WELCOME TO OUR OFFICE

Name____________________ **Age:** ________ **Date:** __________
Occupation________________ **Birth Date:** ________ **Birth Place:** __________
Who referred you to us?______________ **May we send them a thank you note?** ________

Chief Complaints (symptoms) or Areas of Interest?

1.____________ **2.**____________ **3.**____________

Please answer each of the following questions by placing an "X" in the appropriate box. Write in the year diagnosed in the blank.

PERSONAL HISTORY: Do you now, or have you in the past, had any of the following?

ILLNESS	No	Yes	When
Migraine Headaches			
Epilepsy or convulsions			
Asthma			
Hay Fever			
Tuberculosis			
Pneumonia			
Heart Disease			
Rheumatic Fever			
High Blood Pressure			
Stomach Ulcer			
Colitis			
Diabetes			
Kidney Disease			
Phlebitis			
Arthritis / Gout			
Anemia / Sickle Cell Anemia			
Breast Cancer			
Other Cancer			
Serious Depression			
Other ( )			

Allergies	N/Y		N/Y
Penicillin		Tape	
Sulfa		Cosmetics	
Mycins		Food(s)	
Codeine		Other--	
Aspirin			

HEIGHT__________ **WEIGHT**__________
Weight one year ago?__________

Do you smoke?______ How many each day?__________
For how many years?__________

Do you drink any alcoholic beverages?__________
How much / often?__________

SURGERY	NO	YES	YEAR
Tonsillectomy			
Appendectomy			
Breast Biopsy			
Other--			

List ALL prescribed and non-prescribed.

MEDICATIONS	DOSE

FORM 045322 N/11/99 ITEM 8101 COLWELL SYSTEMS 1.800.637.1140

PATIENT INFORMATION.................................... CONFIDENTIAL

(PLEASE PRINT)

Date

PATIENT'S NAME	SSN	MARITAL STATUS S M W D	SEX M F	BIRTH DATE	AGE
STREET ADDRESS	CITY AND STATE	ZIP CODE		HOME PHONE #	
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED?		BUSINESS PHONE #	
EMPLOYER'S STREET ADDRESS	CITY AND STATE			ZIP CODE	
SPOUSE OR PARENT'S NAME	SSN #			NUMBER OF CHILDREN (& AGES)	
SPOUSE OR PARENT'S STREET ADDRESS	CITY AND STATE	ZIP CODE		HOME PHONE #	
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED?		BUSINESS PHONE #	

PLEASE READ: All charges are due at the time of services. If hospitalization is indicated, the patient is responsible for furnishing insurance claim forms to the office prior to hospitalization.

PERSON RESPONSIBLE FOR PAYMENT	STREET ADDRESS, CITY, STATE	ZIP CODE	HOME PHONE #
RELATIONSHIP TO PATIENT	EMPLOYER	WORK PHONE #	

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE COMPANY	INS. CO. ADDRESS		EFFECTIVE DATE	POLICY #
NAME OF INSURED (AS WRITTEN ON POLICY)	RELATIONSHIP TO PATIENT	SSN# OF POLICY HOLDER	DOB of INSURED	GROUP #
EMPLOYER OF INSURED	EMPLOYER'S ADDRESS, CITY, STATE		ZIP CODE	WORK PHONE #
WHAT IS YOUR YEARLY DEDUCTIBLE?	HAVE YOU MET THIS?		OFFICE VISIT COPAY? HOW MUCH?	DO YOU HAVE OUT OF NETWORK BENEFITS?
NAME OF SECONDARY INSURANCE COMPANY	INS. CO. ADDRESS		EFFECTIVE DATE	POLICY #
NAME OF INSURED (AS WRITTEN ON POLICY)	RELATIONSHIP TO PATIENT	SSN# OF POLICY HOLDER	DOB of INSURED	GROUP #
EMPLOYER OF INSURED	EMPLOYER'S ADDRESS, CITY, STATE		ZIP CODE	WORK PHONE #
WHAT IS YOUR YEARLY DEDUCTIBLE?	HAVE YOU MET THIS?		OFFICE VISIT COPAY? HOW MUCH?	DO YOU HAVE OUT OF NETWORK BENEFITS?

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare / Other Insurance company benefits be made either to me or on my behalf to RAMONA L. BATES, MD for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insured or agency shown. In Medicare / Other Insurance company assigned cases, the physician agrees to accept the charge determination of the Medicare / Other Insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare / Other Insurance company.

SIGNATURE____ DATE________________

Disclosure of Information Statement

Ramona L Bates, MD
500 S University, #701
Little Rock, AR 72205
_(501) 663-3385_

Patient's NAME: ______________________________ Date of Birth: ____________
SSN: ______________________________

- I understand that my health information is private and confidential. I understand that the office of Dr. Ramona L Bates works very hard to protect my privacy and preserve the confidentiality of my personal health information.
- I understand that signing this document means that the office of Dr Ramona L Bates may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. Failure to sign this consent may result in the physician declining to treat me.
- The office of Dr Ramona L Bates has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices used to protect her patients' privacy. I understand that I have the right to read the "Notice" before signing this agreement.
- The office of Dr Ramona L Bates may update this "Notice of Privacy Practices". I understand that if I ask, I will be provided with the most current "Notice of Privacy Practices".
- Under the terms of this consent, I can ask the office of Dr Ramona L Bates to restrict how my personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that the office of Dr Ramona L Bates does not have to agree to my request. If Dr Ramona L Bates does agree to my request, I understand that Dr Ramona L Bates would follow the agreed limits.
- I understand that I have the right to cancel this consent in writing, at any time. If I do cancel the consent, I understand that the office of Dr Ramona L Bates may have already used or disclosed information about me and canceling this consent would not effect the information already used or disclosed.

I may cancel this consent at any time by doing one of the following:

- Signing and dating a form that the office of Dr Ramona L Bates can give me called "Revocation of Consent for use and Disclosure of Health Care Information"

OR

- Writing, signing, and dating a letter to Dr Ramona L Bates. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of my personal health information for treatment, payment, and health care operations.

- I understand if I cancel this consent, the office of Dr Ramona L Bates does not have to provide any further health care services to me.
- My signature below indicates that I have been given the chance to review a current copy of Dr Ramona L Bates' "Notice of Privacy Practices".

______________________________ ____________
Patient or Legally Authorized Individual Signature Date

____
Relationship to Patient if signed by anyone other than the patient (Parent, legal guardian, etc)

Ramona L Bates, MD
500 S University, #701
Little Rock, AR 72205
(501) 663-3385

OFFICE FINANCIAL POLICY

Last revised Sept 2008

- The entire office fee is due the day of the office visit. The office will bill you insurance company when appropriate. Any payments received from the insurance company will be promptly refunded to you.

- You will be expected to pay the **FULL** amount of any surgical procedure prior to the surgery– 1 week prior to the surgery date if paying by check, by noon the day before surgery if paying by cash, money order or credit card. Prices quoted for any procedure are good for only 6 months from the date quoted.

- If you are unable to pay in full, the office may work out a payment schedule with you. This will only be done for medically necessary procedures, not cosmetic procedures. If you do not make payments as scheduled, the office will initiate collection procedures.

- The office will be happy to provide you with a copy of your Medical Records upon request. The request must be made in writing or in person, not by phone. There will be no charge for the first copy provided. The charge for additional copies will be $5.00 for the first 10 pages plus $0.10 for each additional page. There will be an additional charge for postage needed to mail them.

- This office is not a "participating provider" with any insurance, but is very willing to take care of anyone who is willing to pay for services.

- **THIS OFFICE ACCEPTS PAYMENT BY CASH, MONEY ORDER, VISA, MASTERCARD, OR DISCOVER.**

Date____________________ **Signature**____

Please bring a signed and dated copy of this with you to the office at the time of your first visit.
Thank you. Have a blessed day!