



Today's Date:

**Patient Information**

Last Name:			First Name:			Middle Initial:		
Gender:				Sex: Male		Female		Intersex
Home Address:						Date of Birth:		
City:			State:	Zip:		Phone Number:		
Email:								
Mailing Address: (if different than above)								
City:			State:			Zip:		
Preferred Pharmacy:					Phone Number:			
Pharmacy Address:								
Patient currently living with:				Parents currently: Married / Divorced / Separated / Together				

**Parent - Guardian Information**

Relationship to Patient:			Mother		/	Father		/	Other: _____		
Last Name:			First Name:			Middle Initial:					
Email:						Date of Birth:					
Phone Number:											
Occupation:				Employer:							
Relationship to Patient:			Mother		/	Father		/	Other: _____		
Last Name:			First Name:			Middle Initial:					
Email:						Date of Birth:					
Phone Number:											
Occupation:				Employer:							

**Insurance Information**

Primary Insurance Name:						PPO		HMO
Subscriber Name:				Date of Birth:				
ID Number:			Group Number:					
Secondary Insurance Name:						PPO		HMO
Subscriber Name:				Date of Birth:				
ID Number:			Group Number:					

**Primary Care Doctor**

Name:			Phone Number:					
Address:			Fax Number:					



Patient Medical History	
Patient Name:	DOB:
Symptoms/Diagnosis:	
Hospitalizations:	
Surgeries:	
Medication Allergies	Food Allergies
Current Medications	Dose

Blood Relative Medical History			
Father Name:	Age:	Height:	
Mother Name:	Age:	Height:	
Number of Pregnancies:	Number of Live Children:	Number of Miscarriages:	
Medical Problems During Pregnancy:			
Medical Problems After Pregnancy (if Breast feeding):			
Sibling Name:	Age:	Height:	Full Half Step
Sibling Name:	Age:	Height:	Full Half Step
Sibling Name:	Age:	Height:	Full Half Step
Sibling Name:	Age:	Height:	Full Half Step
Please include <i>all</i> Blood Relative History of Gastrointestinal Problems:			
Affected Member ( <i>Relationship to patient</i> )		Diagnosis/Symptoms	



**Consent For Release Of Information For  
Treatment, Payment, And Healthcare Operations**

I, \_\_\_\_\_ (parent's name, or patient's name if over 18), hereby authorize Ron Bahar, M.D., to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and healthcare operations. I understand that, while this consent is voluntary, Dr. Bahar can refuse to treat me if I refuse to sign this consent.

A copy of the *Notice of Privacy Standards*, which more formally describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment, and healthcare operations, is available upon request.

I understand that I may revoke this consent at any time by notifying Dr. Bahar, in writing, but if I revoke my consent, such revocation will not affect any actions that Dr. Bahar took before receiving my revocation.

I understand that Dr. Bahar has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Dr. Bahar restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or health operations. I understand that Dr. Bahar does not have to agree to such restrictions, but that once such restrictions are agreed to, she must adhere to these restrictions.

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Name of Parent/Guardian (if under the age of 18)

\_\_\_\_\_  
Signature of Patient or Parent/Guardian (if under the age of 18)

\_\_\_\_\_  
Date

**Consent to disclose information to Family members  
(For patients over the age of 18)**

I, \_\_\_\_\_ (patient's name), hereby authorize Ron Bahar, M.D., to provide a copy, summary, or narrative of my health information which specifically identifies my treatment, payment, and healthcare operations to the following person(s):

Name	Relation to patient

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date



**MEDICAL BILLING POLICY**

As a medical practice our goal is to provide you with the best medical care available in a positive and supportive environment. As a small business, we strive to control our expenses and the cost of doing business. What a patient owes once his or her insurance has paid its portion is a function of each patient's insurance plan. To streamline this system and make it more cost-effective for everyone, we are asking every patient's family to provide us with a credit card or debit card at the time of service so that we can securely keep this information on file. Nothing will be charged to your credit card until after the insurance has been billed and we receive an "Explanation of Benefits" (EOB) from your insurance company. What would be charged to your card would be the "Patient Responsibility" portion as defined by your insurance company's EOB. You will never be charged more than the patient responsibility portion and you will receive a phone or e-mail confirmation with the amount due for the dates of service on the EOB. Thank you for cooperation and understanding.

I understand that as the parent or legal guardian, I am required to pay for services rendered at the time of the visit. I understand that it is my responsibility to be fully informed as to what is excluded or payable from this insurance carrier, as well as the limitations, co-payments and deductibles. Since there are many types of insurance plans, it is my responsibility to be fully informed as to what the requirements, benefits, or limitations are regarding the medical benefits of the above-mentioned patient. The office cannot assume this responsibility. Should I have any questions regarding coverage, I will refer to my personnel department or insurance representative. I authorize payment of any medical benefits directly to the physicians for services rendered.

As a condition of servicing the health care needs of the above listed patient, I hereby attest that the patient is an eligible member of the Health Plan, indicated at this date of service. I further hereby attest and agree that should the patient later be determined "ineligible" for the services rendered by this provider, I shall comply with the demands of payment to the provider of monies (not to exceed actual service costs) deemed by the plan to be compensation for said rendered services.

I authorize Ron Bahar, MD, Inc., or Brynie Collins, MD, Inc., to charge my credit or debit card with the balance due (patient responsibility) portion of my insurance company's EOB or any other fees owed to the office.

By signing below, you acknowledge your understanding of our **MEDICAL BILLING POLICY**.

**Name of patient:** \_\_\_\_\_

**Parent/guardian name:** \_\_\_\_\_

**Parent/guardian's signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Credit Card number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Expiration date (mm/yy):** \_\_\_\_/\_\_\_\_ **CVV:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_



**MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY**

Thank you for trusting your medical care to Dr. Ron Bahar and Dr. Brynie Collins' Office. When you schedule an appointment with Dr. Ron Bahar and Dr. Brynie Collins' Office we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our Appointment Cancellation/No Show Policy below:

Any patient who does not cancel or reschedule an **appointment** with at least 24 hours' notice will be considered a No Show and charged a **\$100 fee** or **may be dismissed from Dr. Ron Bahar and Dr. Brynie Collins' Office and will not be rescheduled.**

The fee is charged to the patient, not the insurance company, and is due before the patient's next office visit. We will charge the credit card information you have already provided.

As a courtesy, when time allows, we send reminder messages for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Office Manager.

You may contact Dr. Ron Bahar and Dr. Brynie Collins' Office 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

By signing below, you acknowledge your understanding of our MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY described above.

\_\_\_\_\_  
Name of Patient or Parent/Guardian (if under the age of 18)

\_\_\_\_\_  
Signature of Patient or Parent/Guardian (if under the age of 18)

Date: \_\_\_\_\_



**Telemedicine Informed Consent Form**

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. Dr. Ron Bahar has explained the alternatives to my satisfaction
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform Dr. Ron Bahar of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

**PATIENT CONSENT TO THE USE OF TELEMEDICINE**

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care. I hereby authorize Dr. Ron Bahar to use telemedicine in the course of my diagnosis and treatment.

\_\_\_\_\_  
Name of Patient or Parent/Guardian (if under the age of 18)

\_\_\_\_\_  
Signature of Patient or Parent/Guardian (if under the age of 18)

Date: \_\_\_\_\_