

The Barfield Clinic

2910B South Church Street, Murfreesboro, TN 37127

Phone: (615) 895-3600 Fax: (615) 895-0024

PATIENT INFORMATION

NAME			GENDER	SOCIAL SECURITY NUMBER	
STREET				APARTMENT NUMBER	
CITY			STATE		ZIP
DATE OF BIRTH	MARITAL STATUS	HOME PHONE		EMAIL	
EMPLOYER		EMPLOYER ADDRESS			
WORK PHONE	EXT.	OCCUPATION		CELL PHONE	
HOW DID YOU LEARN ABOUT OUR PRACTICE					
YELLOW PAGES INTERNET MAIL ADVERTISEMENT LOCATION OTHER:					

FATHER/GUARDIAN'S INFORMATION

NAME		DOB	SS#:		
STREET				APT#:	
CITY			STATE		ZIP
HOME PHONE		WORK PHONE		EMPLOYER	
EMPLOYER ADDRESS					

MOTHER'S INFORMATION

NAME		DOB	SS#:		
STREET				APT#:	
CITY			STATE		ZIP
HOME PHONE		WORK PHONE		EMPLOYER	
EMPLOYER ADDRESS					

INSURANCE INFORMATION

PRIMARY		ID#	GROUP#		
NAME OF INSURED		RELATIONSHIP	DOB	EMPLOYER	
SOCIAL SECURITY NUMBER		COPAY	DEDUCTIBLE		
SECONDARY		ID#	GROUP#		
NAME OF INSURED		RELATIONSHIP	DOB	EMPLOYER	
SOCIAL SECURITY NUMBER		COPAY	DEDUCTIBLE		

EMERGENCY CONTACT INFORMATION (NOT LIVING WITH YOU)

NAME		RELATIONSHIP			
HOME PHONE	WORK PHONE		EXT.	CELL PHONE	

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NAME	DOB
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Social Security Authorization to Release Information and Make Payments

I certify that the information given by me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information to release to the Social Security Administration or it's Intermediaries or Carriers any information needed for claims made for Medicare, Medicaid, or other third party payments. I request that payments of authorized benefits be made directly to The Barfield Clinic, PLLC or its agent on my behalf.

Consent for Treatment

I authorize the health care provider staff of The Barfield Clinic, PLLC to administer such care and treatment as medically indicated and is set forth in my developed plan of treatment.
(NOTE: Persons under 18 years old must have legal guardian to be seen and receive services.)

Health Insurance Portability and Accountability Act (HIPAA)

I certify that I am aware that certain disclosures to third parties, such as my insurance company, are required in order for The Barfield Clinic, PLLC to submit for reimbursement for services. I authorize these disclosures as well as disclosures or communications with:

<p style="text-align: center;">Initial</p> <p>_____ Pharmacies</p> <p>_____ Referring specialists</p> <p>_____ Hospital staff and physicians</p>	<p style="text-align: center;">Initial</p> <p>_____ Family members to whom information may be released:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Relationship</th> <th style="text-align: left; border-bottom: 1px solid black;">Name</th> </tr> </thead> <tbody> <tr> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> </tr> <tr> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> </tr> </tbody> </table>	Relationship	Name				
Relationship	Name						

<p>Signature _____ Patient</p>	<p>Date _____</p>
<p>Signature _____ Legal Guardian (if patient is a minor)</p>	<p>Date _____</p>
<p>Signature _____ TBC Representative</p>	<p>Date _____</p>

This Agency complies fully with:
Title VI of the Civil Rights Act of 1964
Section 504 of the Rehabilitation Act of 1973
The Age Discrimination Act of 1975

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Outpatient Payment and Release of Information Agreement

Authorization to Release Information to Insurance Companies

I hereby authorize The Barfield Clinic, PLLC (TBC) health care providers or their agents, by signing this form, to release such patient-identifiable medical information (which may include drug/alcohol abuse, HIV status or psychiatric treatment) to my insurance companies and managed care organizations, TennCare, Medicaid, and other federal programs as necessary to perform administrative functions and to bill for and verify my treatment.

I authorize TBC, its employees, my physicians and other providers to release the Social Security Administration or its intermediaries any information needed for processing any Medicare claim.

If I am making a claim for expenses under worker's compensation, I also authorize release of information to my employer and/or worker's compensation carrier.

I may revoke this authorization at any time by notifying TBC in writing. If I do not revoke it earlier, my authorization will expire twelve months after the date I signed this form.

Assignment of Benefits

I hereby authorize and request all insurance carriers, HMOs or managed care organizations with whom I have coverage, including TennCare, Medicare, and Medicaid to pay directly to TBC any and all benefits due under the terms of my policy for services provided by TBC, including any settlements or judgments for such services. If my health insurance will not allow direct payment to TBC, I agree to immediately forward to TBC all health insurance payments I receive for my care and treatment at TBC.

Agreement to Pay

I acknowledge and agree that I am responsible and will pay for all regular charges (which are contained in a price list which is in effect on the dates of services rendered) for services and treatment provided to me, including any amount not paid by my insurance plan, to the extent legally permissible.

I understand that I am responsible for any non-covered Medicare services, deductibles and co-insurance.

I hereby agree that if The Barfield Clinic, PLLC or its agents has agreed to bill my insurance or other third party carrier, it has agreed to do as a courtesy, and that TBC has the right, should TBC deem it advisable, to demand payment in full from me at any time prior to full payment from any insurance or third party carrier, unless TBC and my insurance company or third party carrier have agreed that I will not be billed.

I hereby acknowledge having been told that I may be billed by TBC and that this Outpatient Payment Agreement shall cover any and all providers and outpatient hospital accounts. If a delinquent account is referred for collection, I agree to pay the reasonable attorney's fees, court cost and/or collection agency fees of 35% associated with the collection process.

I understand that there is a \$25.00 returned check charge fee.

I HAVE READ THIS AGREEMENT OR HAVE HAD IT READ TO ME. THE INFORMATION WHICH I HAVE PROVIDED IS ACCURATE, BY VOLUNTARILY SIGNING THIS AGREEMENT, I ACCEPT AND AGREE TO COMPLY WITH ITS TERMS. I understand that if I have any questions or need to change my payment arrangements, I should ask TBC/clinic personnel.

Signature of Patient / Legal Representative

Date

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NAME	DATE	GENDER M F
DRUG ALLERGIES	FOOD ALLERGIES	AGE

Please briefly tell us what you would like us to help you with today:

Would you like a FREE enrollment form for our generic medication program (RediRx): Yes No

CURRENT MEDICATIONS

CHRONIC CONDITIONS

SURGERIES/HOSPITALIZATIONS

YEAR

PATIENT AND FAMILY HISTORY (PARENTS, GRANDPARENTS, SIBLINGS OR CHILDREN)

YOU	FAMILY MEMBER	M-Mother	F-Father	S-Sister	B-Brother	C-Child	GP-Grandparent
							HEART ATTACK
							STROKE
							EMPHYSEMA
							BLEEDING DISORDER
							CANCER
							TUBERCULOSIS
							THYROID DISORDER
							KIDNEY DISORDER
							LIVER DISORDER
							MENTAL HEALTH
							HIGH BLOOD PRESSURE
							HIGH CHOLESTEROL

YOU	FAMILY	
		ASTHMA
		SKIN DISORDER
		ARTHRITIS
		PROSTATE PROBLEM
		STOMACH DISORDER
		COLON DISORDER
		FAINING SPELLS
		DIABETES
		SWALLOWING DIFFICULTY
		HEADACHES
		TOBACCO USE