THE BERRY CLINIC

UNDERSTANDING YOUR HIPAA PRIVACY RIGHTS

OUR PRIVACY POLICY

This document summarizes how your health information is used by The Berry Clinic. We are very committed to protecting the personal privacy of our patients. Privacy is a top priority, and we strictly adhere to federal and state guidelines that maintain the confidentiality of your health information. We have zero tolerance for any confidentiality breaches, and we will take disciplinary action against such breeches.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) sets a new national standard to protect health information. It protects information relating to your condition, treatment and payment and introduces new patient rights. Under HIPAA, you have the right to inspect, copy and request amendments to your health information. You also have the right to limit how we use and disclose your health information. All these rights are explained in our Notice of Privacy Practices, found in the patient information booklet located at the front desk. We strongly encourage you to request and read our Notice of Privacy Practices and ask questions if there is anything you do not understand. It is important that you understand how your health information may be used and what your privacy rights are.

Dr. Berry will ensure that our facility is HIPAA compliant and our staff is trained to protect you privacy. If you should ever have any questions or concerns about our privacy practices, please feel free to speak with Dr. Berry about this.

Your privacy and state of the art medicine are THE priorities of The Berry Clinic. We strive to protect your health information to the utmost of our ability and strictly adhere to federal and state guidelines to guarantee your privacy. We are committed to you and are providing this information to help answer any questions that you may have about your HIPAA privacy rights.

Each of our staff members has been trained to protect your privacy in accordance with federal and state laws. They care very much about your privacy and will work to assure that your health information remains as private as possible. If you should have any concerns, please let us know.

HOW YOUR HEALTH INFORMATION IS USED

As a healthcare provider, we may use and disclose your health information to physicians and others for treatment, payment and/or healthcare operations. Healthcare operations refers to those actions we take as a facility to guarantee you the highest quality of care. Any other uses or disclosures outside of treatment, payment or healthcare operations is strictly prohibited unless we receive written authorization from you.

We will work to limit all uses and disclosures of your health information to the absolute minimum necessary. Only that information which is needed will be disclosed, and we will remove as much identifying information as possible.

Our staff members will also make every attempt to assure that your health information remains as private as possible. Discussions relating to your health will be made in a confidential setting, and your medical records will be kept in an encrypted, password protected computer file.

Fon: 731-584-1430 Fax: 731-584-1439
108 Forrest Avenue – Camden, TN 38320

RELEASES THAT REQUIRE YOUR AUTHORIZATION

Your health information will not be shared outside of treatment, payment or healthcare operations unless we receive your written authorization. Should authorization ever be needed, you will be asked to complete an authorization form that describes what is to be disclosed and why.

A FEW INSTANCES WHEN WE MAY ASK YOU FOR AUTHORIZATION INCLUDE

- Disclosures to public and media
- Disclosures to clergy
- Disclosures to our patient directory

SPECIAL REQUESTS

You have the right to request access to your medical records at any time. If you see any information that is inaccurate, you have the right to request an amendment.
You may also request a restriction on how we use and disclose your health information. For instance, you may not want us to disclose information about your health to family members or members of the clergy.
You also have the right to receive confidential communications about your health. For example, you may prefer that we discuss medical matters with you only at work. Or, you may want to be contacted by mail or e-mail rather than by telephone.
You may also request an accounting of where your health information has been disclosed outside of treatment, payment or healthcare operations. This list will contain those disclosures made on or after October 6, 2003, our opening date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Dr. Berry at the address below, or with the Secretary of the Department of Health & Human Services. All complaints must be made in writing. If you choose to file a complaint, it will in no way impact the quality of care you receive.

YOUR FEEDBACK IS WELCOME

Privacy is part of our job and we take it very seriously. If you have any concerns, questions or general feedback, please let us know. Thank you.

--- THE BERRY CLINIC ---

CHILD HEALTH QUESTIONNAIRE (<10 y.o.)

Today's Date:__________ Child's Name:____
Last First MI

Age:_____ D.O.B.__________ SSN:________________ Child's Favorite Name:______________

List who lives in child's primary residence:____

Does the Child's Mother, Father or Brothers or Sisters have any of the following conditions?

- ☐ Diabetes
- ☐ Asthma
- ☐ Migraines
- ☐ Seizures
- ☐ Alcohol / Drug Abuse
- ☐ Heart Disease
- ☐ Bleeding Disorders
- ☐ Depression /Anxiety
- ☐ Developmental Disorders
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Birth Defects
- ☐ Allergies
- ☐ Childhood Death
- ☐ Other____________________

Does anyone smoke in the house or the family car?______________________________________

Pregnancy / Delivery History	**Yes**	**No**	**Explain**
• Was delivery Vaginal?	___	___	____________________
• Was pregnancy normal full-term?	___	___	____________________
• Mom-any problems during pregnancy?	___	___	____________________
• Child-any problems the first month?	___	___	____________________

- Birth Weight _____lbs_____ozs

Has this Child ever stayed overnight in the Hospital?______If yes, explain:____________________

____

Drug Allergies:__________________ Current Medications:________________________________

Are the child's shots Up To Date?_______ We will need a copy of your immunization card…

Does the Child have any of the following?

- ☐ Chest Pain
- ☐ Heart Murmurs
- ☐ Bone/Joint Problems
- ☐ Allergies
- ☐ Tooth Problems
- ☐ Gas/Bowel Problems
- ☐ Vision Problems
- ☐ Problems Breathing
- ☐ Feeding Problems
- ☐ Urinary Problems
- ☐ Skin Rashes
- ☐ Stomach Problems
- ☐ Wears Glasses
- ☐ Hearing Problems
- ☐ Frequent Ear Infections
- ☐ Headaches
- ☐ Sinus Problems
- ☐ Bed Wetting
- ☐ Anxiety / Depression
- ☐ School Problems
- ☐ Other____________________

Who filled out this form for the patient?____

Does this Child attend Daycare or School?____

What is your opinion of your child's General Health?_____________________________________

Do you think your child is Happy?____

THE BERRY CLINIC

PATIENT AND RESPONSIBLE PARTY INFORMATION

Patient's Name:____ Age:_______Gender:_____________
Last First M.I.

SS#:________________________Birthdate:_________________ Marital Status:_________________

Street Address:____

City:________________________ State:__________ZIP:__________ Telephone #:_________________

Work #:_________________ Cellular:________________ E-Mail:_______________________________

Employer Name/Address/Telephone:____

PRIMARY INSURANCE TO BE FILED

Insurance Company:____

Person's Name on Card:______________________________________Their Birthdate:______________
Last First M.I.

Street Address:____and Telephone #:_________________

SS#:___________________ Their Employer:____

Their Employer's Name/Address/Telephone:____

SECONDARY INSURANCE TO BE FILED

☐ Check if none

Insurance Company:____

Person's Name on Card:______________________________________Their Birthdate:______________
Last First M.I.

Street Address:____and Telephone #:_________________

SS#:___________________ Their Employer:____

Their Employer's Name/Address/Telephone:____

How did you hear about our Little Clinic?____

THE BERRY CLINIC

KEN D. BERRY, M.D.
108 NORTH FORREST AVENUE
CAMDEN, TN 38320
731-584-1430

Financial Policy, Assignment of Benefits and Permission for Treatment

Financial Policy

Your insurance contract is an agreement between you, your insurance company, and in many instances, your employer. All charges incurred by you at The Berry Clinic are your responsibility. Any disputes with the insurance company should be handled by you. You will be expected to pay your portion of the total charges at the time of service. If we do not participate with your insurance provider, you will be expected to pay all charges in full at the time of service. As a courtesy to you, we will file a claim with your insurance company "unassigned" so you will receive payment directly from your insurance company.

1. Payment is due when services are rendered. We accept cash, personal checks, and will soon accept most credit cards. There will be a $25.00 charge assessed for all checks returned by your bank not paid.
2. Payment plans on past due patient balances will be considered on a case by case basis and are at the sole discretion of Dr. Berry. This should be discussed with and approved by Dr. Berry. Payment plans may be approved if you can make monthly payments and pay off any outstanding balance in a timely fashion.
3. If you are insured with Medicare, Aetna, Blue Cross Blue Shield, Beech Street Network, ChoiceCare, Cigna, First Health, Health Partners, PHCS, Signature, United Healthcare or USA-MCO we will accept the co-payment or co-insurance, and file the insurance for you at no cost.
4. Concerning minor children, the person bringing the child in is responsible for the bill for that visit.
5. We consider an account delinquent if it has not been paid within 30 days. If we are unable to collect a bill owed by you, we will be forced to forward your account to the collection company of our choice after 90 days of no payment. Unfortunately, Patients and their immediate family members who are referred to a collection company are at risk of being formally discharged from our practice.

By signing below, I agree that I have read this information and understand it, and that I am financially responsible for all charges.

Assignment of Benefits

Non-Medicare Patient

I hereby assign to The Berry Clinic, any and all benefits from any insurance plans or any other protection maintained by the Patient and/or on the Patient's behalf or benefit and authorize and direct such benefits to be paid directly to Ken D. Berry, M.D. d/b/a The Berry Clinic for services provided to the Patient by The Berry Clinic. I certify that the information given by me to The Berry Clinic in applying for payment under my insurance plan or other protection is correct and complete. I authorize release of all records required to act on this release and assignment.

Medicare Patient

I request that payment of authorized Medicare benefits be made to me or on my behalf to The Berry Clinic for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. I certify that the information given by me to The Berry Clinic in applying for payment under the Medicare program is correct and complete. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

By signing below, I agree to be financially responsible for all charges. I have read this information and understand it.

I further agree that in the event my account is placed with a collection agency due to untimely payment, I will be responsible for all additional costs of collection charged by said agency.

I further agree that in the event my account is placed with an attorney for collection, I will be liable for reasonable attorney's fees and any court costs incurred in an attempt to settle my account.

Permission for Treatment

I hereby authorize The Berry Clinic through Dr. Berry, Dr. Butterworth and it's professional staff to treat me for conditions requiring their services. I understand that all procedures will be explained to me in the detail that I require to understand the risks and benefits and that I have the right to refuse any procedure and/or treatment at any time during my visit.

________________ ____

Date | Authorized **Signature** (Parent if Patient is a Minor)

____

Print Name as Signed Above