Burkey & Hundt MDs

Name (as written on insurance card)_____ _____
Last First Middle

Address_____

(if address is a PO BOX, provide street address, too)_____

City_____State_____Zip_____

Marital Status_____ SSN_____-_____-_____

Birthdate_____/_____/_____ Cell# (____)_____

Home# (____)_____ Work# (____)_____

Email Address: _____

#1 Insurance Company **#2 Insurance Company**

_____ _____

Insurance Policy Holder (if different from self)
Full Name _____
Address _____
City_____State_____Zip_____
Home# (____)_____Work# (____)_____
Birthdate_____/_____/____ SSN_____-_____-_____
Relationship to patient_____

Name of Person Financially Responsible (if different from self)_____
Address _____ City_____State__ Zip_____
Home# (____)_____Work# (____)_____
Birthdate_____/_____/____ SSN_____-_____-_____
Relationship to patient_____

Emergency contact person _____Phone#_____
Have you named a *Medical* Power of Attorney? _____
HOW DID YOU HEAR ABOUT US?_____

Required by new government electronic medical record guidelines:
Please circle answer

RACE Black/African American White Asian Native America/Alaskan Native
Hawaiian/Pacific Islander Other Unknown

Ethnicity **Not** Hispanic or Latino Unknown Hispanic or Latino

Burkey & Hundt MDs

Consent for treatment and the assignment of benefits

I give my permission and consent for the treatment of _____. I request that payment of Medicare and other insurance benefits be made on my behalf to Burkey & Hundt MD's and authorize the release of medical information to requesting insurance companies or government agencies to determine these benefits. I understand that regardless of insurance coverage, payment for services rendered is my responsibility and I agree to pay all expenses incurred in the collection of delinquent accounts, including interest of 1.5% per month, court costs and attorney's fees. Payment of charges for non-covered services, for patient co-payments, and by patients without insurance coverage from companies with which we participate is required at the time of visit unless alternative arrangements are made in advance.

Patient or Guarantor Signature _____ Date _____

Relationship to Patient _____

Notice of deemed consent to HIV or Hepatitis B or C testing

A law was enacted in Virginia which authorizes Health Care Providers to test their patients for HIV antibodies or Hepatitis B or C viruses when the Health Care Provider is exposed to the body fluids of a patient in a manner which may transmit Human Immunodeficiency Virus (HIV or Hepatitis B or C viruses.) Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to the release of the test results to the Health Care Provider who may have been exposed. However, you will be explained the test results and you will be given the opportunity to ask any questions you may have. The purpose of this is to inform you of the Virginia Law.
I have read the above and understand.

Patient or Guarantor Signature _____Date_____

Relationship to Patient_____

Authorization to Release Information

Today's Date:_____
Patient Name:_____
Patient's Address_____
_____
_____
Patient's Telephone:_____
Patient's Birth Date:_____
Patient's Social Security Number:_____

Type of information needed:_____
_____

Information being released to:
Name: Burkey & Hundt MDs
Address: 227 McLaws Circle
City, State, Zip: Williamsburg, VA 23185
Phone: 757 564 8182
Fax: 757 564 0077

Information being released from:
Name:_____
Address:_____
City, State, Zip: _____
Phone:_____
Fax:_____

The medical facility and staff is authorized to furnish this information. The medical facility and staff will be released and discharged from any liability and the undersigned will hold the medical facility and staff harmless for complying with this request to release medical information. I am authorizing release of medical records and other information regarding my treatment , hospitalization, and/or outpatient care, including psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, acquired immunodeficiency syndrome or tests for or infection with human immunodeficiency virus. There must be a warning to the effect that the information released pursuant to an authorization may no longer enjoy federal privacy protection. It must state the patient's rights including the right to revoke the authorization and the right to treatment even if the authorization is not signed.
I understand any paper copies of my records will be summarized in my electronic chart and then discarded. If I desire to keep these paper copies I must notify Burkey & Hundt MD's in advance.

Patient's signature:_____

Legal Guardian or Representative:_____

Relationship to Patient:_____

Patient Authorization for Release of Information to Other Persons

Patient Name:

Date of birth:

Many of our patients allow loved ones such as their spouse, certain other family members, friends/neighbors or other persons/corporations who are or may need to be involved in their health care. When your physician shares private health information (PHI), which includes your medical health records and billing information, it is protected by HIPAA Federal law. For some, but not all situations, HIPPA requires you to sign a release form.

If you wish to ensure your PHI can be released to certain persons, please complete and sign this form.

I authorize **Burkey & Hundt MD's** to release my medical and/or billing information without restrictions, including HIV and/or psychiatric treatment, to the following individual(s) or entities if requested verbally or in writing, or when deemed necessary by my physician:

1._____**Phone#**_____

Relation to Patient:_____

2._____ **Phone#**_____

Relation to Patient:_____

3._____ **Phone#**_____

Relation to Patient:_____

I understand I have the right to revoke this authorization at any time by a signed and dated letter delivered by hand or mail service. I have the right to inspect or copy the protected health information to be disclosed. This agreement lists additional persons who may receive my PHI, but does not replace the general Privacy Notice already given to you.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

Signature:

Printed Name:

Date:

Please sign only signature box on back page release. This will enable us to request urgent care and specialist notes in the future.

Authorization to Release Information

Today's Date:_____
Patient Name:_____
Patient's Address_____
_____
_____
Patient's Telephone:_____
Patient's Birth Date:_____
Patient's Social Security Number:_____

Type of information needed:_____
_____

Information being released to:
Name: Burkey & Hundt MDs
Address: 227 McLaws Circle
City, State, Zip: Williamsburg, VA 23185
Phone: 757 564 8182
Fax: 757 564 0077

Information being released from:
Name:_____
Address:_____
City, State, Zip: _____
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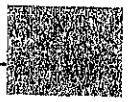
Fax:_____

The medical facility and staff is authorized to furnish this information. The medical facility and staff will be released and discharged from any liability and the undersigned will hold the medical facility and staff harmless for complying with this request to release medical information. I am authorizing release of medical records and other information regarding my treatment, hospitalization, and/or outpatient care, including psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, acquired immunodeficiency syndrome or tests for or infection with human immunodeficiency virus. There must be a warning to the effect that the information released pursuant to an authorization may no longer enjoy federal privacy protection. It must state the patient's rights including the right to revoke the authorization and the right to treatment even if the authorization is not signed.
I understand any paper copies of my records will be summarized in my electronic chart and then discarded. If I desire to keep these paper copies I must notify Burkey & Hundt MD's in advance.

Patient's signature:_____ 

Legal Guardian or Representative:_____

Relationship to Patient:

Burkey & Hundt MDs
227 McLaws Circle, Williamsburg, VA 23185 757-564-8182

Your Information, Your Rights, Our Responsibilities

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Read it carefully.

Your Rights

1. Your have a right to get an electronic or paper copy of your records. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a resonable, cost-based fee.
2. You can ask us to correct health information about you that you think is incorrect or incomplete. we may say, "no" to your request, but we will tell you why in writing within 60 days.
3. You can ask us to contact you in a specific way (for example home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
4. You can ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your healthcare insurer. We will say "yes" unless a law requires us to share the information.
5. You can ask for a list of the times we have shared your health information, who we shared it with and why, for six years prior to the date you ask. We will include all disclosures except those about treatment, payment and health care operations. We will provide one accounting a year for free but will charge a reasonable, cost-based fee if asked for another within 12 months.
6. You can ask for a paper copy of this notice at any time.
7. If you have given someone medical power-of-attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure that this person has this authority and can act for you before we take any action.

Your Choices

1. You can ask us to share information with your family, close friends or others involved with your care.
2. You can tell us to share your information in a disaster relief situation.

Our Uses and Disclosures

1. We will never share your infomation for marketing purposes.
2. We can share your health information with other health professionals who are treating you.
3. We can use and share your health information to run our practice, improve your care, and contact you when necessary.
4. We use and share your health information to bill and get payment from your health insurance plans.
5. We can share health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reportng suspected abuse, neglect or domestic violence; and preventing or reducing a serious threat to anyone's health or safety.
6. We will share health information about you if state or federal law requires it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.
7. We can share health information about you with organ procurement organizations if you are an organ donor.
8. We can share health information with a coroner, medical examiner, or funeral director when you die.
9. We can share health information about you for worker's compensation claims, for law enforcement purposes, with health oversight agences for activities authorized by law, for special government functions such as military and national security.

10. We can share health information about you in response to court or legal actions, administrative order or in response to a subpoena.

We are required by law to maintain the privacy and security of your health information. We will let you know promptly if a breach occurs that may have compromised the privacy and security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you can change your mind at any time. Let us know in writing if you change your mind.

If you feel that we have violated your rights you can complain by contacting the office at 227 McLaws Circle, Williamsburg, VA 23185 or phone:757-564-8182 or fax:757-564-0077. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, DC 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice

We can change the terms of this notice and the changes will apply to all information we have about you. The new notice will be available upon request and in our office.