Bailey Family Care, Inc.

Timothy S. Bailey, DO

REGISTRATION FORM Date:

Patients last name:	First:	Middle:	Marital status:
Mr. Mrs. Ms. Miss. Dr.			Single Married Divorce Separated Widow

Street Address:	City:	State:	Zip Code

Home Phone:	Cell Phone:	Social Security Number:	Race:	Ethnicity:

E mail:	Pharmacy Number:	Occupation:	Employer/Phone number

How do we communicate with you? E mail Phone Text

HIPAA CONTACT INFORMATION

In the following section, please let us know of any person or persons that we can communicate with in regards to your care. This will enable us to let these individuals know about your test results, office visit information, and other sensitive and protected health information. You must list spouses, parents, siblings, friends, and relatives on this document for us to be able to communicate with them. We will not release copies of your medical records to these individuals with your written request to do so. You can revoke this request at time by written or verbal request.

I,_____ hereby request confidential communication of my protected health information to the following individual or individuals:

Contact person:_____ Address:_____

Phone number :_____Relationship:_____

Contact person:_____ Address:_____

Phone number: _____Relationship:_____

EMERGENCY CONTACT

Name of contact:	Relationship:	Home phone:	Cell Phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any remaining balance. I authorize Bailey Family Care, Inc. or my insurance company to release any information to process claims.

Patient signature or guardian if applicable:	Date:

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Patient Financial Policy

We are so thankful that you have chosen Bailey Family Care, Inc. for your medical care and welcome you to the practice. The staff and I are driven to provide you with the best medical care we possibly can in an empathetic and caring manner. It is important to our professional relationship that you have a clear understanding of our Patient Financial Policy. Please carefully review the following information and sign and date the form at the bottom. If you should have any questions about any of the following information, please don't hesitate to ask.

____Registration/Check in: When you register and on occasion thereafter, you will be asked to complete a Registration Form to keep a continued accurate account of personal and insurance information. At your first appointment check in you will be asked to present a current insurance card. Any outstanding balances will be collected at this time. Patients who are under 18 years old will require a parent or legal guardian to be present at their appointment.

___Insurance: Bailey Family Care, Inc. participates in many different types of health insurance plans that may vary in the amount and extent of coverage and medical services provided. It is your responsibility to check with your insurance to verify that Bailey Family Care, Inc. is within your network and your medical services will be covered. If you are unable to show proof of coverage or do not have health insurance, you will be required to pay for services the day of your appointment. You are also responsible for knowing your insurance benefits and coverage. We will gladly file your insurance claim on your behalf with the insurance companies that we participate with and will allow 45 days for them to process the claim. If your insurance company does not process the claim within that period of time, you will be responsible for paying the entire bill. If there should be a dispute between you and your insurance company regarding coverage and /or policy benefit criteria such as co-pays, deductibles, co-insurance, non-covered services, and benefits coordination, we will not become involved. You are responsible for all co-payments at the time of your service. We accept cash, personal checks, money orders, Mastercard, Visa, and Discover.

___No Show for Appointments and Last Minute Cancellations: Appointments at the office can be difficult to obtain secondary to increased demand for medical care. If you do not show up for your appointment or fail to give us 24 hours notice, it makes it very difficult to fill this time slot with another patient that may have a serious medical need for care in the office. If the need should arise to reschedule, we ask that you please give us 48 hours notice before your scheduled appointment. **There will be a $25.00 charge for No Show appointments.**

___Returned Checks: If there is a check that is returned as unpaid by your bank, **there will be a $35.00 Returned Check charge applied.**

___Collections: Please contact us if you have difficulty paying your bill. We will do what we can to work with you. Accounts with outstanding balances of 90 days past due without making any prior arrangements for payment will be considered for our collections agency. If the account is placed in the hands of the collection agency, all non-emergent appointments will be cancelled until the account has been paid.

Patient Name_____Date_____

Patient/Parent/Guardian Signature_____

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HIPAA Notice of Privacy Practice

This form accounts for how medical information about you may be used and disclosed and how you can access this information. **PLEASE REVIEW THIS CAREFULLY.**

The privacy notice is presented to you pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementation regulations. It is meant to tell you how, under federal law, we may use/disclose your Health Information. It has been updated to the HITECH Omnibus Rule requirements.

I. Your Rights.

You have the right to request restrictions on the uses and disclosures of your Health information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of health care charges to your insurance carrier if you pay for those services by other means, in full.

You have the right to receive your Health Information through confidential means and in a manner that is reasonably convenient for your provider.

You have the right to inspect and copy your Health Information. You may request your records to digital format and have your records sent digitally to another provider with written authorization.

You have the right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change this information and will provide you with the information about our denial and how you can disagree with the denial.

You have the right to receive an accounting of disclosures of your Health Information made by us except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an authorization; made in order to notify and communicate with the approved family members; and/or for certain government functions, to name a few.

You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact Bailey Family Care.

II. We May Use Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization. Here is on example of each:

We may provide your Health Information to other health care professionals, including doctors, nurses and technicians, for purposes of providing you with care.
Our billing department may access your information, and send relevant parts to insurance companies to allow us to be paid for services rendered to you.
We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions. Our attorneys and accountants are required to maintain confidentiality when they receive patient information.

III. We may also use or disclose Your Health Information Under Certain Circumstances without Obtaining Your Prior Authorization. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person. Some instances where we may need to disclose information include but are not limited to:
To notify and/or communicate with your family. We will only communicate with the family members that we are authorized to communicate with based on your completion of the Authorization to Disclose Health Information to Family and Friends Form.
As required by law.

For Health Oversight Activities. We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification and other proceedings.
Responding to Civil Subpoenas or/Judicial Administrative Proceedings. As directed in the course of a civil/judicial proceeding.
To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to comply with a court order or grand jury subpoena and other law enforcement purposes.
For Purposes of Organ Donation. We may use or disclose your Health Information for purposes of communicating to organizations involved in procuring, banking, or transplanting organs and tissues.
For Workers Compensation. We may use or disclose your Health Information as necessary to comply with worker's compensation laws.

IV. For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed Authorization. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.
Fundraising. Should our practice use patient information for fund raising we will inform individuals that they have the right to opt out of fundraising solicitations and explain that process. You do have the capability to opt back in with written notice.
Marketing. Should our practice use patient information for marketing purposes we will first obtain your written authorization and fully explain the uses and disclosures of PHI for marketing purposes. Disclosures that constitute a sale of PHI will require a separate written authorization.
Use or Disclosure of Psychotherapy Notes. Written authorization is required if our practice intends to use psychotherapy notes.
Breach Notes. All patients will be informed if there is a breach, as defined by federal rules, of their unsecured protected health information as required by the HIPAA regulations.
Right to Request Restrictions for Disclosures Related to Self-Payment. Our practice is required to comply with a request to disclose health information to a health plan for treatment when the individual has paid, in full, out-of-pocket for a healthcare items or services and signed our "Do Not File Insurance Form".

V. You Should Be Advised that We May Also Use or Disclose Your Health Information for the Following Purposes:
Appointment Reminders. We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.

Change of Ownership. In the event that our Business is sold or merged with another organization, your health information record
will become property of the new owner.

Electronic Exchange. Your information may be shared with other providers, labs and radiology groups through our EMR/EHR system.

VI. Our Duties.
We are required by law to maintain the privacy of your Health Information and to provide you with a copy.

We also are required to abide by terms of this notice.

We reserve the right to amend this Notice at any time in the future and to make the new notice provisions applicable to all of your Health Information even if it was created prior to a change in the notice. If any such amendment is made that materially changes this notice, we will send you another copy.

VII. **Complaints to our Practice and the Government**.

You may make complaints to our HIPAA privacy officer or the Secretary of the Department of Health and Human Services if you believe your rights have been violated.
We will review all complaints in a professional manner and keep you informed of your rights as our patient.
We promise not to retaliate against you for any complaint you make about our privacy practices.

VII. Contact Information.
You may contact us about our privacy practices or file complaint by calling 727-375-9600.

You may contact the DHHS at : The U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201, Telephone; 202-619-0257, Toll Free: 1-877-696-6775.

Living Will

Declaration made this ____day of_____, 2_____, I, _____,
willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and

_____(initial) I have a terminal condition,
or _____(initial) I have an end-stage condition,
or _____(initial) I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I do___, I do not___desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration

Name_____
Street address_____
City_____State_____Zip_____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional instructions, (if needed)_____
_____
_____
_____
_____

Signed_____

Witness_____ Witness_____
Street address_____ Street address_____
City_____State_____ City_____State_____
Phone_____ Phone_____

At least one witness must not be a husband or wife or a blood relative of the principal

Bailey Family Care, Inc.
Timothy S Bailey DO

NEW PATIENT HEALTH HISTORY

Name:_____ Date:_____

SS # :_____ Date of Birth:_____

PAST MEDICAL HISTORY Previous Physician_____Date of last exam:_____

Have you ever been hospitalized, if so for what? Yes_____No_____: _____

Have you ever been vaccinated for hepatitis A or B? (circle one). Ever been tested for Hepatitis A , B , or C ? (circle)

Have you ever been diagnoses with a sexually transmitted disease? Yes___ No___. Diagnosis_____

Have you ever been screened for tuberculosis (TB)? Yes___No___. If yes, results?_____. Treatment? Yes__No__

Please check all that apply:

[ ] AIDS, HIV	[ ] Headache	[ ] Skin Rash	[ ] Other_____
[ ] Allergies	[ ] Heart Attack	[ ] Stroke	[ ] Other_____
[ ] Anemia	[ ] Hepatitis	[ ] Swelling of Feet	[ ] Other_____
[ ] Arthritis	[ ] Herpes	[ ] Hyperthyroid	[ ] Other_____
[ ] Asthma	[ ] High Blood Pressure	[ ] Hypothyroid	
[ ] Back Problem	[ ] Kidney Problems/UTI	[ ] Tonsillitis	
[ ] Cancer. What type?	[ ] Liver Disease	[ ] Ulcer, Colitis	**ALLERGIES:** Please list any
_____	[ ] Nervous / Anxiety	[ ] Lupus	medications allergies you have:
[ ] Diabetes	[ ] Pacer	[ ] Rheumatoid	_____
[ ] Emphysema, COPD	[ ] Psychiatric Care	[ ] Fibromyalgia	
[ ] Epilepsy, seizures	[ ] Reflux Disease, Acid	[ ] Depression	_____
[ ] Glaucoma, Eye	[ ] Sinus Problems	[ ] Menopause	

Please list any SURGERIES you have had in your past:_____

_____

MEDICATIONS Drug Name Mg Dosage (use back if needed)

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Social History

Do you smoke? Yes _____No _____ Packs per day?_____Have you in the past? Yes____No_____

Do you chew tobacco? Yes___No___ Have you in the past? Yes___No____

Do you drink alcohol, beer, wine , spirits? Yes___No___Drinks per Week?____In your past? Yes___No___

Do you wear seatbelts? Yes___No___ Do you wear a helmet? Yes___No___Do you exercise? Yes__No___

Do you drink coffee or caffeinated beverages? Yes___ No___ How many cups, cans, glasses?_____

Family History: Living Age (or at death) Please list serious illnesses

Mother [ ] Yes [ ] No_____
Father [ ] Yes [ ] No_____
Sister (s) [ ] Yes [ ] No_____
Brother (s)[ ] Yes [ ] No_____
_____

Has anyone in your family had any of the following: Which Family Member?

Anemia or blood disorders, clotting disorders_____
Cancer. What kind? _____
Diabetes _____
Genetic disorders of any kind _____
Glaucoma, eye disorders _____
Heart Disease _____
High /blood Pressure _____
HIV, Infectious diseases _____
Mental Issues, Depression, Anxiety, Bipolar_____
Stroke _____
Rheumatoid, lupus, rheumatological disease_____

Female Obstetric and Gynecological History: How many times have you been pregnant?_____
Date of last PAP smear?_____ Ever had and abnormal PAP smear? Yes___No___ Treatment_____
Date of last mammogram?_____ Any abnormal results? Yes____No____Diagnosis/Treatment_____

With my signature, I certify that the information that I have given on this form is true, complete, and accurate to the best of my knowledge.

Patient/ Legal Guardian Signature_____ Date _____

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PATIENT RESPONSIBILITY

Please be aware that in the event that your insurance does not pay for your visit and services rendered, you are responsible for payment.

Thank you for your cooperation and understanding in this matter.

Patient name printed:_____

Date:_____

Signature:_____

Witness:_____

Primary Insurance:_____

Subscriber ID#:_____

Secondary Insurance:_____

Subscriber ID#:_____

Bailey Family Care, Inc.
Timothy S Bailey DO

Acknowledgement of Receipt of Privacy Practices

I have received a copy of Bailey Family Care, Inc. and Timothy S Bailey DO Notice of Privacy Practices.

Patient signature:_____

Patient Printed Name:_____

Date:_____

Patient Representative (if needed)_____

Bailey Family Care, Inc.
Timothy S Bailey DO
1815 Health Care Drive, Suite B
Trinity, FL. 34655
727-312-4445
Fax 727-312-4643

Authorization for Disclosure of Health Information to Bailey Family Care, Inc.

PATIENT INFORMATION

Name: _____

Date of Birth: _____Phone Number: _____

Address: _____

City: _____State: _____ Zip: _____

RELEASE OF INFORMATION FROM:

Facility/Provider: _____

Address: _____

City: _____State: _____Zip: _____

The type and amount of information to be used or disclosed is as follows:

_____Complete Health Record _____Lab results, diagnostics, X-ray reports
_____Physical Exam _____Consultation reports
_____Immunization Records _____Other_____

This information may be disclosed to and used by BAILEY FAMILY CARE, INC. and TIMOTHY S BAILEY DO. 1815 Health Care Drive. Ste B. Trinity, FL. 34655. Phone number (727) 312-4445. Fax (727) 312-4643

I understand and acknowledge that the requested information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS related conditions, and/or alcohol/drug abuse.

I understand I have the right to revoke this authorization at any time. I also understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Any revocation will not apply to information that has already been released in response to this authorization. If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days. I do not have to sign this document in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided by CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal rules. If I have any questions about the disclosure of my health information, I can contact the Privacy Officer for Bailey Family Care, Inc.

_____/ _____ ____/____/_____
Signature of Patient/Personal Representative Printed Name Date

_____
Relationship if not Patient