Michael J. Barimo, D.O.
Marie Christensen, M.D.
Max S. Watzman, D.O.

Name: _____

Address: _____

_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

May we leave a message? _____ Yes _____ No

Primary doctor:

____ Dr. Barimo ____ Dr. Christensen ____ Dr. Watzman

Email Address: _____

Employer: _____

Address: _____

_____

Employer Phone#: _____

Occupation: _____

Pharmacy: _____

Address: _____

Phone#: _____

Barimo Family Medicine
"We Care About Your Health"

Family History

FAMILY MEMBER	LIVING OR DECEASED	PRESENT AGE OR AGE AT DEATH	MAJOR ILLNESS AND/OR CAUSE OF DEATH
FATHER			
MOTHER			
SIBLINGS (NAME) CIRCLE SEX			
M F			
M F			
M F			
M F			
M F			
CHILDREN (NAME) CIRCLE SEX			
M F			
M F			
M F			
M F			
M F			

Spouse/Partner's name (if applicable): _____

Who referred you to us, or how did you hear about our practice? _____

Do you smoke cigarettes/use tobacco? _____ For how many years? _____ # Per day? _____

If applicable, when did you quit smoking? _____

How much alcohol do you drink on an average daily, weekly, or monthly basis? _____

List all surgeries you have had and approximate dates? _____

_____

List all medications you are allergies to or have had reactions to: _____

_____

List all medications you are currently taking with dosages: _____

_____

_____

What major medical problems have you had in your lifetime? (i.e. cancer, diabetes, high blood pressure, ect.)

_____

_____

_____

_____

Local Pharmacy (Name and Phone Number): _____

Mail-Order Pharmacy (Name and Phone Number): _____

Name _____ Signature _____ Date _____

MICHAEL J. BARIMO, D.O.
MARIE CHRISTENSEN, M.D.
BENNETT FELD, PA-C

PLEASE PRINT

CHILD INFORMATION SHEET

PLEASE PRESENT INSURANCE CARDS FOR COPYING

CHILD'S NAME: _____ AGE: _____ DATE OF BIRTH: _____

SCHOOL: _____ COUNTY: _____

KNOWN ALLERIGIES: _____

SOCIAL SECURITY #: _____

PARENT GUARDIAN INFORMATION

MOTHER'S NAME: _____ AGE: _____ DATE OF BIRTH: _____

FATHER'S NAME: _____ AGE: _____ DATE OF BIRTH _____

STREET ADDRESS: _____ CITY & STATE: _____ ZIP: _____

HOME PHONE: ( ) _____ DRIVER'S LIC.#: _____ STATE: _____

MOTHER'S PLACE OF EMPLOYMENT: _____

BUSINESS PHONE: ( ) _____ OCCUPATION: _____

FATHER'S PLACE OF EMPLOYMENT: _____

BUSINESS PHONE: ( ) _____ OCCUPATION: _____

MOTHER'S S.S.#: _____ FATHER'S S.S#: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ POLICY/GROUP #: _____

ADDRESS: _____

GROUP EMPLOYER NAME: _____ POLICY OWNER/ _____

SECONDARY INSURANCE: _____ POLICY/GROUP #: _____

ADDRESS: _____

GROUP EMPLOYER NAME: _____ POLICY OWNER/ _____

HOW DID YOU HEAR ABOUT US? _____

***PLEASE READ THE INFORMATION ON THE REVERSE AND SIGN WHERE INDICATED.**

NEXT OF KIN (NOT IN THE SAME HOUSEHOLD)

NAME: _____ RELATIONSHIP: _____

ADDRESS, CITY, STATE & ZIP: _____

_____ PHONE #: _____

PLEASE READ AND SIGN BELOW

1. I AUTHORIZE PAYMENT DIRECTLY TO MICHAEL J. BARIMO, D.O., P.A., BY MY INSURANCE COMPANY. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL DEDUCTIBLES AND CO-INSURANCE PAYMENTS.

2. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY MEDICAL CLAIMS.

3. ALL OFFICE VISITS MUST BE PAID FOR UPON RECEIPT OF SERVICE, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE WITH THE OFFICE MANAGER OR BOOKKEEPER.

4. THIS OFFICE ACCEPTS MEDICARE ASSIGNMENT, HOWEVER, THE PATIENT MUST SUBMIT ALL SECONDARY INSURANCE CLAIMS, UNLESS PATIENT HAS MEDIGAP COVERAGE.

5. ALL HMO'S ARE REQUIRED TO PAY APPROPRIATE CO-PAYMENT AT TIME OF SERVICE TO AVOID CANCELLATION OF INSURANCE.

6. WE WILL FILE, AS A COURTESY, GROUP INSURANCE CLAIMS FOR SERVICES RENDERED, HOWEVER, IF PAYMENT IS NOT RECEIVED WITHIN 30 DAYS THE BALANCE BECOMES THE PATIENT'S RESPONSIBILITY.

7. THERE WILL BE A $25.00 CHARGE FOR EACH CHECK THAT IS RETURNED BY YOUR FINANCIAL INSTITUTION.

8. THERE WILL BE A $25.00 CHARGE FOR ALL MISSED APPOINTMENTS WITHOUT 24 HOURS ADVANCED NOTICE OF CANCELLATION.

_____

SIGNATURE DATE

MICHAEL J. BARIMO, D.O.
MARIE CHRISTENSEN, M.D.
MAX S. WATZMAN, D.O.

I, _____ *authorize the following people to have*
(Print patient's name here)

access to my medical information including referrals, prescriptions, appointments, lab reqs, and reports. ie: (Family, friends, or no one)

Please print names:

_____

_____

_____

_____

_____

_____

_____

_____
Signature

_____
Date

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your heath information.

We may use and disclose your medical records only for each of the following purposes:
Treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.
Payment means such activities as obtaining reimbursement for service, confirming coverage, billing, or collecting activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by the written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions in writing on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests in writing to receive confidential communications of protected health information from us by alternative means.

The right to a copy of your protected health information at the cost of $1.00 per page.

The right to request in writing an amendment to your protected health information. We may or may not honor the request, but will be happy to include your statement in your file.