Welcome to Buffington Family Medicine. We are honored to be your medical home and we are committed to providing you the best medical care available. Our hope is that we form a partnership to keep you as healthy as possible.

We look forward to helping you achieve your healthcare goals. It is our hope that we can have a relationship in which the lines of communication are always open. Our goal is that this clinic is more patient friendly than any medical practice you have ever encountered.

Patient Information:

Name_______________________________________ Date of Birth________________________________

Cell Phone__________________________________ Email______________________________________

Street Address_______________________________ City and Zip_________________________________

How did you find us? ___________________________

Emergency Contact:

Name __________________________________ Relationship ____________ Phone__________________

Insurance Information:

Insurance Company ___________________________

Primary Card Holder __________________________ Relationship to Patient________________________

Responsible Party (if patient is a minor):

Name_____________________________ Date of Birth___________ Relationship to Patient____________

Phone_____________________________Address____

Pharmacies:

Local Pharmacy________________ Location________________________________ Phone_____________

Mail Order Pharmacy____ Phone_____________

Privacy:

Is there someone that you want to have access to your health information? If so, please list them below:

Name_____________________________ Relationship_____________ Phone_________________________

Name_____________________________ Relationship_____________ Phone_________________________

Name_____________________________ Relationship_____________ Phone_________________________

Have you experienced these symptoms today or yesterday?

Constitutional	Yes	No
Feeling tired		
Feeling weak		
Fever or chills		
Body aches		
Recent weight gain or loss		

Ear, Nose, Throat	Yes	No
Nasal congestion or drainage		
Sore throat		
Difficulty swallowing		
Earache		

Urinary	Yes	No
Pain during urination		
Increased/decreased urination		
Blood in urine		
Urinating more than 1 time at night		

Gastrointestinal	Yes	No
Decreased appetite		
Abdominal pain		
Nausea or Vomiting		
Diarrhea		
Constipation		
Heartburn		
Blood in stool		

Women Only	Yes	No
Unexplained vaginal bleeding		
Vaginal discharge		
Vaginal pain, itching or burning		

Skin and Musculoskeletal	Yes	No
Skin rash		
New or changing moles		
Neck or back pain		
Joint pain		

Chest	Yes	No
Cough		
Excessively loud snoring		
Shortness of breath		
Heart racing		
Heart skipping beats		
Chest pain or discomfort		

Endocrinology	Yes	No
Easy bruising		
Excessive sweating		
Sweating heavily at night		
Excessive thirst		
Temperature intolerance		

Neurologic and Eyes	Yes	No
Headache		
Dizziness		
Ringing in the ears		
Numbness or tingling		
Decrease in strength		
Red eyes		
Sleep disturbances		
Depression		
Anxiety		

Notice of Privacy Practices

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

Understanding Your Health Information

Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made in order to manage the care you receive. Buffington Family Medicine (BFM) understands the medical information that is recorded about you is personal. The confidentiality of your health information is also protected under both state and federal law.
This notice of Privacy Practice describes how BFM may use and disclose your information and the rights that you have regarding your health information.

Your Health Information Rights

Although your health information is the physical property of BFM, the information belongs to you, and you have certain rights over that information. You have the right to:

- Request, in writing, a restriction on certain uses and disclosures of your health information. However, agreement with the request is not required by law, such as when it is determined that compliance with the restriction cannot be guaranteed.
- Inspect or obtain a copy of your health record as provided by the law.
- Request, in writing, that your health record be amended as provided by the law, if you feel the health information we have about you is incorrect or incomplete. We may deny your request under certain circumstances.
- Request that we communicate with you about your health information in a specific way at a specific location. Reasonable requests will be accommodated.
- Obtain an accounting of disclosures of your health information as provided by law;
- Obtain a paper copy of this Notice of Privacy Practices on request.

You may exercise these rights by directing a request to the privacy contact listed on this notice.

Our Responsibilities

BFM has certain responsibilities regarding your health information, including the requirement to:

- Maintain privacy of your information.
- Provide you with this notice that describes BFM's legal duties and privacy practices regarding the information that we maintain about you.
- Abide by the terms of the Notice currently in effect.

BFM reserves the right to change these information privacy policies and practices and to make the changes applicable to any health information that we maintain. If changes are made, the revised Notice of Privacy Practices will be made available to each Buffington Family Medicine facility, posted on the Buffington Family Medicine website and will be supplied when requested.

Uses and Disclosures of Health Information Without Authorization

When you obtain services from BFM, certain uses and disclosures of your health information are necessary and permitted by law in order to treat you, to process payments for your treatment and to support the operations of the entity and other involved providers. The following categories describe ways that BFM uses or discloses your information, and some representative examples are provided in each category. All of the ways your health information is used or disclosed should fall within one of these categories.

Your health information will be used for treatment.
For example: Disclosure of medical information about you may be made to doctors, nurses, technicians and others who are involved in taking care of you at BFM. This information may be disclosed to other physicians who are treating you or other healthcare facilities involved in your care. Information may be shared with pharmacies, laboratories or radiology centers for the coordination of different treatments.

Your health information will be used for payment.
For example: Health information about you may be disclosed so that services provided to you may be billed to an insurance company or third party. Information may be provided to your health plan about treatment you are going to receive in order to obtain prior approval or to determine if your health plan will cover the treatment.

Your health information will be used for healthcare operations.
For example: The information in your health record may be used to evaluate and improve the quality of the care and services we provide.

Business Associates:
There are some services that we provide through contracts with third party business associates. Examples include external laboratories, transcription agencies and copy services. To protect your health information, BFM requires these business associates to appropriately protect your information.

Disclosures Requiring Verbal Agreement

Unless you give notice of an objection, and in accordance with your Authorization to Verbally Release Health Information, medical information may be released to a family member or other person who is involved in your medical care who helps pay for your care. Information about you may be disclosed to notify a family member, legally authorized representative or other person responsible for your care about your location and general condition. This may include disclosures of information about you to an organization assisting in a disaster relief effort, such as the American Red Cross, so that your family can be notified about your condition. You will be given an opportunity to agree or object to these disclosures except as due to your incapacity or in emergency circumstances.

Disclosures Required by Law or Otherwise Allowed Without Authorization or Notification

The following disclosures of health information may be made according to state and federal law without your written authorization or verbal agreement:

- When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or for law enforcement. Examples would be reporting gunshot wounds or child abuse or responding to court orders.
- For public health purposes, such as reporting information about births, deaths and various diseases, or disclosures to the FDA regarding an adverse effect related to food, medicine or devices.
- For health oversight activities, such as audits, inspections or licensure investigations.

- To organ procurement organizations for the purpose of tissue donation and transplant.
- For research purposes, when the research has been approved by an institutional review board has reviewed the research proposal and established guidelines to provide for the privacy of your health information.
- To coroners and funeral directors for the purpose of identification, the determination of the cause of death, or to perform their duties as authorized by law.
- To avoid a serious threat to health or safety of a person or the public.
- For specific government functions such as protection of the President of the United States;
- To military command authorities as required for members of the armed forces;
- To authorize federal officials for national security and intelligence activities as authorized by the law;
- To correctional institutions or law enforcement officials concerning the health information of inmates, as authorized by the law.
- Contacting you to provide appointment reminders for treatment or medical care as well as to recommend treatment alternatives, notifying you of health-related benefits and services that may be of interest to you.

Required Uses and Disclosures

Under the law we must make disclosures when required by the secretary of the Department of Health and Human Services to investigate or determine our compliance with federal privacy law.

Uses and Disclosures Requiring Authorization

Any other uses or disclosures of your health information not addressed in this Notice or otherwise required by law will be made only with your written authorization. You may revoke such authorization at any time.

Privacy

I authorize Buffington Family Medicine to communicate my health information to the person(s) that I listed above (under Privacy) for the following purposes: to discuss my health care, diagnosis, prognosis, and treatment plans. This authorization also applies to discussing billing and payment for medical services provided by Buffington Family Medicine.
I understand that this authorization applies to all healthcare providers and/or employees at Buffington Family Medicine. I understand that this authorization is voluntary. I understand that once this information is disclosed to Designated Person(s), it may be re-disclosed by them and may no longer be protected by state or federal privacy laws. I understand that this authorization will be effective for this office visit, unless revoked by me, and for one year following my death. I further understand that I may revoke this authorization at any time. If I revoke this authorization, it will not have any effect on any actions taken by Buffington Family Medicine prior to the processing of the revocation. I understand that my refusal to sign this authorization will not negatively affect my health care services at Buffington Family Medicine.

You have the right to file a complaint if you believe your privacy rights have been violated. This complaint may be addressed to the Privacy Contact listed in this Notice, or to the Secretary of the Department of Health and Human Services. There will be no retaliation for registering a complaint.

Privacy Contact - Address any questions about this Notice or how to exercise your privacy rights to the applicable Privacy Officer Cyndi Dronette

Effective Date - February 1, 2009
Phone: (817) 431-9199

On Time Policy

At Buffington Family Medicine we believe your time is as valuable as ours. In order to better serve you and to keep you from having to wait longer than what is absolutely necessary, we ask you to **please check in 15 minutes prior to your appointment. If you are more than 20 minutes late for your check in time you may be asked to reschedule.** This will allow us to keep everyone's appointments on time and keep you from having the long wait times that have become standard practice in most physician's offices. We will do our best, however, to accommodate everyone.

Cancellation and No Show Policy

Buffington Family Medicine requires a 24-hour notice to cancel or reschedule an appointment. If a 24-hour notice is not provided, your appointment will be considered a No-Show. After three (3) No-Shows, we will no longer be able to put you on our schedule.

Prescription Refill Policy

Prescription refills can take up to 48 to 72 business hours. We will do our best to accommodate your requests more quickly, however, especially in urgent situations.

Financial Policy

Payment for services is **always** due at the time services are rendered.

For scheduled appointments, prior balances **must** be paid in full prior to the visit. Appointments may be rescheduled if this is not possible. We will, however, work with you to make payment arrangements if necessary. It is your responsibility to provide us with the correct insurance information for filing claims. Inaccurate or untimely information given to the staff that results in denial or non-coverage by your insurance company will cause you to be responsible for payment. It is also your responsibility to understand your benefits and what is covered. While Dr. Buffington and his staff will do their best to help you understand your insurance and the benefits it provides, you are ultimately responsible for anything your insurance refuses to cover.

General Consent For Treatment:

Any balance outstanding longer than 90 days will be forwarded to our collection agency. We accept cash, checks, Visa, MasterCard, American Express and Discover cards. A $35 NSF fee will be charged for any checks returned for insufficient funds and you will be responsible for the remainder. On occasion the primary insurance will not pay without the secondary insurance also paying and, in those cases, you will be responsible for the entire amount.

Assignment of Benefits

I have requested medical services from Buffington Family Medicine for myself and/or my necessary dependent(s). I give permission to Buffington Family Medicine to examine and treat myself and/or my dependent, as they deem necessary.
I authorize Buffington Family Medicine to release any information necessary to my insurance carrier(s) to process medical claims. I assign all insurance benefits to be paid directly to Buffington Family Medicine. A photocopy of this assignment is to be considered as valid as the original.

I understand and agree to the policies above

Signature of patient, parent or legal guardian