



Welcome to Julia Burrow, MD & Associates! We are glad you have chosen us as your provider. Dr. Burrow and her associates are dedicated to providing you the highest quality psychiatric and psychological care with meticulous attention to your comfort and privacy in an environment that fosters security and trust. We appreciate in advance the time you will spend in completing the documents below.

- ✓ This completed Patient Information sheet
- ✓ Signed Consent Authorization form
- ✓ Signed HIPAA E-mail consent form
- ✓ Copy of current insurance card
- ✓ Signed Billing & Insurance Information sheet

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### Patient Information

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Legal Name: \_\_\_\_\_ SSN# \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Preferred Name (if different): \_\_\_\_\_

Sex (assigned at birth):  Male  Female  Decline to State

My gender is:  Male  Female  Trans\*  Non-binary  Not Sure  Other \_\_\_\_\_

If patient is less than 18 years old, please complete the following:

Parent/Guardian Name: \_\_\_\_\_

Parents Married  Parents Divorced  Custodial Parent \*Custody Paperwork is required on file

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email Address: \_\_\_\_\_ May we leave a message? (Y) (N)

Home Phone: \_\_\_\_\_ May we leave a message? (Y) (N)

Cell Phone: \_\_\_\_\_ May we leave a message? (Y) (N)

Preferred method of communication: Text \_\_\_\_\_ Voice \_\_\_\_\_ Email \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Referral Source: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Preferred Pharmacy Name and Phone Number: \_\_\_\_\_

Who is responsible of paying the fees? Self: \_\_\_\_\_ Parent: \_\_\_\_\_ Other: \_\_\_\_\_

**PAYMENT AGREEMENT**

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As a client, I understand that I am financially responsible for professional services received by me or those for whom I am responsible. It is my intention to carry out my financial responsibly in the following manner:

\_\_\_\_\_ **Self-Pay:**

I will pay for all professional series at the time they are offered.

\_\_\_\_\_ **Insurance:**

I participate in a health insurance plan. I understand that Julia Burrow, MD & Associates will bill my in-network health insurance company directly for all professional services. I understand that my required co-payment will be paid at the time services are offered. I, hereby authorize and direct the below insurance carrier(s) to make checks or payments for medical expense incurred by me directly payable to my attending physician or his/her associated practice. I also authorize the release of any information regarding my medical condition or treatment to said insurance carrier(s) and to any third-party account collection or administrators as may be necessary for billing expenses not covered by my insurance. I understand and acknowledge that. If my primary insurance carrier has paid or rejected payment, I am responsible for the payment of the entire remaining balance. The In- Network secondary carrier (if any) may be billed one time by the physician or practice as a courtesy to me.

\_\_\_\_\_  
Signature of person responsible

\_\_\_\_\_  
Date

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**PATIENT INSURANCE INFORMATION**  
**Please present a copy of your current insurance card**

Primary Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Guarantor Information:**

Relationship to Patient: Self Spouse Child Other      Sex: Male Female

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Guarantor Information:**

Relationship to Patient: Self Spouse Child Other      Sex: Male Female

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

**CARD ON FILE**

**VERY IMPORTANT PLEASE READ**

- HIPAA stands for the *Health Insurance Portability and Accountability Act*
- HIPAA was passed by the U.S. government in 1996 to establish privacy and security protections for health information
- Information stored on our computers is encrypted
- Most popular email services (ex. Hotmail, Gmail, Yahoo) do not utilize encrypted email
- **When we send you an email or text, or you send us an email or text, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the internet. In addition, once the email or text is received by you, someone may be able to access your email account and read it.**
- Email and text are very popular and convenient way to communicate for a lot of people, so in their latest modifications to the HIPAA act, the federal government provided guidance on email and HIPAA
- The information is available in a pdf (page5634) on the U.S. Department of Health and Human Services website –<http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf>

The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email

**OPTION 1-ALLOW EMAIL AND TEXT MESSAGES**

I understand the risks of unencrypted email and do hereby give permission to Dr. Julia Burrow, MD & Associates to send me personal health information via unencrypted email

|  |             |                     |                      |
|--|-------------|---------------------|----------------------|
| <hr/>  | <hr/>       | <hr/>               | <hr/>                |
| <b>Signature</b><br>(parent or guardian if patient is a minor) | <b>Date</b> | <b>Printed name</b> | <b>Email address</b> |

**OPTION 2- DO NOT ALLOW EMAIL**

I do not wish to receive personal health information via email

|                  |             |                     |                      |
|------------------|-------------|---------------------|----------------------|
| <hr/>            | <hr/>       | <hr/>               | <hr/>                |
| <b>Signature</b> | <b>Date</b> | <b>Printed Name</b> | <b>Email Address</b> |

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## Acknowledgement

Please initial next to each acknowledgement then sign and date below.

\_\_\_\_\_ Acknowledgement of Receipt of Office Policies and Procedures

By signing this form, you are agreeing that you have received or reviewed a copy of our Office Policies and Procedures and agree to follow our policies as outlined in the document.

\_\_\_\_\_ Acknowledgement of Receipt of Privacy Notice

By signing this form, you are agreeing that you have received or reviewed a copy of the Privacy Notice for this office, which describes how we use and disclose your health information. You have the right to refuse to sign this acknowledgement, in which case we must document our good faith effort to obtain acknowledgement and the reason why it was not obtained.

\_\_\_\_\_ Acknowledgement that I authorized of Julia Burrow MD LLC & Associates to provide services to me/this minor. I am entering into treatment voluntarily and understand the limitations and risks of treatment.

\_\_\_\_\_ Acknowledgement of Financial Responsibility I understand that I am financially responsible for all charges including missed appointments and appointments cancelled without giving 24-hour notice.

I have read and understand these statements.

\_\_\_\_\_  
Signature of patient/guardian

\_\_\_\_\_  
Date

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## Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting the Office Manager. This authorization will remain in effect until cancelled.

PATIENT NAME: \_\_\_\_\_ Account # \_\_\_\_\_

| Credit Card Information                    |                                     |                               |   |
|--|-------------------------------------|-------------------------------|---|
| Card Type:                                 | <input type="checkbox"/> MasterCard | <input type="checkbox"/> VISA | <input type="checkbox"/> Discover <input type="checkbox"/> American Express |
| Cardholder Name (as shown on card) : _____ |                                     |                               |   |
| Card Number : _____                        |                                     | Expiration Date mm/yy) _____  |   |
| CVC ( 3 – Digit Code): _____               |                                     | Billing Zip Code: _____       |   |

I, \_\_\_\_\_, authorize Julia Burrow MD and Associates to charge

my credit card for the following: Insurance Copay/Deductible, Self-Pay Office Visit Fee and Balance Payment

I understand that my credit card information will be saved on file for future transaction on my account. Julia Burrow MD & Associates are not liable for **any** fees associated with credit card processing.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date