

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.
275 Collier Road NW, 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 Surgical Services, 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 Surgical Services, 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 Surgical Services, PC. I authorize the release of medical information including x-rays, pathology, laboratory and operative reports to Barber Surgical Services, PC. A copy of this authorization shall be valid as the original.

PATIENT OR GUARDIAN SIGNATURE DATE

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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 _____

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Atlanta, Georgia 30309

Receipt of Notice of Privacy Practices
Written Acknowledgement Form.

I, _____, have reviewed a copy of Barber Surgical Services,
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.
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HEATHER RICHARDSON, M.D., F.A.C.S.
AMANDA J. MOREHOUSE, M.D.

NEW BREAST PATIENT

Name _____ Today's Date _____ Age _____

Occupation _____ Employer _____

Reason for visit _____

Height _____ Weight _____ Bra size _____

Age first period _____ Age at delivery of 1st child _____ Age of menopause _____

List of current physicians with first and last name (i.e. primary care, gyn, cardiologist):

Number of drinks:

Caffeine: Daily _____ Alcohol: Daily _____ Weekly _____ Rarely _____ None _____

Do you or have you ever smoked tobacco or used illicit substances? _____ No _____ Yes

If you answered "Yes", please elaborate. _____

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

	Y or N	Comments
Nipple discharge	_____	_____
Estrogen/ HRT	_____	_____
Pregnancies	_____	_____
Family history of breast cancer	_____	_____
Family history of other cancers	_____	_____
Have you ever had a breast biopsy, or surgery?	_____	If so, when, where, and results? _____ _____

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MEDICAL HISTORY

Date: _____

Name: _____ Birthdate: _____

If you have ANY of the following medical issues please check.

- | | | |
|--|--|--|
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Depression | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Weight loss/gain |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Bleeding disorder |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Migraines | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Angina | <input type="checkbox"/> PCOS | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Irregular Heart Rate/Rhythm | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Stomach Ulcers/Reflux | <input type="checkbox"/> Other |

If you answered yes to any above, please explain: _____

Medications Dosage Frequency

Are you allergic to any medications? If you answered yes, please list medication and describe type of reaction:
