WELCOME TO DAVID BARNES, D.O.

(PLEASE PRINT)

PATIENT INFORMATION

DATE: ____________

HOME PHONE NUMBER: ____________

CELL PHONE NUMBER: ____________

MAY WE LEAVE A MESSAGE ON PHONE? YES NO

NAME: ____________

(LAST) (FIRST) (MI)

BIRTH DATE: ____________ SOCIAL # ____________ SEX: MALE / FEMALE

MAILING ADDRESS: ____________

CITY: ____________ STATE: ____________ ZIP: ____________

PHYSICAL ADDRESS: ____________

CITY: ____________ STATE: ____________ ZIP: ____________

EMPLOYED BY: ____________ WORK PHONE: ____________

MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOWED OTHER: ____________

SPOUSE'S NAME: ____________ SOCIAL # OR BIRTHDATE ____________

(IF THEY ARE PRIMARY ON INSURANCE)

REFERRED BY: ____________ PREFERRED PHARMACY: ____________

EMERGENCY CONTACT NAME: ____________ RELATIONSHIP: ____________

PHONE NUMBER: ____________

ASSIGNMENT AND RELEASE

I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE DOCTOR. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE, INCLUDING ANY COLLECTION OR PROCESSING FEES. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFIT AND THE USE OF THIS SIGNATURE BELOW ON ALL INSURANCE SUBMISSIONS.

PATIENT SIGNATURE: ____________ DATE: ____________

HEALTH HISTORY

(CONFIDENTIAL)

NAME: ______________________ DATE OF LAST PHYSICAL EXAMINATION: ______________________

REASON FOR VISIT: ______________________

SYMPTOMS Check any symptoms you currently have or have had in the past:

GENERAL
- ☐ CHILLS
- ☐ DEPRESSION
- ☐ DIZZINESS
- ☐ FAINTING
- ☐ FEVER
- ☐ FORGETFULNESS
- ☐ HEADACHES
- ☐ LOSS OF SLEEP
- ☐ LOSS OF WEIGHT
- ☐ NERVOUSNESS
- ☐ NUMBNESS
- ☐ SWEATS

MUSCLE/JOINT/BONE
(PAIN, WEAKNESS, NUMBNESS)
- ☐ ARMS ☐ HIPS
- ☐ BACK ☐ LEGS
- ☐ FEET ☐ NECK
- ☐ HANDS ☐ SHOULDERS

GENITO-URINARY
- ☐ BLOOD IN URINE
- ☐ FREQUENT URINATION
- ☐ NO BLADDER CONTROL
- ☐ PAINFUL URINATION

GASTROINTESTINAL
- ☐ APPETITE POOR
- ☐ BLOATING
- ☐ BOWEL CHANGES
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ EXCESSIVE HUNGER
- ☐ EXCESSIVE THIRST
- ☐ GAS
- ☐ HEMORRHOIDS
- ☐ INDIGESTION
- ☐ NAUSEA
- ☐ RECTAL BLEEDING
- ☐ STOMACH PAIN
- ☐ VOMITING
- ☐ VOMITING BLOOD

CARDIOVASCULAR
- ☐ CHEST PAIN
- ☐ HIGH BLOOD PRESSURE
- ☐ IRREGULAR HEARTBEAT
- ☐ LOW BLOOD PRESSURE
- ☐ POOR CIRCULATION
- ☐ RAPID HEARTBEAT
- ☐ SWELLING OF ANKLES
- ☐ VARICOSE VEINS

EYE/EAR/NOSE/THROAT
- ☐ BLEEDING GUMS
- ☐ BLURRED VISION
- ☐ CROSSED EYES
- ☐ DIFFICULTY SWALLOWING
- ☐ DOUBLE VISION
- ☐ EARACHE
- ☐ EAR DISCHARGE
- ☐ HAY FEVER
- ☐ HOARSENESS
- ☐ LOSS OF HEARING
- ☐ NOSEBLEEDS
- ☐ PERSISTENT COUGH
- ☐ RINGING IN EARS
- ☐ SINUS PROBLEMS
- ☐ VISION FLASHES/HALOS

SKIN
- ☐ BRUISE EASILY
- ☐ HIVES
- ☐ ITCHING
- ☐ CHANGE IN MOLES
- ☐ RASH
- ☐ SCARS
- ☐ SORE(S) THAT WON'T HEAL

MEN ONLY
- ☐ BREAST LUMP
- ☐ ERECTION DIFF.
- ☐ LUMP IN TESTICLES
- ☐ PENIS DISCHARGE
- ☐ SORE ON PENIS
- ☐ OTHER: ______________________

WOMEN ONLY
- ☐ ABNORMAL PAP SMEAR
- ☐ BLEEDING BETWEEN PERIODS
- ☐ BREAST LUMP
- ☐ EXTREME MENSTRUAL PAIN
- ☐ VAGINAL DISCHARGE
- ☐ HOT FLASHES
- ☐ NIPPLE DISCHARGE
- ☐ PAINFUL INTERCOURSE
- ☐ OTHER: ______________________

DATE OF LAST PERIOD: ____________

DATE OF LAST PAP SMEAR: ____________

DATE OF LAST MAMMOGRAM: ____________

NUMBER OF CHILDREN: ____________

CONDITIONS CHECK ANY CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST:

- ☐ AIDS
- ☐ ALCOHOLISM
- ☐ ANEMIA
- ☐ ANOREXIA
- ☐ APPENDICITIS
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ BLEEDING DISORDERS
- ☐ BREAST LUMP
- ☐ BRONCHITIS
- ☐ BULIMIA
- ☐ CANCER
- ☐ CATARACTS
- ☐ CHEMICAL DEPENDENCY
- ☐ CHICKEN POX
- ☐ DIABETES
- ☐ EMPHYSEMA
- ☐ EPILEPSY
- ☐ GLAUCOMA
- ☐ GOITER
- ☐ GONORRHEA
- ☐ GOUT
- ☐ HEART DISEASE
- ☐ HEPATITIS
- ☐ HERNIA
- ☐ HERPES
- ☐ HIGH CHOLESTEROL
- ☐ HIV POSITIVE
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ MEASLES
- ☐ MIGRAINE HEADACHES
- ☐ MISCARRIAGE
- ☐ MONONUCLEOSIS
- ☐ MULTIPLE SCLEROSIS
- ☐ MUMPS
- ☐ PACEMAKER
- ☐ PNEUMONIA
- ☐ POLIO
- ☐ PROSTATE PROBLEM
- ☐ PSYCHIATRIC CARE
- ☐ RHEUMATIC FEVER
- ☐ SCARLET FEVER
- ☐ STROKE
- ☐ SUICIDE ATTEMPTS
- ☐ THYROID PROBLEMS
- ☐ TONSILLITIS
- ☐ TUBERCULOSIS
- ☐ TYPHOID FEVER
- ☐ ULCERS
- ☐ VAGINAL INFECTIONS
- ☐ VENEREAL DISEASE

MEDICATIONS LIST ANY YOU ARE CURRENTLY TAKING	**ALLERGIES** TO MEDICATIONS/SUBSTANCES

(ALL INFORMATION IS STRICTLY CONFIDENTIAL)

FAMILY HISTORY FILL IN HEALTH INFORMATION ABOUT YOUR FAMILY
CHECK IF ANY BLOOD RELATIVES HAD ANY OF THE FOLLOWING

RELATION	AGE	AGE AT DEATH	CAUSE OF DEATH	☑	DISEASE	RELATIONSHIP TO YOU
FATHER					ARTHRITIS, GOUT	
MOTHER					ASTHMA, HAY FEVER	
BROTHER					CANCER	
					CHEMICAL DEPENDENCY	
					DIABETES	
					HEART DISEASE, STROKES	
SISTER					HIGH BLOOD PRESSURE	
					KIDNEY DISEASE	
					TUBERCULOSIS	
					OTHER	

HOSPITALIZATIONS

YEAR	HOSPITAL	REASON FOR HOSPITALIZATION

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES NO IF YES, PLEASE LIST DATES: ______________________________

PREGNANCY HISTORY

NO. OF PREGNANCIES	NO. OF LIVE BIRTHS	COMPLICATIONS (IF ANY)

HEALTH HABITS CHECK WHICH SUBSTANCES YOU USE AND DESCRIBE HOW OFTEN YOU USE THEM

	CAFFEINE	
	TOBACCO	
	DRUGS	
	ALCOHOL	
	OTHER	

OCCUPATIONAL CONCERNS CHECK IF YOUR WORK EXPOSES YOU TO THE FOLLOWING

	STRESS
	HAZARDOUS SUBSTANCES
	HEAVY LIFTING
	OTHER
	YOUR OCCUPATION:

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD MY DOCTOR OR ANY MEMBERS OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN COMPLETION OF THIS FORM.

SIGNATURE: ______________________________ DATE: ______________

PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

David Barnes, D.O.
3719 E. Meridian Loop, Suite A
Wasilla, AK 99654

The department of Health and Human Services has established a "Privacy Act" to help insure that personal health care information is protected for privacy. The Privacy Act was also created in order to provide a standard for health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take responsible precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide services that are in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect relationships with you (i.e. laboratories that only interact with physicians) and may have to disclose personal health information for the purpose of treatment, payment, or health care operations. Their entities are not required to obtain patient consent.

I understand that my health information may include information both created and received by the practice, may be in the form of writing, electronic records, spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health related information. I understand and agree that this practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plans or insurance coverage, and submit bills, claims and other related information to insurance companies or a responsible agent for payment of my health care.
- Perform various office, administrative and business functions that support my physician's effort to provide me with, arrange and be reimbursed for quality health care.

You may refuse to consent to the use or disclosure of your personal health information but this must be in writing as mandated by the Privacy Act. Under this law, we have the right to refuse treatment should you choose not to disclose your information. I also understand that I have the right to ask that some or all of my health care information not be used or disclosed, and understand that this practice is not required by law to agree with such requests.

I HAVE REVIEWED AND UNDERSTAND THIS CONSENT FORM:

______________________________ ______________________________

Patients Printed Name Patients Signature

____

Date

OFFICE POLICIES

To better serve all of the patients in the practice, my staff and I think that all office policies need to be very apparent and that all of our patients are informed of them. These are not made to inconvenience you; they are made to be a benefit to your care.

REFILLS / SAMPLES

- All prescription refill(s) request require 2 business days, there will be absolutely NO EXCEPTIONS. Please take weekends and holidays into consideration when calling in for refills.
- Requests will all be done and ready for fax/pick-up at the end of the second day.
- If you wish to request samples the same policy applies.
- Samples are given on a first come first serve basis and will only be held for one week. After that TIME, they will be restocked and given out to other patients.
- If no samples are available there can be a prescription written up and faxed to the pharmacy of your choice.

APPOINTMENTS

- Patients are seen by appointment only.
- If you feel that you need to be seen by a doctor immediately and are not on the schedule for that day you can go either to AIC or the emergency room. If at all possible we may try to work you into the day's schedule but you will be charged for an emergency visit instead of just an office visit.
- If you show up 10 minutes or later for an appointment you will be rescheduled to the next available time slot.
- Please limit how many family members/friends you have going into the exam room with you, as the rooms are very small.
- A "no show" appointment may put yourself at risk for being discharged as a patient from the practice.

CALL OUTS

- All call-outs will be done no later than the day before your appointment; if you are not available we will leave a message saying what time your appointment is.
- We ask that you please give 24 hours' notice if you will not be able to make your scheduled appointment time.

MEDICAL RECORDS

- If you are requesting for your medical records to be copied this requires a 48-hour notice.
- If you have already received a copy of your medical records, there will be a $25.00 charge to receive another copy or for them to be mailed somewhere.
- You will need to sign a release for us to get your medical records from another physician or for us to send your records to another physician.
- Absolutely **NO** results will be given out over the phone, if you want to discuss them you will need to make an appointment or await their results in the mail.

RECEPTIONIST

- All flat co-pays and deductibles are due at time of service. Please have your payment ready when you check in. If you are unable to provide payment your appointment may be rescheduled.
- If referral appointments are needed, our office will send the referral & it will be your responsibility to schedule the appointment.

CALLS/MISC.

- Please limit your phone calls to the office to no more than 2-3 phone calls in one day.
- Any questions or messages left for the doctor/nurse will either be returned by the end of the day or the following business day, please keep in mind no results will be given out over the phone.
- **ABSOLUTELY NO PAIN MANAGEMENT WILL BE TREATED OR FOLLOWED IN THIS OFFICE.**

I HAVE REVIEWED AND UNDERSTAND THESE POICIES:

______________________________ Patients Printed Name

______________________________ Patients Signature

______________ Date

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164

Authorization:

I authorize the office of Dr. David Barnes to use and disclose the protected health information described below to the following individuals of my choice (family, friends or other designees)

Who may we speak to on your behalf? This does not include other medical providers.

Name: ______________________ Name: ______________________

Name: ______________________ Name: ______________________

Effective Period

(Please indicate A or B in box provided. IF B is chosen please indicate dates.)

A. All Past, Present and Future Periods ☐
B. Or from __________ to __________

Extent of Authorization

I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS and treatment of alcohol or drug abuse). ☐ (INITIAL IN BOX)

OR: I authorize the release of my complete health record with the **exception** of the following information:

- o Mental Health Records
- o Communicable Diseases (including HIV and AIDS)
- o Alcohol/drug abuse
- o Other (please specify)

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until ______________ (date or event), at which time this authorization expires.

I understand I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

______________________________ ______________________
Printed Name of Patient or Personal Representative — Relationship to Patient

______________________________ ______________________
Signature of Patient or Personal Representative — Date

Patient Portal Authorization Form

Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect. We will do our best to maintain electronic security. However, keeping messages secure depends on two factors:

1.) The secure message must reach the correct email address
2.) Only the correct individual (or someone authorized by that individual) must be able to have access to the message.)

Only you can make sure these two factors are present. It is important that our practice has your correct email address and that you inform us of any changes to your email address.

You also need to keep track of who has access to your email account so that only you, someone you authorize, can see the message you receive from David L. Barnes, D.O., P.C. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should go promptly to the website and change it.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at login. I understand the risks associated with online communication between my provider's office (David L. Barnes, D.O., P.C.) and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communication. I understand and agree with the information that has been provided.

Secure Email Address: ______________________________

______________________________ Patients Printed Name

______________________________ Patients Signature

______________________________ Patients Date of Birth

______________________________ Date

Complete the following if the email address does not belong to the patient (please note portal access is not available for patients aged 13-17 years old):

______________________________ Printed Name of Parent/Guardian Requesting Access

______________________________ Relationship to Patient

Our Patient Portal Site Address: https://health.healow.com/drdavidbarnes