PATIENT INFORMATION

Patient Name_____ Date_____

Address _____

City, State, Zip _____ Sex ☐ Male ☐ Female

Home Phone _____ Work Phone _____

Mobile Phone _____ Email _____

Communication Preference ☐ E-Mail ☐ Home Phone ☐ Mobile Phone

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Date of Birth _____ Age _____

Social Security # _____ Occupation _____ Employer_____

ETHNICITY ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to specify
RACE ☐ Black or African American ☐ White ☐ Other Race ☐ Declined

INSURANCE INFORMATION

Primary Insurance Provider _____

Subscriber ID _____

Secondary Insurance Provider _____

Subscriber ID _____

EMERGENCY CONTACT INFORMATION

Name and Relationship of Emergency Contact _____

Address_____ City, State, Zip _____ Telephone _____

LABORATORY AND PHARMACY PREFERENCE

Pharmacy Name and Address _____

Laboratory Name and Address _____

PATIENT HEALTH HISTORY

Medications
Please list ALL medications you take, including the over the counter medications and vitamins. Include specific doses and when taken.

Medication	Dosage	Reason for Taking

Are you allergic to any medications
☐ No ☐ Yes (please list below)

Name	Reaction

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

I HAVE RECEIVED THIS OFFICE'S NOTICE OF PRIVACY PRACTICES

PRINTED NAME_____

SIGNATURE_____ DATE_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices as required by law, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited acknowledgement
_____ An emergency situation prevented acknowledgment
_____ Other (please specify)

OFFICE AND BILLING POLICIES

Our office accepts PPO insurance and is in network with several different HMOs as well. We do our best to help you know before you come in if your insurance will cover a visit with us. Insurance companies often make changes in coverage without notifying providers. It is, however, ultimately your responsibility to know your plan, whether your insurance information is current and to check with your carrier first to make sure we will be considered in-network for your visit. If you have an HMO plan, please make sure you are assigned to Dr. Joseph Barbara as your primary doctor.

Our office also accepts non-insured, cash paying, patients. The rates we offer non-insured patients are similar to the average reimbursement from an insurance company. We do not charge more than the average, and we may not, per our contracts with insurance companies, charge less.

All co-pays and outstanding balances must be paid and collected at the time of your visit. For our cash pay patients, you will be given a balance and you must pay before any services are rendered. All charges may be settled using cash, checks, Visa, Mastercard, American Express or Discover. You will receive a statement from our office showing what remittance advice, if any, we received from your insurance company. All undisputed amounts owed should be paid within 30 days of you receiving your first statement.

We offer 0% interest payment plans. The most important thing is that you call and speak with our billing specialist to arrange a plan as soon as you are aware that you need some assistance in managing the payment. We have the ability to keep your credit card on file and charge the card that is kept on file with our office to collect the agreed upon amounts on the agreed upon dates. Any balances that are unpaid for more than 90 days from a final determination by your insurance carrier will be sent to collections.

If you are an insured patient, your agreement with your insurance company dictates how your charges are to be shared between you and your insurance carrier. We send the charges to your carrier; they tell us how to allocate the charges per your assigned plan. Our agreement with them is very clear and it is state and federal law that we abide by the contract. We must collect what is owed or we can be dropped as a provider and the insurance companies can take legal action against us. If you are under financial hardship, and even an interest free payment plan will not suffice, there is a process by which you can document your hardship to the satisfaction of your insurance company so that we will be allowed to somewhat reduce the amount that you owe.

ACKNOWLEDGEMENT OF FINANCIAL POLICIES AND GUARANTEE OF PAYMENT

By signing my name below

I hereby guarantee payment in full within ninety (90) days of all charges established by Joseph C. Barbara MD, Inc. for service rendered to me or my dependent, unless other arrangements satisfactory to Joseph C. Barbara MD, Inc. This includes any charges that a third-party payer may determine to exceed usual and customary limits. I authorize all relevant payers to pay Joseph C. Barbara MD, Inc on my behalf for any services furnished to me or my dependents. I certify that I have read this assignment of benefits, that the information given by me is correct and that I agree to all the provisions contained in it. The insurance information I have provided is current and correct. If I sign this form and the insurance card is found later to be outdated or invalid, I understand that I am responsible for paying for the services in full and will need to file with the insurance carrier myself. My insurance copay is due at the time of service, per my insurance company.

Print Name _____ Signature _____Date_____