PLEASE COMPLETE ALL LINES. IF AN ITEM DOES NOT APPLY, PLEASE WRITE "N/A" OR "NONE."

BUCKLES FAMILY HEALTH CARE

PATIENT'S NAME: _____ DOB___/___/___ AGE____ SEX____

STREET_____CITY_____ST_____ZIP_____

HOME TEL #_____ SOC SEC #_____

CELL #_____EMAIL ADDRESS_____

PREFERRED METHOD OF COMMUNICATION ☐PHONE ☐E-MAIL ☐ MAIL

LANGUAGE PREFERENCE_____

ETHNICITY (OPTIONAL) ☐ ASIAN ☐ NATIVE HAWAIIAN ☐ OTHER PACIFIC ISLANDER ☐WHITE

☐BLACK/AFRICAN AMERICAN ☐AMERICAN INDIAN ☐HISPANIC/LATINO ☐OTHER

EMPLOYER _____WORK TEL#_____

EMPLOYER ADDRESS _____

SPOUSES NAME _____DOB___/___/___AGE_____

IF PATIENT IS A MINOR, PLEASE COMPLETE

MOTHER _____SOC SEC #_____DOB___/___/___

EMPLOYER _____WORK #_____

FATHER _____SOC SEC #_____DOB___/___/___

EMPLOYER _____WORK#_____

PATIENT LIVES WITH_____

EMERGENCY CONTACT INFORMATION

1. NAME_____RELATIONSHIP_____TEL #_____

2. NAME_____RELATIONSHIP_____TEL#_____

(SOMEONE THAT DOESN'T LIVE WITH YOU)

INSURANCE INFORMATION

PRIMARY INSURANCE NAME_____TEL #_____

ADDRESS_____

SUBSCRIBERS NAME_____DOB___/___/___SOC SEC #_____

EMPLOYER_____TEL #_____

CONTRACT #_____GROUP #_____EFF DATE___/___/___

RELATIONSHIP TO PATIENT_____

SECONDARY INSURANCE NAME_____TEL #_____

ADDRESS_____

SUBSCRIBERS NAME_____DOB___/___/___SOC SEC #_____

EMPLOYER_____TEL #_____

CONTRACT #_____GROUP #_____EFF DATE___/___/___

RELATIONSHIP TO PATIENT_____

IT IS UNDERSTOOD AND AGREED THAT ALL PROFESSIONAL SERVICES MUST BE PAID AT THE TIME THE SERVICE IS RENDERED UNLESS PRIOR ARRANGEMENTS ARE MADE WITH THE OFFICE. EVEN THOUGH AN INSURANCE CLAIM MAY BE FILED, YOU ARE RESPONSIBLE FOR THE TOTAL AMOUNT OF YOUR ACCOUNT AND YOU WILL RECEIVE A STATEMENT IF YOUR ACCOUNT HAS A BALANCE DUE. THIS OFFICE CANNOT ACCEPT RESPONSIBILITY FOR COLLECTING YOUR INSURANCE CLAIM OR NEGOTIATING A SETTLEMENT ON A DISPUTED CLAIM. I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS A CLAIM AND PAYMENT OF MEDICAL BENEFITS TO THE TREATING PHYSCIAN.

X_____ X_____

PATIENTS SIGNATURE (PARENT OR GUARDIAN IF PATIENT IS A MINOR) DATE

Buckles Family Health Care

Health Questionnaire

Patient:_____ Date of Birth: _____

Allergies: _____ Height: _____ Weight: _____

Have you ever been diagnosed with any of the following conditions (Please circle):

AIDS HIV ARCS
Anemia
Asthma
Blood Transfusion
Bronchitis
Cancer
Chest Pain
Congestive Heart Failure
COPD
Depression
Diabetes
Emphysema
Fibromyalgia
Glaucoma
Heart Attack
Heartburn
Heart Murmur
Hepatitis
High Blood Pressure
High Cholesterol
Kidney Disease
Macular Degeneration
Migraines
Osteoporosis
Pregnancy
Rheumatic fever
Rheumatoid Arthritis
Seasonal Allergies
Seizures
Shortness of Breath
Stroke
Swollen Ankles
Thyroid Disease
Tuberculosis
Venereal Disease

Please list all surgeries you have had:_____

_____

Do you use tobacco products: Y/N
If yes, how much?_____
How many years?_____
Are you interested in quitting? Y/N

Do you currently use recreational drugs? Y/N
If yes, what type and how much?_____
_____

Do you drink Alcohol? Y/N
If yes what type and how much? _____

Medications (prescription, over-the-counter, and herbal): _____

_____

_____

_____ _____
Signature (Parent or Guardian if patient is a minor) Date
I, the above signed, attest the answers are true to the best of my knowledge.

BUCKLES FAMILY HEALTH CARE
220 S WOODBINE
ST JOSEPH, MO 64506

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Buckles Family Health Care** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Buckles Family Health Care**. I understand that diagnosis or treatment of my by **Dr Randy Buckles** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Buckles Family Health Care** is not required to agree to the restrictions that I may request. However, If **Buckles Family Health Care** agrees to a restriction that I request, the restriction is binding on **Buckles Family Health Care** and **Dr. Randy Buckles**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Dr Randy Buckles,** or **Buckles Family Health Care** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right review **Buckles Family Health Care's** Notice of Privacy Practices prior to signing this document. The **Buckles Family Health Care's** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Buckles Family Health Care.** The Notice of Privacy Practices for **Buckles Family Health Care** is also provide at 220 S Woodbine, St. Joseph, MO 64506. This Notice of Privacy Practices also describes my rights and the **Buckles Family Health Care's** duties with respect to my protected health information.

Buckles Family Health Care reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the **Buckles Family Health Care's** website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

X_____
Signature of Patient or Personal Representative

X_____
Print Name of Patient or Personal Representative

X_____
Date

_____
Description of Personal Representative's Authority

FAMILY HEALTH CARE, L.L.C.

PAYMENT POLICIES

Payment is due at the time services are rendered unless arrangements have been approved in advance. By law, we are required to collect your co-payment at the time of service. Payment will be collected at the front desk prior to seeing the doctor. Failure to pay will require us to reschedule your appointment.

FINANCIAL POLICY STATEMENT

It is our policy to bill your insurance carrier as a courtesy to you. However, you are responsible for the entire bill when the services are rendered. We require that arrangement for payment of your estimated share be made today. If your insurance carrier 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 of your account, we will promptly refund the credit.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to Family Health Care, L.L.C.

I understand and agree that if I fail to make any payment for which I am responsible in timely manner after such default and upon referral to a collection agency or attorney by Family Health Care, L.L.C., I will be responsible for all costs of the attorney by Family Health Care, L.L.C. I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

WORKERS COMPENSATION, LITIGATED OR THIRD PARTY CLAIMS

Family Health Care L.L.C. requires you to pay for each visit at the time of your appointment. This office cannot accept responsibility for collecting your workers' compensation, litigated or third party claims payments. If Family Health Care receives payment from your workers' compensation, litigated or third party insurance we will promptly refund any credit.

MEDICARE

We will submit your charges directly to Medicare and file any secondary claims. However, any deductibles and/or co-insurance balances that are not covered will be your responsibility.

BENEFIT ASSIGNMENT/ RELEASE OF INFORMATION

I, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to Family Healthcare L.L.C. I, hereby authorize said assignee to release all information necessary including medical records to secure payment. A photocopy of this assignment is to be considered as valid as the original.

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Family Health Care L.L.C. to furnish medical care and treatment considered necessary and proper in diagnosing or treating the patient's physical condition.

NON-COVERED SERVICES

I understand that my insurance may or may not cover all services rendered. I understand and accept full responsibility for payment of any charges not covered by my insurance.

I have read and understand the above information.

X_____ _____

Patient's Signature **Date**

(Signed by parent or guardian if patient is a minor or unable to sign)

BUCKLES FAMILY HEALTH CARE

220 S WOODBINE
ST JOSEPH, MO 64506

Authorization Form – A
Authorization for Use or Disclosure of Information for Purposes Requested by Physician's Office.

I,_____, hereby authorize **Buckles Family Health Care** to
Print Name of Patient

__use the following protected health information, and/or

__disclose the following protected health information to_____
Print Name & Relationship to Patient
(Spouse, Family Member, Guardian, etc.)

[Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptor such as dated of service, type of service proved, level of detail to be released, origin of information, etc.]

This protected health information is being used or disclosed for the following purposes:
[List specific purposes here.]

This authorization shall be in force and effect until _____ at which time is authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **Buckles Family Health care** at **220 S Woodbine, St Joseph, Missouri 64506.** I understand that a revocation is not effective to the extend that **Buckles Family Health Care** has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Buckles Family Health Care will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested used or disclosure.

I understand that I have the right to:

____ Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides Greater access rights.)
____ Refuse to sign this authorization.

[The use or disclosure requested under this authorization will result in direct or indirect remuneration to the **Buckles Family Health Care** from a third party.] [If applicable.]

X_____
Signature of patient or Parent or Guardian

X_____
Print Name of Patient

X_____
Date

_____
Your Relationship to Patient