRCLE):

1. Weight changes more than 6 pounds in last 3 months YES or NO
2. Recent chills or fever YES or NO
3. Weakness or fatigue YES or NO
4. Major surgical operations YES or NO
5. Serious injuries YES or NO
6. Allergic reaction to a medicine YES or NO
7. Cancer or malignant disease YES or NO
8. Amount of alcohol intake, _____ day YES or NO
9. Smoking, packs/day _____ duration _____yrs. YES or NO
10. Vision problems YES or NO
11. Glaucoma or cataracts YES or NO
12. Inflamed eyes YES or NO
13. Difficulty in hearing YES or NO
14. Ear infections YES or NO
15. Noises in ears YES or NO
16. Severe dizziness YES or NO
17. Sinus or allergy problems YES or NO
18. Persistent hoarseness YES or NO
19. Frequent colds or sore throats YES or NO
20. Bleeding or sore gums YES or NO
21. Soreness in mouth or tongue YES or NO
22. Nosebleeds YES or NO
23. Lumps or swelling in neck YES or NO
24. Persistent cough YES or NO
25. Coughed up blood YES or NO
26. Shortness of breath YES or NO
27. Pneumonia or lung infections YES or NO
28. Tuberculosis YES or NO

HAVE YOU EVER HAD OR HAVE ANY OF THE FOLLOWING PROBLEMS (PLEASE CIRCLE):

29. Abnormal chest x-ray/spot on lungs YES or NO
30. Asthma or wheezing YES or NO
31. A known heart disease YES or NO
32. Heart attack or failure YES or NO
33. High blood pressure YES or NO
34. Irregular or fast heartbeat YES or NO
35. Chest pain or tightness when active YES or NO
36. Need to sleep on several pillows YES or NO
37. Heart murmurs YES or NO
38. Swelling of legs or ankles YES or NO
39. Leg pain with or after walking YES or NO
40. Varicose veins YES or NO
41. Poor appetite YES or NO
42. Difficulty swallowing YES or NO
43. Heartburn or indigestion YES or NO
44. Recent changes in bowel movements/habits YES or NO
45. Vomiting blood YES or NO
46. Passing black stools or rectal bleeding YES or NO
47. Stomach abdominal pain YES or NO
48. Stomach or duodenal ulcers YES or NO
49. Hepatitis or liver diseases YES or NO
50. Frequent nausea or vomiting YES or NO
51. Gallstones or gallbladder problems YES or NO
52. Chronic constipation YES or NO
53. Chronic diarrhea or loose stools YES or NO
54. Hemorrhoids or rectal problems YES or NO

55. Excessive gas or bloating YES or NO
56. Passing blood in urine YES or NO

HAVE YOU EVER HAD OR HAVE ANY OF THE FOLLOWING PROBLEMS (PLEASE CIRCLE):

57. Frequent or painful urination (3 or more times) YES or NO
58. Frequent urination at night YES or NO
59. Difficult to start urination YES or NO
60. Difficult to control bladder YES or NO
61. Changes in urine color YES or NO
62. Sugar or albumin in urine YES or NO
63. Kidney or bladder stones YES or NO
64. Known kidney disease YES or NO
65. Frequent bladder or kidney infections YES or NO
66. Venereal diseases (syphilis or gonorrhea, etc.) YES or NO
67. Lumps in groins or genitals YES or NO
68. Hemias YES or NO
69. Impotence or sexual dysfunction YES or NO
70. Menstrual problems or irregularity YES or NO
71. Unusual vaginal bleeding YES or NO
72. Frequent vaginal infections YES or NO
73. Lumps in breast YES or NO
74. Nipple discharge YES or NO
75. Frequent or chronic joint pain YES or NO
76. Joints swollen for weeks YES or NO
77. Bursitis or tendonitis YES or NO
78. Injections in the joints YES or NO
79. Gout YES or NO
80. Bone diseases or osteoporosis YES or NO
81. Back or neck injuries YES or NO
82. Frequent back or neck pain or stiffness YES or NO
83. Numbness or tingling in hands or feet YES or NO

HAVE YOU EVER HAD OR HAVE ANY OF THE FOLLOWING PROBLEMS (PLEASE CIRCLE):

84. Rash or itching YES or NO
85. Psoriasis YES or NO
86. Skin ulcers YES or NO
87. Hives or eczema YES or NO
88. Frequent headaches or migraine YES or NO
89. Head injuries or loss of consciousness YES or NO
90. Convulsions or fits YES or NO
91. Fainting or blackout spells YES or NO
92. Numbness or paralysis (temporary or permanent) YES or NO
93. Nervous breakdown YES or NO
94. Consulted a psychiatrist YES or NO
95. Taken medicine for nervousness YES or NO
96. Difficulty sleeping YES or NO
97. Crying or blue spells YES or NO
98. Anemia YES or NO
99. Bruise easily YES or NO
100. Frequent bleeding YES or NO
101. Blood transfusion(s) in the past YES or NO
102. Diabetes YES or NO
103. Goiter YES or NO
104. Taken thyroid medications YES or NO
105. Heat or cold intolerance YES or NO
106. Hormone medication YES or NO
107. Cortisone medications YES or NO
108. Excessive water drinking YES or NO
109. Excessive sweating YES or NO

FAMILY HISTORY (SIBLINGS, CHILDREN, PARENTS, RELATIVES)

High blood pressure YES or NO
Heart disease YES or NO
Stroke YES or NO
Cancer type YES or NO
Kidney diseases YES or NO
Lung Diseases YES or NO

Blood diseases YES or NO
Tuberculosis YES or NO
Diabetes YES or NO
Epilepsy YES or NO
Asthma YES or NO
Psychoemotional Disturbances (i.e. Bipolar, Depression, Anxiety, Schizophrenia, etc.) YES or NO

List medications you are allergic to

_____

_____

_____

Other diseases (specify) _____ YES or NO

Any other information pertinent to your physical and psychological health problems?

_____

_____

_____

_____

Prior hospitalizations and why

_____

_____

_____

Thomas C. Fain, Ph.D., M.P.A.P.
10641-1 Hillary Court
Baton Rouge, LA 70810
(225) 387-3325

Authorization for Release of Confidential Information

I, _____, give my consent for the release of confidential information concerning:

my son/daughter

Information to be released is limited to:

all findings

Disclosure of this information is for the purpose of:

evaluation or treatment

Information shall be exchanged between:

Thomas C. Fain, Ph.D., M.P.A.P.

_____

And the following person(s): (Ex: other parent/guardian, primary care physician, etc.)

_____

_____

This consent may be revoked in writing at any time, but such revocation shall not be retroactive.

This consent shall expire not later than one year after treatment ends

_____ _____
Date Signature

_____
Witness

Thomas C. Fain, Ph.D., M.P.
10641-1 Hillary Court
Baton Rouge, LA 70810
(225) 387-3325

Authorization for Release of Confidential Information
Part II

I, _____, give my consent for the release of confidential information concerning:

my son/daughter _____

Information to be released is limited to:

my findings _____

Disclosure of this information is for the purpose of:

evaluation or treatment _____

Information shall be interchanged between:

Thomas C. Fain, Ph.D., M.P. _____

and:

YOUR INSURANCE PROVIDER _____

This consent may be revoked in writing at any time, but such revocation shall not be retroactive.

This consent shall expire not later than one year after treatment ends.

_____ _____
Date Signature

_____
Witness

Thomas C. Fain, Ph.D., M.P.A.P.
10641-1 Hillary Court
Baton Rouge, LA 70810
(225) 387-3325

Insurance Filing Requirements

Our current office policy requires payment at the time of service. We will file with all in-network managed care companies if indicated below. If you do not wish for us to file with your in-network insurance company, we will not backdate services if you later decide you want us to file. However, we will start filing your claims starting on the date you sign a new 'Insurance Filing Requirements' form allowing us to do so. If you have out-of-network insurance, we will not file for you but you are allowed to file on your own. Please note that insurance companies have limitations on which diagnoses and services are covered, and this information may be used in determining future insurance eligibility. **This means you are responsible for any payments not covered under your insurance policy.** Refer to your policy for these details.

- ☐ I do want this office to file with my in-network insurance company at this time
- ☐ I do not want this office to file with my in-network insurance company at this time
- ☐ I have out-of-network insurance and will handle this on my own.
- ☐ I do not have health insurance at this time

_____
Signature of Authorized Party

_____
Date

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Please sign, date, and sign.
Do not fill out the rest.

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1										
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)