

# Linda M. Bugbee M.D. & Associates

## Please Print

Please list any drug Sensitivities or Allergies: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Sex: \_\_\_\_\_  
(First) (Middle) (Last)

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_

Marital Status: Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Separated \_\_\_ Partnered \_\_\_

Email address: \_\_\_\_\_ Would you like email appointment reminders? \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer or School: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ May we contact you at work? \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Which phone number may we use to leave messages? \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Current Therapist: \_\_\_\_\_ Phone: \_\_\_\_\_

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### ***PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD(S) WITH THIS FORM***

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Subscriber Place of Employment: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Subscriber Place of Employment: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

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### **Payment for Services:**

If your clinician participates with your insurance plan, then your insurance company will be billed for covered services. Otherwise, payment in full is expected at the time of service. **Any unpaid balance is the responsibility of the patient or responsible party.** Parents or guardians are responsible for payment of services rendered to a minor. Call the office for an up-to-date list of insurance plans we participate with—insurance companies often have outdated lists.

***There will be a \$40.00 Charge (\$100 for initial appointments) for any missed appointment not cancelled at least 24 hours prior to the scheduled appointment time.***

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### **Authorization to Release Information and Assignment of Insurance Benefits**

I hereby authorize Linda M. Bugbee, MD & Associates to release medical information to the insurance company(ies) listed above. I authorize payment directly to Linda M. Bugbee, MD & Associates of any benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. If my account is turned over to an attorney or collection agency for collection, I will be responsible for collection and/or attorney fees in the amount of thirty-five percent (35%) of the total debt plus court costs and interest at the rate of 1.5% per month on the unpaid balance from the date that payment was first due. Additionally, any debt older than one year will be subject to collection fees of fifty percent (50%) of the total debt.

**Signature of Patient/Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Drug Allergies \_\_\_\_\_

Reason for Evaluation: \_\_\_\_\_

**Current Medications:**

Name	Dosage (mg)	# of pills/day	prescribed by

**Hospitalizations:**

Date	Reason

**Medical Conditions:**

<input type="checkbox"/> Diabetes –If so, do you take insulin? yes no	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Asthma	<input type="checkbox"/> Irritable Bowel Syndrome
<input type="checkbox"/> Heart Disease	Women: Approximate date of last menstrual period _____
<input type="checkbox"/> Other (please specify) _____ _____	Current method of birth control (if any) : _____ _____

**Family History:**

	Father	Mother	Children	Siblings	Grandparents	Others (specify)
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other mental illness:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Substance Use:**

**Amount used and frequency**

Alcohol	
Cigarettes	
Caffeine	
Other	

**Linda M. Bugbee, M.D. & Associates**  
**4101 Cox Road, Suite 340**  
**Glen Allen, Virginia 23060**  
**P: 804-346-2087**  
**F: 804-346-8535**

**AUTHORIZATION TO OBTAIN & RELEASE MEDICAL INFORMATION**

Patient Name (please print): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I hereby authorize Linda M. Bugbee, M.D. & Associates to obtain and/or release any pertinent medical information including my evaluation and treatment plan to the following:

PCP: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Therapist: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Signature (if patient is a minor): \_\_\_\_\_

*This authorization shall remain in effect for 1 year from date of signature.*

# NOTICE OF PRIVACY: POLICIES AND PRACTICES

Linda M. Bugbee, M.D. & Associates

## THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Linda M. Bugbee, MD & Associates, we are committed to treating and using protected health information about you responsibly. This notice describes the personal information we collect, and how we use or disclose that information. It also describes your rights as they relate to your protected health information (PHI). This notice is effective March 1, 2004 and applies to all protected health information (PHI) as defined by federal regulations.

### **UNDERSTANDING YOUR MEDICAL RECORD / PHI**

Each time you visit Linda M. Bugbee, MD & Associates a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment and any other pertinent healthcare data. This information may serve as:

- A basis for planning your care and treatment
- A means of communication with other health professionals involved in your care
- A legal document outlining and describing the care you receive
- A tool that you, or another payer (i.e. insurance company) will use to verify that services billed were actually provided
- A source for medical research
- A basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards
- A tool that we can reference to ensure the highest quality of care and patient satisfaction.

Understanding what is in your record and how your health information is used helps you to ensure it's accuracy, determine what entities have access to your PHI, and make an informed decision when authorizing the disclosure of this information to other individuals.

### **YOUR RIGHTS**

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your PHI
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your PHI unless it is determined that this would be detrimental to your health
- The right to amend or submit corrections to your PHI
- The right to receive an accounting of how and to whom your PHI has been disclosed
- The right to receive a printed copy of this notice.

### **OUR RESPONSIBILITIES**

Linda M. Bugbee, MD & Associates is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have regarding communication of PHI via alternative means and locations

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. These revision will be applied to all PHI that we maintain. ***We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to procedures included in the authorization.***

## HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

1. **We will use your health information for treatment.** Your health information may be disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.
2. **We will use your information for payment.**
3. **Communication with family.** Unless you have specifically given permission to share information, we will only contact family members in the case of an emergency.
4. **Healthcare Oversight.** Federal law requires us to release your information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.
5. **Subpoenas.** In some rare instances we may be required by law to submit PHI when our practice is served with a subpoena. In this instance, we will make every effort to contact you first, but are not required to have your authorization to turn over requested health information.
6. **Appointment reminders.** The practice may use your information to remind you about upcoming appointment.
7. **Other uses and disclosures.** Disclosure of your PHI or its use for any purpose other than those listed above requires your specific written authorization.

## FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have complaints, questions, or need additional information, please see our Office Manager and she will be glad to address any concerns you may have. If you believe that your privacy rights have been violated, please contact our Office Manager, or you may file a complaint directly with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either this practice, or with the Office for Civil Rights. The address for the Office for Civil Rights is listed below:

OFFICE FOR CIVIL RIGHTS  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Room 509F, HHH Building  
Washington, D.C., 20201

**Linda M. Bugbee, M.D. & Associates**

*Authorization of Use and Disclosure of Protected Health Information (PHI)*

**Appointment Reminders:** The practice may use your information to remind you about upcoming appointments. Typically, an appointment reminder consists of a brief, non-specific message left on your answering machine if we cannot otherwise reach you by phone. Please indicate how you would like to be contacted.

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Other \_\_\_\_\_

If you have an answering machine, may we leave messages regarding appointments or other information pertinent to your healthcare, including insurance or payments for health services provided?

\_\_\_\_\_ Yes \_\_\_\_\_ No If no, how else may we contact you regarding this information?

***Please note that appointment reminders are done as a courtesy. It is ultimately the patient's responsibility to remember and keep appointments. Failure to receive a reminder does not constitute a valid reason for missing an appointment.***

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***Please list any other restrictions regarding messages or reminders about your healthcare:***

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**Other Uses and Disclosures:** Disclosure of your health information or its use for any purpose other than those listed in the "Notice of Privacy Policies and Practices" brochure and/or consent require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. You have the right to request restrictions on use and disclosure of your health information.

\_\_\_\_\_ I would like the following restrictions regarding the use and disclosure of my health information:

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**Persons Authorized to Receive Information:**

PHI Dr. Linda Bugbee & Associates collects or receives about you may be disclosed to the following persons:

\_\_\_\_\_  
Name of person / relation / organization

\_\_\_\_\_  
Name of person / relation / organization

**Use and Disclosure of Information:**

\_\_\_\_\_ I authorize the person(s) listed above to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided by Dr. Linda M. Bugbee & Associates.

\_\_\_\_\_ I do not authorize the following information to be disclosed to any other parties except to me as the patient (Please specify):

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*Linda M. Bugbee, M.D. & Associates*

*Consent to Use and Disclose Protected Health Information*

**HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION**

Dr. Linda M. Bugbee & Associates is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the “Notice of Privacy Policies and Practices” provided to you. ***PLEASE REVIEW IT CAREFULLY***

**YOU MAY REVOKE THIS CONSENT AT ANYTIME**

You may revoke this consent at anytime; however, Dr. Linda M. Bugbee & Associates requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the date you request.

**CHANGES TO PRIVACY PRACTICES**

Dr. Linda M. Bugbee & Associates reserves the right to change or modify the privacy practices outlined in the Notice of Privacy. We will notify you of any changes of privacy practices either by mail, at your next appointment, or any other pre-approved method that you request.

**SIGNATURE**

I have reviewed this consent form, received the “Notice of Privacy Policies and Practices” and give my permission to Dr. Linda M. Bugbee & Associates to use and disclose my health information in accordance with this consent and the notice provided. Furthermore, by signing, I acknowledge the person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

\_\_\_\_\_  
Name of Patient (please print)

\_\_\_\_\_  
Signature of Patient / Date

\_\_\_\_\_  
Patient Representative (please print)

\_\_\_\_\_  
Signature of Representative / Date

\_\_\_\_\_  
Relationship to Patient

