BARBER & RICHARDSON, PC.
William A. Barber, M.D.
Heather Richardson, M.D.
Amanda J. Morehouse, M.D.
275 Collier Road, Suite 470 Atlanta, GA 30309
Tel: 404-351-1002 Fax: 404-350-8290

PATIENT INFORMATION SHEET

PHYSICIAN YOU ARE SEEING TODAY____

DATE OF OFFICE VISIT_______________ REFERRING PHYSICIAN____________________________

_________________________________ _______________________________ _________
LAST NAME FIRST NAME MI

______________________________ ___________________ ____________________________
PATIENT'S SOCIAL SECURITY # DATE OF BIRTH EMAIL ADDRESS

____
STREET ADDRESS

____
CITY, STATE, ZIP

_________________________ __________________________ _____________________
HOME PHONE BUSINESS PHONE MOBILE/CELL

MARITAL STATUS S___ M____W_____ SPOUSE NAME_____________________________

_____________________________ ____
PATIENT'S EMPLOYER EMPLOYER ADDRESS

_____________________________ ____
INSURANCE COMPANY INSURANCE ID#

We scan all insurance cards so the insurance ID is not required

_____________________________ _______________________ _____________________
EMERGENCY CONTACT RELATIONSHIP PHONE NUMBER

____ ____________________________
RESPONSIBLE PARTY IF OTHER THAN PATIENT RELATIONSHIP

____________________________ ________________________ _____________________
HOME PHONE BUSINESS PHONE MOBILE/CELL

___________________________________ ____
RESPONSIBLE PARTY EMPLOYER EMPLOYER ADDRESS

I hereby authorize Barber & Richardson, PC. to bill my insurance carrier for any services rendered by him or any agents of his practice. With this authorization I assign any and all benefits payable for services rendered by Barber Surgical Services, PC. or agents of his practice to Barber & Richardson, PC. I understand that I am responsible for any amount not covered by my insurance plan.

I hereby authorize the release of any and all medical information necessary to the treatment I receive while under the care of Barber & Richardson, PC. I authorize the release of medical information including x-rays, pathology, laboratory and operative reports to Barber & Richardson, PC. A copy of this authorization shall be valid as the original.

____ _________________________
PATIENT OR GUARDIAN SIGNATURE DATE

BARBER & RICHARDSON, PC.
William A. Barber, M.D.
Heather Richardson, M.D.
Amanda J. Morehouse, M.D.

OUR FINANCIAL POLICY

Our doctors and staff are very concerned about the cost of your healthcare and want to address some current issues related to the cost of medical services in this office. Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity of the care rendered and the skill and expertise required for your care. Our fees are comparable with fees of other surgeons in the metro area.

PAYMENT POLICY

We take Medicare assignment. We will submit claims for up to 2 policies on your behalf.
If you are a member of an HMO or PPO in which we participate, your deductible, coinsurance and/or co-payment is required at the time of service. You are responsible to see that we have a current referral on file, if your insurance company requires one. If there is no current referral on file with our office you have the following options: **#1** You may return to your Primary Care Physician to obtain a referral prior to being treated or **#2** You may choose to pay in full for the services and waive your right to an insurance claim for said services. Our agreement is with you and not your insurance company. While we have participation agreements with most carriers, you have chosen your insurance coverage, and you are responsible to know its limitations and reimbursement levels. The patient will be billed for any service provided in the office that is not a covered benefit of their insurance plan.
Again, it is the patient's responsibility to provide the proper referral at the time of service and the most current insurance information available. In the event that we are provided with incorrect insurance information, the patient will be responsible for the balance. If we do NOT contract or participate with your insurance carrier we require payment at the time of service for office visits and procedures. To assist you in filing your own insurance claim, we will provide you with an itemized statement.

Fees for non-physician services:

Returned check fees are $25.00. A billing fee of $2.50 will be added to all account balances carried from one month to the next. The fee for completion of forms including disability forms, cancer policy claim forms, letters for cancellations of airline reservations, excuses from services such as jury duty, etc. is $25.00. Additional form completions are $15.00. We follow the State of Georgia’s fee schedule for copies of medical records. A copy of those fees is available on request.
If you have any questions about our financial policy or your insurance reimbursement, please feel free to discuss them with our business office staff. I have read and understand my financial responsibilities under this policy.

Patient signature____Date___________________

BARBER & RICHARDSON, PC.
William A. Barber, M.D.
Heather Richardson, M.D.
Amanda J. Morehouse, M.D.
275 Collier Road N.W., Suite 470
Atlanta, Georgia 30309

Receipt of Notice of Privacy Practices
Written Acknowledgement Form.

I, ________________________, have reviewed a copy of Barber & Richardson, PC,
Patient Name

P.C.'s Notice of Privacy Practices.

____________________________________ ________________
Signature of Patient Date

I, ________________________ , decline to review and or sign a copy of Barber and Richardson,
Patient Name

P.C.'s Notice of Privacy Practices.

________________________ __________________
Signature of Patient Date

Please choose one option

BARBER & RICHARDSON, PC.
WILLIAM A. BARBER, M.D., F.A.C.S.
HEATHER RICHARDSON, M.D., F.A.C.S.
AMANDA J. MOREHOUSE, M.D.

NEW BREAST PATIENT

Name____Today's Date____________Age______

Occupation______________________

Reason for visit____________________________________Date of last period ____________

Age at time of first period_____________ Age at delivery of 1st child_____________

Height ______________ Weight ____________

If you have or have had any of the following please check and describe:

	Yes	No	Comments
Nipple discharge	( )	( )	________________________________
Pain in breasts	( )	( )	________________________________
Estrogen/Birth Control Pills	( )	( )	________________________________
Fertility Medications	( )	( )	________________________________
Pregnancies	( )	( )	________________________________
Did you breast feed?	( )	( )	________________________________
Family History of Breast Cancer	( )	( )	________________________________
Family History of Other Cancers	( )	( )	________________________________
			WHEN WHERE RESULTS
Recent Mammogram	( )	( )	________________________________
Breast ultrasound	( )	( )	________________________________
Breast Biopsy or Surgery	( )	( )	________________________________

Caffeine drinks daily_____ Alcohol: Daily_____ Weekly_____ Rarely_____ None_____

BARBER & RICHARDSON, PC.
WILLIAM BARBER, M.D.
HEATHER RICHARDSON, M.D.
AMANDA J. MOREHOUSE, M.D.

MEDICAL HISTORY

Date:_______________

Name:_____________________________ Birth date:__________________

Reason for Visit:____

If you have any of the following medical problems with or without surgery please check and describe below.

____Lung trouble/Emphysema	____Anemia	Allergies
____Asthma	____Bleeding Disorder	____Penicillin
____High Blood Pressure	____Blood Clots	____Novocain
____Heart Attack/Angina	____Diabetes	____Iodine dye
____Liver trouble/Cirrhosis	____Arthritis	____Sulfa
____Stomach Ulcers	____Gout	____Latex (rubber)
____Kidney trouble	____Cancer	____Tape
____Hernia	____Epilepsy	Others____________
____Others – explain below	____Thyroid trouble	

Do you smoke? _____No _______Yes How much_____________ How many years______

If you selected "No", have you ever smoked?__________ If yes, how long ago?____________________

Medical Problems	Previous Surgery
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Medications dosage how often	Other Comments
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

BARBER AND RICHARDSON, PC
NOTICE OF PRIVACY PRACTICES

UPDATED DECEMBER, 2010

As required by the privacy regulations created as a result of the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about has (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.
Please review this notice carefully.

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI.

The terms of this notice apply to all records containing IHII that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment of this notice will be effective for all your records that our practice has created or maintained in the past and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT:

April Binion, HIPAA Office
275 Collier Rd, NW   Suite 470
Atlanta, GA 30309
404-351-1002

WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IHII) IN THE FOLLOWING WAYS:

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have a laboratory test, and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice, including but not limited to our doctors and nurses, may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
2. **Payment**. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits, and we may provide your insurer with details regarding your treatment to determine if your insurer will cover or pay for your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.
3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost management and business planning activities for our practice.
4. **Appointment Reminders**. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.
5. **Treatment Options**. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required by Law**. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

USE AND DISCLSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

1. **Public Health Risks.** Our practice may disclose your IIHI to public health aurhorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury of disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agencies and authorities regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities**. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and similar proceedings**. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in a dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:
   - regarding a crime victim in certain situations, if we are unable to obtain the person's agreement.
   - concerning a death we believe has resulted from criminal conduct.
   - regarding criminal conduct at our offices.
   - in response to a warrant, summons, court order, subpoena or similar legal process.
   - to identify/locate a suspect, material witness, fugitive or missing person
   - in an emergency, to report a crime, including the location or victim(s) of the crime, or the description, identity or location of the perpetrator.
5. **Deceased Patients.** Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
6. **Organ and Tissue Donation**. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
7. **Research**. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: Our use or disclosure was approved by and Institutional Review Board or a Privacy Board; We obtain the oral or written agreement of a researcher that the information being sought is necessary for the research study, the use or disclosure of your IIHI is being used only for the research and the researcher will not removed any of your IIHI from our practice; or the IIHI sought by the researcher only relates to decedents, and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.
8. **Serious Threats to Health and Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. **Military.** Our practice may disclose your IIHI if you are a member of the US or foreign military forces (including veterans) and if required by the appropriate authorities.
10. **National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
11. **Inmates**. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: For the institution to provide health care services to you; For the safety and security of the institution; And/or to protect your health and safety or the health and safety of other individuals.
12. **Worker's Compensation.** Our practice may release your IIHI for worker's compensations and similar programs.

YOUR RIGHTS REGARDING YOUR IIHI

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain locations. For instance, you may ask that we contact you at home rather than work. In order to request a type of confidential communication, you must make a written request to our office staff, specifying the requested method of contact or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agreet to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to our office staff. Your request must describe in a clear and concise fashion:

- the information you wish restricted
- whether you are requesting to limit our practice's use, disclosure or both
- to whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about your, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our office staff in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct the review.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our office staff. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request and the reason supporting your request in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: Accurate and complete; not part of the IIHI kept by or for the practice; not part of the IIHI which you would be permitted to inspect and copy; or not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures.** All of our patients have the right to request an 'accounting of disclosures'. An 'accounting of disclosures' is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example: the doctor sharing information with the nurse, or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to our office staff. All requests for an accounting of disclosures must state a time period, which may not be longer that six years from the date of disclosures and may not include dates before April 13, 2003. The first list you request within a 12 month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice**. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact our office staff.

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Stephanie Jeffords at 404-351-1002. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After your revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

If you have any questions regarding this notice or our health information privacy policies, please contact April Binion, Office Manager at 404-351-1002.