

**WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE.**

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**SECTION G**

**OFFICE POLICY ON PAYMENT:**

It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. All accounts over 60 days will be charged an interest rate of 1 1/2 percent per month (18% per annum) or a \$2.00 minimum. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, which costs will not exceed 20% of said unpaid balance, including a reasonable attorneys fee.

**INSURANCE POLICY:**

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. **You are responsible for all deductibles and charges not covered by insurance.** Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:**

I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

**I have read the above and accept financial responsibility in full for this account.**

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
Patient, Parent, or Guardian

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**SECTION H**

**IN CASE OF EMERGENCY PLEASE CONTACT:**

**NAME:** \_\_\_\_\_

**PHONE NUMBER:** \_\_\_\_\_ **RELATIONSHIP TO CLIENT:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

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## SECTION F

### Notice of Privacy Policy Practices

We may use and disclose your medical records in the following ways:

**Treatment:** We use medical information about you for example to order lab tests or respond to a pharmacy call for a prescription refill. We may disclose medical information to other healthcare providers involved in your care.

**Payment:** We may use and disclose medical information in order to bill and collect payment for services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits or to determine if coverage exists for treatment to be provided. We may disclose this information to other health care providers and entities in their billing and collection efforts. Should you restrict disclosure of information to your insurance carrier, you will accept responsibility for the charges incurred for your care.

**Healthcare operations:** We may use and disclose medical information to operate our practice. For example, to help evaluate the quality of care you receive from us or to conduct business planning activities for our practice. We may also use and disclose medical information to other healthcare providers to assist them in their operations (hospitals, for example).

**Appointment reminders:** We may use and disclose medical information when we contact you to remind you of an appointment. **If you communicate with us by email, BE SURE that it is a secure email address and that any confidential information can be transmitted to this email address as needed.**

**Release of information to others:** We may use or disclose medical information to a family member when you are not coherent or capable of making medical decisions, ie: if you are medicated, hysterical or not conscious.

**Research:** We may use or disclose medical information for research purposes in limited circumstances. Prior to any use or disclosure, we would seek and obtain written authorization as appropriate.

**Military:** We may disclose medical information if you are a member of the US or foreign military forces and if required by appropriate authorities.

**Disclosure required by law:** We will use or disclose medical information when we are required to do so by federal, state or local law enforcement. (see below for examples)

#### **Disclosure for special circumstances:**

**Public Health Risks:** We may disclose medical information to public health authorities authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Reporting reactions to drugs or problems with products or devices
- Notifying persons if a product or device they may be using has been recalled

**Health Oversight Activities:** We may disclose Medical information to a health oversight agency, for activities authorized by law. Examples of this include inspections, audits, surveys, investigations, civil, administrative or criminal procedures.

### Notice of Privacy Policy Acknowledgement

I, \_\_\_\_\_ am a patient of J. Patrick Ware, MD. I have been made aware of the "Notice of Privacy" Policy. I have chosen the following action: (Please initial the appropriate choice of 3 or make comments on number 4 as desired.)

1. \_\_\_\_\_ I have requested and received a copy of the Notice of Privacy Policy.
2. \_\_\_\_\_ I have reviewed the Notice of Privacy Policy. I do not choose to receive a copy.
3. \_\_\_\_\_ I have been made aware of the Notice of Privacy Policy and do not choose to either review or receive a copy of it.
4. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

We are required to present this notice to you one time. Should you change your mind in the future, please advise the staff or the privacy officer. Thank you,  
J Patrick Ware, MD  
Privacy Officer

**WE APPRECIATE THE OPPORTUNITY OF SERVING YOU.**

**SECTION D**

**FOR SELF/PRIVATE PAY CLIENTS: (To be completed with Dr. Ware in session)**

**Professional Services Fee Agreement**

I, \_\_\_\_\_ (Please circle) (client, parent, guardian, and/or account guarantor) request J. Patrick Ware, MD to provide Psychiatric Evaluation and/or treatment professional services to: \_\_\_\_\_ beginning on \_\_\_\_\_ and continuing until modified in writing by the undersigned or Dr. Ware. I understand that Dr. Ware's fees are \$\_\_\_\_\_ per 60 minute hour (prorated to actual time spent) and are due at the time of service unless otherwise arranged with Dr. Ware (as noted below). I also understand that any current or future third party payor (Insurance company) that I may have or will obtain will not be billed by Dr. Ware and that if I am to attempt to gain reimbursement from that Insurance company that my pursuit of that reimbursement is entirely my responsibility and that the amount if any of that reimbursement is to be determined solely by the third party payor (Insurance company) and myself. I additionally understand that Dr. Ware will provide necessary information (Diagnosis, CPT code, length of service, place of service, amount billed and amount paid on the account) to me at my request should I attempt to gain reimbursement from the Insurance company. I acknowledge that finance charges may be applied for past due accounts over 30 days in the absence of suitable alternative payment arrangements. I agree to pay any reasonable collection, attorney fees and/or court costs in the event a collections procedure is implemented.

\_\_\_\_\_  
Client

\_\_\_\_\_  
Parent/Guardian/Account Guarantor

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**SECTION E**

**ACCOUNT PAY AGREEMENT (To be completed only when account arrangements are made.)**

**Account payment arrangements:**

I, \_\_\_\_\_ agree to pay \$\_\_\_\_\_ per \_\_\_\_\_ due on the \_\_\_\_\_ day of the \_\_\_\_\_ on the account of \_\_\_\_\_ on the current balance of \$\_\_\_\_\_ until the debt is paid in full. Finance charges may apply if I default on any payments.

\_\_\_\_\_  
Authorizing Signature

\_\_\_\_\_  
Account Name (Please Print)

\_\_\_\_\_  
Authorization Name (Please Print)

\_\_\_\_\_  
Parent/Guardian/Account Guarantor

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**SECTION C****INSURANCE INFORMATION**

PRIMARY INSURANCE COMPANY: \_\_\_\_\_ Pre-certification Phone #(if required) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

CONTRACT (ID#) NUMBER: \_\_\_\_\_ SUBSCRIBER'S NAME: \_\_\_\_\_

SUBSCRIBER ID: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ PATIENT RELATIONSHIP TO SUBSCRIBER:(circle one)SELF SPOUSE CHILD OTHER

Referral Required?  Yes  No GROUP NAME: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

PLAN NUMBER: \_\_\_\_\_ COPAYMENT AMOUNT: \$ \_\_\_\_\_

INSURED DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ MENTAL HEALTH CLAIMS ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ EFFECTIVE COVERAGE DATE: \_\_\_\_\_

MENTAL HEALTH BENEFITS: (THESE BENEFITS DIFFER FROM YOUR **MEDICAL** BENEFITS):

DEDUCTABLE: (CALENDAR YEAR): \$ \_\_\_\_\_ CLIENT CO-PAYMENT: \$ \_\_\_\_\_ VISITS AUTHORIZED: \_\_\_\_\_

AUTHORIZATION NUMBER: \_\_\_\_\_ NUMBER OF VISITS: \_\_\_\_\_

CPT CODES AUTHORIZED (NUMBER OF) 90801: \_\_\_\_\_ 90807 \_\_\_\_\_ 90846 \_\_\_\_\_ Other; \_\_\_\_\_; \_\_\_\_\_;  
\_\_\_\_\_;

YEARLY MAX NUMBER OF VISITS: \_\_\_\_\_ CALENDAR YEAR MAX BENEFITS: \$ \_\_\_\_\_ LIFETIME MAX: \$ \_\_\_\_\_

LIFETIME MAX REMAINING: \$ \_\_\_\_\_ NAME OF INSURANCE COMPANY REPRESENTATIVE WHO ASSISTED YOU IN THE

AUTHORIZATION PROCESS AND CONFIRMATION OF THESE BENEFITS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ NAME OF PERSON OBTAINING THIS INFORMATION: \_\_\_\_\_

DATE: \_\_\_\_\_

SECONDARY INSURANCE COMPANY: \_\_\_\_\_ Pre-certification Phone # (if required) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

CONTRACT (ID#) NUMBER: \_\_\_\_\_ SUBSCRIBER'S NAME: \_\_\_\_\_

SUBSCRIBER ID: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ PATIENT RELATIONSHIP TO SUBSCRIBER:(circle one)SELF SPOUSE CHILD OTHER

Referral Required?  Yes  No GROUP NAME: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

PLAN NUMBER: \_\_\_\_\_ COPAYMENT AMOUNT: \$ \_\_\_\_\_

INSURED DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ MENTAL HEALTH CLAIMS ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ EFFECTIVE COVERAGE DATE: \_\_\_\_\_

MENTAL HEALTH BENEFITS: (THESE BENEFITS DIFFER FROM YOUR **MEDICAL** BENEFITS):

DEDUCTABLE: (CALENDAR YEAR): \$ \_\_\_\_\_ CLIENT CO-PAYMENT: \$ \_\_\_\_\_ VISITS AUTHORIZED: \_\_\_\_\_

AUTHORIZATION NUMBER: \_\_\_\_\_ NUMBER OF VISITS: \_\_\_\_\_

CPT CODES AUTHORIZED (NUMBER OF) 90801: \_\_\_\_\_ 90807 \_\_\_\_\_ 90846 \_\_\_\_\_ Other; \_\_\_\_\_; \_\_\_\_\_;  
\_\_\_\_\_;

YEARLY MAX NUMBER OF VISITS: \_\_\_\_\_ CALENDAR YEAR MAX BENEFITS :\$ \_\_\_\_\_ LIFETIME MAX: \$ \_\_\_\_\_

LIFETIME MAX REMAINING: \$ \_\_\_\_\_ NAME OF INSURANCE COMPANY REPRESENTATIVE WHO ASSISTED YOU IN THE

AUTHORIZATION PROCESS AND CONFIRMATION OF THESE BENEFITS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ NAME OF PERSON OBTAINING THIS INFORMATION: \_\_\_\_\_

DATE: \_\_\_\_\_

## CLIENT GENERAL AND ACCOUNT INFORMATION

CHART #: \_\_\_\_\_

PROVIDER: J. Patrick Ware, MD

**PLEASE NOTE: AN ACCOUNT CANNOT BE OPENED UNTIL THIS INFORMATION IS COMPLETED IN FULL. IF YOU HAVE PROBLEMS WITH ANY SECTION YOU MAY CONTACT DR. WARE BY EMAIL OR PHONE ([DrJimPat@aol.com](mailto:DrJimPat@aol.com)) OR THE BILLING OFFICE ([JKBilling@midsouth.rr.com](mailto:JKBilling@midsouth.rr.com)). Please print out the questionnaire and bring with you on your first visit. Clients with existing accounts must verify account information annually to continue services.**

### SECTION A

### PATIENT INFORMATION

PATIENT NAME: \_\_\_\_\_

LAST

FIRST

MIDDLE

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ WORK PHONE #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER GRADE: (Youth) \_\_\_\_\_

LEGAL GUARDIANSHIP: \_\_\_\_\_ GUARDIAN RELATIONSHIP TO CLIENT: \_\_\_\_\_

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: SELF SPOUSE CHILD OTHER \_\_\_\_\_

(circle one) SEX: (circle one) FEMALE MALE PRIMARY CARE PHYSICIAN: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ REFERRAL CONTACT PHONE NO. : \_\_\_\_\_

ACCOUNT TYPE: (INSURANCE/SELF-PAY/OTHER THIRD PARTY): \_\_\_\_\_

PATIENT'S EMPLOYER INFORMATION: COMPANY NAME: \_\_\_\_\_

COMPANY ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE #: \_\_\_\_\_

ACCIDENT INFORMATION: DATE OF ACCIDENT: \_\_\_\_\_ WORK RELATED? \_\_\_\_\_ AUTO: \_\_\_\_\_ OTHER: \_\_\_\_\_

PRIVAT PAY AGREEMENT SIGNED? YES/NO HIPPA ACKNOWLEDGED? YES/NO

### SECTION B

### RESPONSIBLE (OR INSURED) PARTY INFORMATION

RESP. PARTY NAME: (TO WHOM HE BILL WILL BE SENT): RELATIONSHIP TO CLIENT: \_\_\_\_\_

\_\_\_\_\_

LAST

FIRST

MIDDLE

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX: (circle one) FEMALE MALE

HOME PHONE #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ WORK PHONE #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

CELL PH: (\_\_\_\_) \_\_\_\_\_ SOCIAL SECURITY NO: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

RESPONSIBLE PARTY EMPLOYER INFORMATION: COMPANY: \_\_\_\_\_

COMPANY ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP : \_\_\_\_\_ PHONE #: \_\_\_\_\_