Tricia Birdwell MD

1521 N. Schnoor, Suite 103, Madera CA 93637

DATE:_____

PATIENT NAME:_____DATE OF BIRTH:_____

MAILING ADDRESS:_____APT #_____

CITY:_____ ZIP:_____ BEST PHONE NUMBER:_____

SOCIAL SECURITY #:_____-_____-_____ ALTERNATE PHONE NUMBER:_____

EMAIL ADDRESS:_____

EMERGENCY CONTACT:_____PHONE NUMBER:_____

ARE YOU THE PRIMARY INSURANCE POLICYHOLDER? IF NOT:_____

DATE OF BIRTH OF PRIMARY POLICYHOLDER:_____RELATIONSHIP TO PATIENT:_____

PRIMARY INSURANCE POLICY NUMBER (MEMBER ID)_____

SECONDARY INS POLICY NUMBER (IF APPLICABLE)_____

ARE THERE ANY OTHER PARTIES YOU WOULD LIKE TO AUTHORIZE TO VIEW OR RECEIVE MEDICAL OR BILLING INFORMATION? IF SO, PLEASE LIST BELOW:

_____ _____

_____ _____

Thank you for choosing our office for your medical needs. As a provider of medical services to patients subscribing to Medicare and many other insurance programs, our office or our designated 3rd party billing service may need your signature on file to submit insurance claims on your behalf and direct your insurance to pay directly to **TRICIA BIRDWELL MD INC** for medical services rendered. As policy and procedure in our office, your insurance co-pay and/or un-fulfilled deductible amount for relevant services rendered, are due at the time of service.

You should ALWAYS call your insurance plan to make certain that your specific plan covers visits to Dr. Birdwell's office. We see many insurance plans, and we have a general idea of which plans are accepted or not, but there are hundreds of specific individual plans, with restrictions and network details that we simply cannot know. If you do not call your insurance company to confirm that your plan is considered, "in-network" at our office, you will be responsible for any charges not covered as a result.

PATIENT OR RESPONSIBLE PARTY SIGNATURE:_____ RELATIONSHIP TO PATIENT:_____DATE:_____

HIPAA Privacy Policy and Practices Form

June 25, 2018

This form is an outline of how our office will obtain and disclose your personal, protected health information. You have many rights with regard to how your medical information is handled and disclosed, and those practices are outlined below.

In the course of your treatment at this office, by Dr. Tricia Birdwell or her staff, it may be necessary to obtain medical records from other providers who currently treat you, or have treated you in the past. We will follow HIPAA guidelines to ensure your medical information is treated by our staff with the privacy protection the law requires, and will not disclose that medical information unless required to do so under the law, or under exceptional circumstances. Our staff is trained to protect your information and we do not take that responsibility lightly.

Billing information (insurance information, payment information and financial information) will necessarily require disclosure to our 3rd party medical billing service in order to try to obtain payment from an insurance plan or the responsible party for services by Dr. Birdwell, her office or staff. Billing information is discussed separately in another form in this packet.

Among your rights under the law, you may limit the type of information this office may disclose to other medical offices, specialists or facilities, limit the period during which the office may disclose your records, request to view your medical records, request a copy of your medical records and ask that errors be reviewed and amended by the provider. When you sign this form, you are acknowledging that a copy of our Privacy Policy was made available to you. This form will be updated periodically and the latest version of it will be made available at the front desk upon request.

Below are a few of the options you have to determine how we disclose your medical information to other offices, as indicated below by a mark in the checkbox next to your selection(s):

☐ -I understand that during the course of my treatment by Dr. Birdwell, her office or staff, my medical records may be requested from previous medical providers. I understand that Dr. Birdwell's office may need to disclose my medical information to specialists or other medical providers in the normal course of my care. I understand that Dr. Birdwell's office may receive record requests from other medical providers or specialists or 3rd parties and these requests are to be fulfilled, without restriction, with my permission. I understand that I can revoke my permission to disclose my medical information at any time, in writing. I understand that disclosures of my medical information prior to my written revocation will not be effected, as those disclosures were made during a period of my consent.

OR

☐ -I understand that **I can limit the time frame** during which Dr. Birdwell, her office or staff can disclose my medical information. I understand that if I enter a date below, Dr. Birdwell, her office, or staff may not disclose my medical information beyond that date unless legally required to do so, or in the case of an emergency where I may not be physically able to provide consent. I wish to allow Dr. Birdwell, her office and staff, to release my medical information through the following date, but not beyond:_____ (leaving this blank allows Dr. Birdwell, her office or staff, to release my medical information indefinitely, unless I revoke my permission in writing).

☐ -I understand that **I can limit what type of information** Dr. Birdwell, her office or staff may disclose from my medical records to other specialists, medical providers or facilities, except as required by law. An example of a disclosure against your consent would be, if our office were legally compelled to disclose your information by law, or in an emergency situation where you may not be physically capable of providing consent. Under normal circumstances, I do NOT want Dr. Birdwell, her office or staff to disclose the following specific medical information as it pertains to my medical records, as indicated below by my mark in the checkbox:

□ Mental health records

□ Communicable diseases (including HIV and AIDS)

□ Alcohol/drug abuse treatment

□ Other (please specify):_____

I understand that the Privacy Policy and procedures outlined in this form will remain in effect indefinitely unless I have specified an effective period as described above, or this office has received written notice from me to revoke my authorization or change the type of medical information I wish to not be disclosed.

I understand that if I feel my privacy rights as outlined in this form have been violated, I can contact the Office and Privacy Manager directly @ 559.395.4009, or contact HHS at their website, www.HHS.gov to file a complaint.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization form.

SIGNATURE OF PATIENT OR REPRESENTATIVE:_____

NAME:_____**DATE:**_____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

PATIENT NAME:_____

DATE OF BIRTH:_____ SS#:_____

I hereby authorize the release of all information in my medical records from:

NAME OF RELEASING PROVIDER:_____

TO BE RELEASED TO:

TRICIA BIRDWELL MD

1521 N. SCHNOOR, SUITE 103

MADERA CA 93637

PHONE: 559.395.4009

FAX: 559.664.5069

SPECIFIC INFORMATION TO BE DISCLOSED:_____

_____

I understand that this authorization will expire on the following date (if specified):_____

I authorize the release of the above specified information from my medical records. I understand that the requestor may not further use or disclose the medical information without my written consent if after the date I specified. I understand that I may be charged for copying costs, or the costs associated with sending and receiving this information. This authorization may be revoked at any time. My revocation will be effective upon written receipt, but will have no impact on uses or disclosures while my authorization was valid. This authorization is valid for 1 year from the date of signing, except for financial records, disclosures or transactions, wherein the authorization is valid indefinitely. I may inspect and obtain a copy, at my expense, of the health information that I am authorizing for use or disclosure. A photocopy of this release is as effective as the original signed document.

SIGNATURE OF PATIENT OR REPRESENTATIVE:_____DATE:_____

AUTHORIZATION TO BE REVOKED ON (If wanted, otherwise leave blank):_____

ADDITIONAL BILLING INFORMATION

The office of Tricia Birdwell MD Inc. may use a 3rd party billing service. This service is responsible for billing notifications, delinquency notices, payments (except in-office transactions such as co-pay collection) and when necessary, referral to an outside collection service.

This is the most important thing to know about your insurance when dealing with our office: we don't know if your plan will pay for visits to Dr. Birdwell's office. There are hundreds of different plans available, and we don't know the specific limitations of many of them. We know which insurance companies are contracted with our office (Blue Cross, Blue Shield, United Healthcare, etc…), but there are so many possible plans available through each one of those insurance companies, that we simply cannot know which particular plans are going to cover your visits here and which will not. **There is only one way to be sure: Call your insurance prior to your first visit.** The phone number is generally on the back of the card and may be shown as the, "Member Services" phone number. Tell them you are interested in seeing Dr. Birdwell and ask if your particular plan will cover the services provided. If your insurance company does not cover charges incurred as a result of a visit here, you will be responsible for them and you will be billed. It is the patient's responsibility to confirm with their insurance if visits to our office will be covered. Taking 5 minutes to call your insurance and ask before your visit can save time and money.

If outdated or incorrect information is provided to our office, your insurance company will not pay for services received, in part or entirely. Any portion of your bill not covered by your insurance company is solely the patient's responsibility (or designated 'responsible party').

I understand that Tricia Birdwell MD Inc., the staff or office of Tricia Birdwell MD Inc. or a 3rd party billing service will attempt to submit claims on my behalf to my insurance carrier ***as a courtesy***. Tricia Birdwell MD Inc., the staff or office of Tricia Birdwell MD Inc. or a 3rd party billing service designated by Tricia Birdwell MD Inc. will make reasonable efforts to obtain payment from the insurance company I designate, based upon the information I provide at the time of service, but I understand that payment, coverage details and policy information are my responsibility, not the healthcare provider. The efforts made by **Tricia Birdwell MD Inc**, the staff or office of **Tricia Birdwell MD Inc** or a 3rd party service to collect insurance payments for services rendered by **Tricia Birdwell MD Inc** are done so as a courtesy to the patient. There is no guarantee of payment by the insurance company. If the services rendered by Dr. Birdwell or staff are not covered by my insurance, I (or my designated 'Responsible Party') will be responsible for the balance due.

My signature below indicates I (or my 'responsible party') have been informed of my financial responsibilities associated with medical care provided by **Tricia Birdwell MD Inc**. and understand the information provided.

SIGNATURE:_____ **DATE:**_____ **PRINT NAME:**_____

Additional Charges and Fees

FILE COPY SERVICE OR RECORD TRANSFER SERVICE: **$15, $25 plus any mailing fees**

The office or staff of Tricia Birdwell MD Inc. will charge a nominal fee for copying, mailing, faxing or electronically transmitting medical records or forms on behalf of the patient and at the direction thereof (or designated 'responsible party'). **We charge $15 for document copy services** up to 25 pages, and **$25 for amounts in excess of 25 pages**. We **also charge a fee to mail** (USPS, Fed-Ex or UPS services) copied documents for the patient. This fee is in addition to the copy service and is typically, but not always, the mailing fee charged by the service used.

FORM FILING: **$20 form filing fee**

From time to time patients may need to have forms signed by the provider (Tricia Birdwell MD). Some, but not all forms are very time consuming. The typical school release/work release are not subject to charges. This charge is for the lengthy, multi-page claim forms, typically. Some examples of this type of form are, but not limited to: Applications for benefits, Disability forms, Supplemental insurance paperwork and claim forms. **Prior to giving these forms to Dr. Birdwell for review and completion/signature, they should be filled out as completely and accurately as possible**. The portions that then need to be filled out by Dr. Birdwell will be completed in a timely fashion. They can then be picked up at our office and mailed by the patient (or 'responsible party' requesting the form) or we can mail them on your behalf. If these forms require special Fed-Ex, UPS or USPS mailing, they should be picked up at our office and mailed by the patient. If they can be faxed in, we will be happy to do so, up to 15 pages for no additional charge.

By signing below, I acknowledge and understand the additional office fees charged by the office of Tricia Birdwell MD Inc. and when such services are requested, I agree to pay the above listed charges at the time of the requested service.

SIGNATURE:_____ **DATE:**_____ **PRINT NAME:**_____

MISSED APPOINTMENT POLICY LATE POLICY

We ask that you give our office the courtesy of 24 HOUR NOTICE whenever you are not able to make an appointment. By not calling us in advance of your appointment to cancel, other patients are denied the chance to come in when they're sick...because Dr. Birdwell is waiting on you to show up.

There is only 1 doctor here. She has to be as efficient as possible to care for sick patients. Scheduling is critical to her being accessible. We don't charge a fee like other doctors' offices, but we will ask you to find another doctor if you fail to provide 24 hour notice…

IF YOU MISS 2 SCHEDULED APPOINTMENTS IN ANY 6 MONTH PERIOD, WITHOUT PROVIDING 24 HOUR NOTICE, YOU WILL NO LONGER BE ABLE TO SCHEDULE APPOINTMENTS WITH DR. BIRDWELL.

In a similar fashion, we ask that if you're running late for your appointment, you notify our office. We will do our best to accommodate you, but may need to reschedule your visit if it adversely impacts patients scheduled after you.

By signing below, I agree to the terms for missed appointments and late visits without prior notice. I understand that missing 2 appointments without calling 24 hours in advance, will likely result in…looking for a new doctor.

SIGNATURE:_____ DATE:_____ PRINT NAME:_____

Electronic Reminders and Contact Information

We value your privacy. **By providing our office with your e-mail address, you will be able to access your health information via our on-line portal**. You can view appointments, review your medical information, and pay your bill if you'd like. To access these functions, **we'll need your e-mail address**:

EMAIL:_____

Your e-mail will be used only by our office or our designated medical software and billing company to contact you. You can opt out of the e-mail notifications and close your access to the portal on-line or by calling our office should you choose to do so.

We are now offering **appointment reminders** by text message, e-mail, or by an automated phone call 2 days prior to your appointment. You can select the method of contact you prefer below. Please check the box by the preferred method.

- ☐ **HOME PHONE # FOR REMINDER CALL**:_____
- ☐ **CELL PHONE # FOR REMINDER TEXT/CALL**:_____
- ☐ **E-MAIL ADDRESS FOR REMINDER MSG**:_____
- ☐ **DO NOT CONTACT ME WITH APPOINTMENT REMINDERS BY ANY METHOD**

You are entitled to a copy of this packet. If you would like a copy, please notify the front desk and a copy will be provided to you at no charge.

SIGNATURE:_____**DATE:**_____

Medi-Cal Policy

Our office **DOES NOT ACCEPT** Medi-Cal (Medicaid). We **DO NOT** accept Cal-Viva, or any Medi-Cal specific insurance plans.

We **DO** accept Medicare (red, white and blue card).

If you have Medi-Cal, Cal-Viva, or another Medi-Cal specific plan, you can still see Dr. Birdwell or another provider in our office, but you will be responsible for paying the bill out of pocket. Our office 'Self Pay' rates (cash pay) are $100 for the first visit (New Patient), and $65 for each subsequent visit. These prices are for typical visits and do not include procedures such as wound care (sutures/stitches), injections, or medications, if they are needed. The price for those services will be in addition to the regular office visit prices, and will be discussed with you, and due, at the time of service.

We have many patients who have both Medicare AND Medi-Cal insurance plans. If you have both of these plans and wish to see a provider in our office, you will be responsible for the portion of the bill ordinarily covered by your Medi-Cal insurance. That typically means an annual bill from our office for your unmet deductible, as well as 20% of each visit billed during the year. A typical bill for a patient with Medicare and Medi-Cal that sees a provider in our office 4-5 times in a calendar year, is roughly $300-400 for that year ($200 deductible plus 20% of each visit). This is not a guarantee that your cost will fall within this example as each plan and visit type can vary greatly, however this is what we typically see billed to patients with Medi-Cal as a secondary insurance.

By signing below, you acknowledge that our office does NOT accept Medi-Cal, Cal-Viva, or other Medi-Cal associated insurance plans. You also understand that if you choose to visit our office as a patient and have one of these plans, **YOU WILL BE FINANCIALLY RESPONSIBLE** for the portion of your bill ordinarily covered by Medi-Cal, Cal-Viva, or other Medi-Cal associated insurance plan(s).

PRINT NAME: _____ **DATE:** _____

SIGNATURE: _____

Family Medical History

Patient:_____Date_____

Has anyone in your family had any of the following conditions? If so, please indicate relationship to you.

Medical Condition	Relationship	If deceased, age of death	Medical Condition Cause of death (Y/N)
Cancer, breast			
Cancer, colon			
Cancer, prostate			
Cancer, melanoma			
Cancer, lung			
Cancer, blood			
Cancer, other			
Diabetes			
High Blood Pressure			
High Cholesterol			
Heart Failure			
Heart Attack			
Stroke			
Aneurysm			
Dementia			
Substance Abuse/Addiction			
Depression			
Anxiety			
Schizophrenia			
Asthma			
COPD			
Anemia			
Blood Clots			
Varicose Veins			
Osteoporosis			
Kidney stones			
Autoimmune disorder			
Thyroid disorder			
Seizures			
Other			

Personal Medical History

Have you had any of the following medical conditions? (check if Yes)

◊Diabetes	◊Asthma	◊Anemia
◊High Blood Pressure	◊COPD	◊Blood Clots
◊High Cholesterol	◊GERD	◊Kidney Disease
◊Heart Murmur	◊Irritable Bowel Syndrome	◊Liver Disease
◊Heart Failure	◊Major Depression	◊Kidney Stones
◊Heart Attack	◊Anxiety Disorder	◊Seizures
◊Stroke	◊Fibromyalgia	◊Spine problems
◊Aneurysm ◊Cancer:	◊Eye Problems	◊Osteoporosis ◊Other:
	◊Bladder Incontinence	
	◊Prostate Problems	

Personal Surgical History- have you had any of the following surgeries (check if Yes, write age)

◊Tonsillectomy	◊Prostate Surgery	◊Spine Surgery
◊Appendectomy	◊Bladder Surgery	◊Knee Surgery
◊Gall Bladder Removed	◊Hernia Repair	◊Hip Surgery
◊Hysterectomy	◊Bariatric Surgery	◊Shoulder Surgery
◊Ovaries Removed	◊Colon Surgery	◊Thyroid Surgery
◊Ceserean	◊Heart Surgery	◊Other

Social History. Please <u>CIRCLE</u> the appropriate

Married - Single - divorced (circle one)

Tobacco use: Smoker - Chew - none: Since age:_____ Quantity:_____

Alcohol use (leave blank of none): Drinks per week:_____ Sober since:_____

Drug use (leave blank if none):_____ Since age:_____ Sober since:_____

Medications/Supplements- please list or provide list/bottles

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

NAME:_____ DOB:_____