Beacon Health Group, LLC

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.

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain law suits and law enforcement.

Appointment Reminders

Our organization may use and disclose your protected health information to remind you that you have an appointment.

Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.
- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.
- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fund raising communications.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Privacy Officer

Phone number: 317-559-7970

Fax number: 317-559-7971

Office for Civil Rights

http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

Beacon Health Group, LLC

Date: _____

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ☐ Male ☐ Female	MARITAL STATUS ☐ Single ☐ Married ☐ Other_____
PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)	EMPLOYER PHONE	

INSURED/RESPONSIBLE PARTY INFORMATION RELATION TO PATIENT: ☐spouse ☐parent ☐guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
SECONDARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

PRIMARY DOCTOR/FAMILY DOCTOR	REFFERING DOCTOR	
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):	

TURN THE PAGE OVER AND COMPLETE ALL ENTREES, PLEASE BE SURE TO LIST YOUR PREFERRED PHARMACY AT THE TOP ON PAGE 2

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)

**** Preferred Pharmacy:**

Allergies

❑ NONE/No Known Allergies ❑ Penicillin ❑ Dairy Products ❑ Aspirin ❑ Codeine

OTHER: (list allergies)

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING (Brother/Sister)
Anesthesia Problems			
Arthritis			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			
Drug/Alcohol addiction			
Explain family history:			

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____ ☐ Retired ☐ Disabled (reason _____)

☐**Yes** ☐**No -** Do you drink alcohol? ☐ Daily ☐Weekly _____ # of drinks per day/week? how long? _____

☐**Yes** ☐**No -** Do you use tobacco? ☐ Smoke (___ packs per day) ☐ Chew/dip how much? _____ how long? _____

*When you wake up in the morning how long does it take to start smoking?

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

- ❑ NONE of the problems listed
- ❑ allergies
- ❑ anemia (low blood count)
- ❑ arthritis conditions
- ❑ asthma
- ❑ arterial fibrillation
- ❑ bleeding problems
- ❑ CAD coronary artery disease
- ❑ cancer (type? _____)
- ❑ cardiac arrest
- ❑ celiac disease
- ❑ chest pain
- ❑ CHF congestive heart failure
- ❑ chronic fatigue syndrome
- ❑ depression
- ❑ diabetes
- ❑ drug/alcohol abuse
- ❑ erectile dysfunction
- ❑ fibromyalgia
- ❑ gastric reflux (Gerd)
- ❑ heart disease
- ❑ high cholesterol
- ❑ hypogonadism (low testosterone)
- ❑ high blood pressure
- ❑ hyperlipidemia
- ❑ hypertension
- ❑ hypothyroidism (low thyroid)
- ❑ infection problems
- ❑ insomnia
- ❑ irritable bowel syndrome
- ❑ kidney problems
- ❑ menopause
- ❑ migraines/headaches
- ❑ neuropathy
- ❑ nail fungus (onychomycosis)
- ❑ osteoporosis
- ❑ pulmonary embolism/blood clot in legs
- ❑ prostate enlargement
- ❑ seizure disorders
- ❑ shortness of breath
- ❑ sinus conditions
- ❑ stroke
- ❑ tremors
- ❑ wheat allergy
- ❑ food allergy
- ❑ other _____

Medications: List any medications you are currently taking (please include over the counter medications):

MEDICATION	DOSAGE	PERSCRIBING DOCTOR

Name: _____ **Today's Date:** _____

REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: _____

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Integ. (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

Medicare/Medicaid Acknowledgement
for
Peter D. Farr, MD

By signing this document, you acknowledge that Dr. Peter Farr has chosen NOT to participate in Medicare and Medicaid. Therefore, if you are enrolled in those programs and still choose to see Dr. Farr, **you** will be responsible for the payment for services provided. You understand that there are other offices that take your insurance, and you are choosing to be a self-pay patient in this office. You agree you will not submit a claim for services provided by Dr. Farr.

You also acknowledge that if you have an out of state Medicaid program, you will not submit a claim for services provided by Dr. Farr.

Patient Printed Name: _____

Patient Signature: _____

Date: _____

BEACON PC, LLC
7440 Shadeland Ave., Suite 200
Indianapolis, IN 46250

BEACON
HEALTH GROUP

Payment Policy

Thank you for choosing Beacon as your healthcare provider. Please read our payment policy and feel free to ask us any questions you may have, and sign in the space provided.

1. **Payment** in full is expected at each visit. If you are unable to pay **in full** at the time of the visit, your appointment will be rescheduled.
2. **Commercial Insurance**. We are considered "Out of Network" with commercial insurance companies. As a courtesy and at your request, we can provide a Superbill/Receipt for your visit which you may submit to your commercial insurance company for possible reimbursement, if you have "Out of Network" benefits. This does ***NOT*** apply to any Medicaid or Medicare Insurance.
3. **Nonpayment**. If your account is past due, you will receive a notice stating that you have 90 days to pay your account in full. During that 90 days, you will be required to pay in full for scheduled office visits. If you are unable to pay in full for the visit, we will reschedule your appointment. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you may be discharged from this practice. If this is to occur, you will be notified that you have 30 days to find alternative medical care. During that 30-day period, our provider will only be able to treat you on an emergency basis.
4. **Missed appointments**. Our policy is to charge $50.00 for missed appointments in which we have not received 24-hour notice.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of Patient or Responsible Party Date

_____

Printed Name of Patient or Responsible Party Date

7440 N Shadeland Ave., Suite 200
Indianapolis, IN 46250
Phone: 317-559-7970
Fax: 317-559-7971

BEACON HEALTH GROUP

Information Regarding Email/Text

We want to be sure you understand there are risks if you email or text your personal health information. These risks are outlined below.

Risk of using email/texting

The transmission of client information by email and/or texting has several risks that patients should consider prior to the use of these forms of communication. These include, but are not limited to, the following:

a. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
c. Backup copies of emails and text may exist even after the sender and/or the recipient has deleted his or her copy.
d. Employers and on-line services have a right to inspect emails sent through their company systems.
e. Emails and texts can be intercepted, altered, forwarded, or used without authorization or detection.
f. Email and texts can be used as evidence in court.
g. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

If you choose to email or text the office or your healthcare provider outside of our patient portal, you understand that you are accepting the risks discussed above.

☐ **I consent to communicating through email or text.**

☐ **I do NOT consent to communicating through email or text.**

Date: _____

Patient Printed Name: _____

Patient Signature: _____

7440 N Shadeland Ave., Suite 200
Indianapolis, IN 46250
Phone: 317-559-7970
Fax: 317-559-7971

Beacon Health Group, LLC

RELEASE OF MEDICAL INFORMATION

PLEASE PRINT YOUR NAME: _____

BY SIGNING BELOW, I AUTHORIZE BEACON HEALTH GROUP, LLC TO RELEASE MY MEDICAL AND BILLING INFORMATION TO:

RELATIONSHIP			NAME OF DESIGNATED PERSON
SPOUSE	☐ YES	☐ NO	_____
CHILDREN	☐ YES	☐ NO	_____
IN-LAWS	☐ YES	☐ NO	_____
CAREGIVERS	☐ YES	☐ NO	_____
PARENTS	☐ YES	☐ NO	_____

OTHERS _____

PATIENT SIGNATURE _____ DATE _____

PARENT SIGNATURE _____ DATE _____

We ask that if you have any change in this request, that you please inform the receptionist.

BEACON HEALTH GROUP, LLC MAY LEAVE APPOINTMENT INFORMATION ON MY VOICEMAIL:

HOME	☐ YES	☐ NO
CELL	☐ YES	☐ NO
RELATIVE	☐ YES	☐ NO

PATIENT SIGNATURE _____

I AUTHORIZE THE FOLLOWING TO PICK UP PRESCRIPTIONS, X-RAYS, ETC.

RELATIONSHIP			
SPOUSE	☐ YES	☐ NO	_____
RELATIVE	☐ YES	☐ NO	_____
CAREGIVER	☐ YES	☐ NO	_____

PATIENT SIGNATURE _____ DATE _____

I UNDERSTAND THAT BEACON HEALTH GROUP,LLC WILL ASK FOR IDENTIFICATION OF THE PERSON PICKING UP PATIENT MEDICAL INFORMATION OR PRODUCTS.

NAME: _____ DATE: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
⑤	⑤	⑤	⑤

Name:_____ Date: _____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.