DONALD R. BASSMAN, MD

PLEASE PRINT **TODAY'S DATE ___/_____/___**
Name (last) _____ (first) _____(m.i.)_____
Mailing address_____
(City)_____ (state) _____ (zip)_____
Home Phone (area code) _____Work phone (area code) _____
Cell Phone (area code)_____Date of Birth_____Age_____
Sex_____Marital Status_____SS#_____

Ethnicity (circle one)
Hispanic/Latino Non-Hispanic Unknown
Race (circle one)
American Indian or Alaskan African American Asian Caucasian
Native Hawaiian or other Pacific Islander Other Unknown
Language (circle one) English Spanish French Chinese German
Portuguese Korean Other

Employer Name_____Occupation_____
Spouse Name_____Date of Birth_____

IS THIS AN AUTO ACCIDENT, WORKMAN'S COMPENSATION OR LIABILITY?___

PARENT OR RESPONSIBLE PARTY (INSURANCE CARD HOLDER)
Name (last) _____ (first) _____(m.i.)_____
Address_____(city)_____ (zip)_____
Home Phone (area code) _____Work Phone (area code) _____ Sex_____
Date of Birth_____SS#_____

INSURANCE INFORMATION (please present insurance card at time of check in)
Primary Insurance Name_____Secondary Insurance Name_____
Insured's Name _____ Insured's Name _____
Insured's DOB _____Insured's DOB _____
Insured's ID#_____Insured's ID#_____
Group #_____Group#_____
Employer Name_____Employer Name_____
Employer Address_____ Employer Address_____
Employer Phone (area code) _____ Employer Phone (area code) _____
Relationship of patient to insured_____Relationship of patient to insured_____

Donald Bassman, M.D.

EMERGENCY INFORMATION
In case of emergency, who should we notify?_____
Relationship to patient_____Phone number (area code) _____

PRIMARY PHYSICIAN
Name_____Phone number (area code) _____

HOW DID YOU LEARN ABOUT DR. BASSMAN?
WEB SITE?_____ YELLOW PAGES?_____ FRIEND?_____OTHER?_____
REFERRING PHYSICIAN? NAME_____PHONE NUMBER_____

I hereby assign payment of authorized benefits to include major medical benefits to which I am entitled, to be made on my behalf to Donald R. Bassman, M.D. for any services furnished to me by that practitioner. I authorize release of medical information needed to determine these benefits payable to related services. I understand that I am financially responsible for all charges whether or not paid by said insurance. I agree to pay any additional charges related to the cost of collection, (including but not limited to, collection agency fees, reasonable attorney fees and court cost,) in the event that I would fail to pay my bill.
Donald Bassman, M.D. does not deny any benefits or services because of race, color, national origin, age, gender, disability, religious or political beliefs. If you feel you have been discriminated against, you may file a complaint of Discrimination with the manager of this facility. Your will not suffer any penalty because you file a complaint.

GUARANTOR SIGNATURE (OR LEGAL GUARDIAN IF MINOR)

_____DATE_____

OPEN AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (MEDICAL INFORMATION/RECORDS)

DO WE HAVE YOUR PERMISSION TO?
Leave a message on your answering machine at home?_____
“ “cell phone?_____
“ “at your place of employment?_____

I hereby, authorize Donald R. Bassman, M.D. to release any and all protected health information maintained in my medical record to the following individuals, concerning my status as a patient, treatment or payment of services provided by Dr. Donald R. Bassman.

NAME_____ Relationship to patient_____

NAME_____Relationship to patient_____

NAME_____Relationship to patient _____

This authorization is given freely with the understanding that:
1.)This authorization is valid until revoked by me.
2.) I may revoke this authorization at any time, except where information has already been released, by completing Dr. Donald Bassman’s REVOCATION OF AUTHORIZATION FORM.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have received a summary of Donald R. Bassman’s NOTICE OF PRIVACY PRACTICES and consent to the use of disclosure of my protected health information by Donald R. Bassman for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, to conduct health care operations of Donald R. Bassman, and as required by law.
I also acknowledge that I was offered the entire notice and that I understand I may obtain a full version of the notice at any time. I understand my rights as a patient of the practice concerning my protected health information (PHI), as it is outlined in this notice. I am aware Donald R. Bassman reserves the right to change the privacy practices that are described in this notice of privacy practices. I may obtain a revised notice of privacy practices by contacting the office and requesting that a revised copy be sent in the mail or asking for one at the time of my next appointment.

NAME OF PATIENT (PRINT) _____DOB_____

SIGNATURE OF
PATIENT_____DATE_____
(OR LEGAL GAURDIAN IF MINOR)

DONALD R. BASSMAN, M.D.

PRINT NAME:_____DOB_____
MALE_____ FEMALE_____ HEIGHT_____ WEIGHT_____
CHIEF COMPLAINT_____
RIGHT_____LEFT_____ BOTH_____ DATE OF ONSET_____
HOW DID THIS INJURY OR PROBLEM OCCUR? _____
WORK _____AUTO ACCIDENT_____SPORTS_____NO INJURY_____OTHER_____
EXPLAIN_____
HAVE YOU HAD THE SAME OR SIMILAR PROBLEM? _____SPECIFY_____
ARE YOU WORKING? _____REGULAR_____LIGHT DUTY_____OFF WORK_____
HOW WOULD YOU DESCRIBE YOUR PROBLEM? _____
_____
WHAT MAKES IT BETTER OR WORSE? _____
WHEN DOES IT OCCUR? _____HOW SEVERE? _____
WHAT OTHER SYMPTOMS? _____
DID YOU DO ANYTHING THAT MIGHT HAVE CAUSED THIS? _____
HAVE YOU HAD ANY TESTS, X-RAYS OR LAB WORK DONE? ANY MEDICATIONS? ___
_____
_____
HAVE YOU BEEN TREATED FOR THIS BY ANYONE ELSE? WHO AND WHEN?
_____

DRUG ALLERGIES: PLEASE LIST MEDICATION AND REACTION:

_____
_____
_____
_____
_____

WHAT MEDICATIONS ARE YOU TAKING INCLUDE OVER THE COUNTER MEDS:

_____
_____
_____
_____
_____

SURGICAL HISTORY: PLEASE LIST ALL SURGERIES AND THE DATE PERFORMED.
_____

FAMILY HISTORY: WHO, IF ANYONE, HAS HAD THE FOLLOWING?

DIABETES_____ HIGH BLOOD PRESSURE_____
HEART DISEASE_____ CANCER_____
STROKE_____

SOCIAL HISTORY:

USE OF ALCOHOL NEVER_____RARELY_____MODERATE_____DAILY_____
USE OF TOBACCO: NEVER_____PREVIOUSLY_____CURRENT PACKS PER DAY_____
USE OF ILLEGAL/STREET DRUGS: NEVER_____TYPE/FREQUENCY_____
ARE YOU ON ANY SPECIAL DIET? _____

PATIENT SIGNATURE_____DATE_____
(OR LEGAL GAURDIAN)

PHARMACY NAME_____PHONE NUMBER_____
PHARMACY ADDRESS_____

Patient Name: _____ Date: _____

DONALD R. BASSMAN, M.D.
MEDICAL HISTORY AND REVIEW OF SYSTEMS

Do you now or have you ever had any problems related to the following? Please circle yes or no for each condition listed. Please question anything that you do not understand.

CONSTITUTIONAL

Fever	Y	N
Chills	Y	N
Night Sweats	Y	N

EYES

Visual Change	Y	N
Glaucoma	Y	N

CARDIOVASCULAR

Heart Attack	Y	N
Angina	Y	N
Heart Failure	Y	N
Heart Murmur	Y	N
Abnormal Heart Rhythm	Y	N
High blood pressure	Y	N
Stroke/Mini-stroke	Y	N
Aneurysm	Y	N
Poor circulation in legs	Y	N
Raynaud's Disease	Y	N

RESPIRATORY

Pneumonia	Y	N
Asthma	Y	N
Emphysema	Y	N
Bronchitis	Y	N
Tuberculosis	Y	N

GASTROINTESTINAL

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N
Stomach Ulcers	Y	N
Irritable Bowel Syndrome	Y	N

GENITOURINARY

Bladder Problems		
Frequent Urinary Infections	Y	N
Blood in urine	Y	N
Kidney Stones	Y	N
Kidney Failure	Y	N

PSYCHIATRIC

Depression	Y	N
Sleeping Disorder	Y	N

MUSCULOSKELETAL

Back Pain	Y	N
Osteoporosis	Y	N
Arthritis	Y	N
Joint Pain	Y	N
Fractures	Y	N
Dislocations	Y	N
Sprains	Y	N

INTEGUMENTARY/BREAST

Skin rash	Y	N
Sore that will not heal	Y	N
Breast lump/discharge	Y	N
Mitral Valve Prolapse	Y	N

NEUROLOGICAL

Dizzy Spells	Y	N
Seizures/Convulsions	Y	N
Headaches	Y	N
Head injury	Y	N
Multiple sclerosis	Y	N

ENDOCRINE

Diabetes (Please circle type)	Y	N
Adult Onset Insulin Dependent		
Juvenile Onset Non–Insulin Dependent		
Thyroid Dysfunction	Y	N
Gout	Y	N

HEMATOLOGY/LYMPHATIC

Anemia	Y	N
Bruise Easily	Y	N
Enlarged Lymph Nodes	Y	N
Lupus	Y	N

ALLERGY/IMMUNOLOGY

Aids/HIV	Y	N
Hay Fever	Y	N
Hepatitis	Y	N

CANCER

History of cancer	Y	N

Type_____

Any other medical illness not listed?

_____

_____

RED FLAGS NOTIFICATION (IDENTITY THEFT)

IT IS THE POLICY OF DR. BASSMAN TO FOLLOW ALL THE FEDERAL AND STATE LAWS CONCERNING IDENTITY THEFT.

IDENTITY THEFT OCCURS WHEN SOMEONE ELSE USES ANOTHER PERSONS IDENTIFYING INFORMATION TO COMMIT FRAUD OR OTHER CRIMES.

WE HAVE DEVELOPED AND IMPLEMENTED POLICIES AND PROCEDURES TO PROTECT OUR PATIENTS FROM IDENTITY THEFT.

AS OF AUGUST 1, 2009, THE LAW STATES WE MUST ENFORCE THESE POLICIES AND PROCEDURES.

AT APPOINTMENT TIME, ALL NEW PATIENTS MUST SHOW AN INSURANCE CARD AND PHOTO IDENTIFICATION. IF THE ADDRESS ON THE PHOTO IDENTIFICATION IS DIFFERENT FROM THE ADDRESS LISTED ON THE DEMOGRAPHIC SHEET, THEN A PROOF OF RESIDENCY MUST ACCOMPANY THE IDENTIFICATION (UTILITY BILL OR OTHER CORRESPONDENCE SHOWING THE PATIENTS CURRENT ADDRESS).

ALL PATIENTS WILL BE ASKED TO COMPLETE THE “RED FLAGS VERIFICATION FORM” OR AN UPDATED INFORMATION PACKET EVERY SIX MONTHS.

WE APPOLOGIZE FOR ANY INCONVIENCE AS WE REMAIN DEDICATED TO PROTECTING YOUR IDENTITY AND YOUR PRIVACY.

DR. DONALD BASSMAN

PATIENT FINANCIAL POLICY

1).MONTHLY STATEMENT: A STATEMENT WILL BE SENT EACH MONTH FOR THE PORTION OF THE BILL FOR WHICH YOUR ARE RESPONSIBLE. WE ASK THAT YOU PAY YOUR ACCOUNT IN FULL EACH MONTH. IF YOU NEED TO SET UP A PAYMENT ARRANGEMENT, PLEASE CONTACT OUR PATIENT ACCOUNT REPRESENTATIVE, SHANNON, AT (618-207-6146) OR (618-236-9002 EXT. 6146). IF YOUR ACCOUNT IS SUBSEQUENTLY TURNED OVER TO AN OUTSIDE COLLECTION AGENCY, YOU WILL BE CHARGED ANY COST ASSOCIATED WITH THE COLLECTION EFFORTS (INCLUDING BUT NOT LIMITED TO, COLLECTION AGENCY FEES, REASONABLE ATTORNEY FEES AND COURT COSTS).

2).CO-PAYS: ANY CO-PAYMENTS REQUIRED BY AN INSURANCE COMPANY **MUST BE PAID AT THE TIME OF YOUR VISIT,** UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. AS THIS IS A REQUIREMENT BASED ON YOUR CONTRACT WITH YOUR INSURANCE PLAN.

3). PRIVATE INSURANCE: WE WILL SUBMIT CLAIMS TO YOUR PRIVATE INSURANCE COMPANY AS A COURTESY, HOWEVER, WE ARE NOT RESPONSIBLE FOR NEGOTIATING INSURANCE CLAIMS ON YOUR BEHALF. YOU ARE RESPONSIBLE FOR FULL PAYMENT OF YOUR ACCOUNT. YOU MUST BRING YOUR CURRENT INSURANCE CARD WITH YOU TO EACH VISIT. THIS HELPS THE PRACTICE MAINTAIN THE MOST CURRENT INFORMATION ALLOWING DR BASSMAN TO SUBMIT ACCURATE CLAIMS ON YOUR BEHALF. **PLEASE ALERT THE FRONT DESK IF YOU HAVE NEW INSURANCE**. YOUR NEW CARD WILL NEED TO BE PROCESSED WITH OUR BUSINESS OFFICE

4). NO INSURANCE COVERAGE: IF YOU HAVE NO INSURANCE COVERAGE, YOU WILL BE REQUIRED TO PAY $175.00 TOWARDS THE SERVICES RENDERED ON THE DAY OF YOUR FIRST VISIT. YOU ARE RESPONSIBLE FOR FULL PAYMENT OF YOUR ACCOUNT. YOU WILL BE REQUIRED TO PAY $95.00 TOWARDS THE SERVICES RENDERED ON SUBSEQUENT VISITS. THESE AMOUNTS ARE OFFICE VISIT CHARGES ONLY. THIS DOES NOT INCLUDE POTENTIAL PROCEDURES, FRACTURE CARE, INJECTIONS, XRAYS, ETC.

5). MEDICAL ASSISTANCE: IF YOU ARE IN THE PROCESS OF APPLYING FOR MEDICAL ASSISTANCE, YOU WILL BE CONSIDERED PRIVATE PAY, AND REQUIRED TO PAY $175.00 TOWARDS THE SERVICES RENDERED ON THE DAY OF YOUR FIRST VISIT. ONCE YOU HAVE RECEIVED YOUR INSURANCE INFORMATION, YOU ARE REQUIRED TO CONTACT OUR BUSINESS OFFICE AT THE ABOVE NUMBERS. YOU WILL RECEIVE A REFUND FOR ANY PAYMENTS YOU HAVE MADE TOWARD SERVICES COVERED BY MEDICAL ASSISTANCE ONCE YOUR CLAIM HAS BEEN PROCESSED BY THE CARRIER.

6).WORKER'S COMPENSATION: YOU ARE RESPONSIBLE FOR HAVING YOUR WORKCOMP CARRIER OR EMPLOYER, CALL OUR OFFICE TO PROVIDE US WITH THE REQUIRED INFORMATION BEFORE YOUR APPOINTMENT IS MADE. (NAME OF YOUR EMPLOYER, INSURANCE COMPANY, ADDRESS, TELEPHONE NUMBER, CONTACT PERSON AND CLAIM NUMBER). WE WILL BILL YOUR WORKER'S COMPENSATION INSURANCE COMPANY AND ACCEPT THEIR PAYMENT AS PAYMENT IN FULL FOR SERVICES RENDERED. **DEPARTMENT OF LABOR** WORK COMPENSATION PATIENTS MUST BRING IN THEIR LETTER, FROM THE DEPARTMENT OF LABOR, INCLUDING AN APPROVED DIAGNOSIS CODE. THERE MUST BE A CLAIM NUMBER FOR EVERY ANATOMICAL INJURY (IE. SEPARATE CLAIM NUMBERS FOR EACH PART OF THE BODY).

7). ACCIDENT CLAIM (AUTO AND LIABILITY): YOU ARE RESPONSIBLE TO PROVIDE THE FOLLOWING INFORMATION: INSURANCE COMPANY NAME, ADDRESS, TELEPHONE NUMBER, CONTACT PERSON AND CLAIM NUMBER. WE WILL BILL THE AUTO/LIABILITY INSURANCE COMPANY ONCE WE HAVE THE COMPLETE INFORMATION. YOU ARE RESPONSIBLE FOR ANY PORTION OF THE BALANCE THAT IS NOT COVERED BY THE INSURANCE COMPANY.

8). RETURNED CHECKS: THERE IS A $15.00 FEE FOR ANY CHECK RETURNED FOR NON-PAYMENT.

9). DIVORCE: IN CASE OF DIVORCE OR SEPARATION, THE PARENT, WITH WHOM THE CHILDREN RESIDE, WILL BE LISTED AS THE GUARANTOR OF THE ACCOUNT AND THEREFORE RESPONSIBLE FOR ANY BALANCE ON THE ACCOUNT. IF THE DIVORCE DECREE REQUIRES THE OTHER PARENT TO PAY ALL OR PART OF THE MEDICAL EXPENSES, IT IS THE CUSTODIAL PARENTS RESPONSIBILITY TO COLLECT FROM THE OTHER PARENT.

10). WRITTEN PAPER REFERRAL: CERTAIN INSURANCE COMPANIES REQUIRE THE PATIENT HAVE A WRITTEN REFERRAL FROM THEIR PRIMARY CARE DOCTOR. THIS IS THE PATIENTS RESPONSIBILITY TO HAND CARRY THIS TO THE OFFICE. IF THIS REFERRAL IS TO BE FAXED, PLEASE CALL BEFORE YOUR APPOINTMENT TO MAKE SURE WE HAVE RECEIVED THE APPROPRIATE PAPER WORK.