David J. Stansfield, D.O., L.L.C.

Policies and Procedures

We are committed to providing quality medical care to our patients. In order to become familiar with the policies and procedures of our office, please read the following information.

Confidentiality of Records: All patient records are confidential. Reports will be released only upon your request with written consent. You must sign a release of information form if we must send your records to another physician. Many insurance companies (HMO, PPO and POS) request reports in order to process payment for services. Your signature on file allows insurance companies the right to access your medical records.

Office Hours: Our normal office hours are Monday, Tuesday and Wednesday 8:30 a.m. to 4:30 p.m. and Friday 8:30 a.m. to 1:00 p.m. The doctor is not in the office on Thursday's, however our staff is available from 8:30a.m. to 3:00 p.m. We are typically closed from 12:00 to 1:00 p.m. daily for lunch.

Scheduling Policy: Patients will be scheduled in the first available time slot, however, urgent care patients will receive priority services. If you are unable to keep your scheduled appointment, please call our office as soon as possible. We do require 24 hours cancellation notice or your account will be subject to a late cancellation fee. In addition, we will imply a service fee for all no shows. Our schedule is very tight and it is frequently difficult to work-in patient's who are acutely ill and need an appointment. It is very frustrating as an office to have time to see a patient that is not utilized due to a patient not showing up or canceling too late for the appointment to be filled. We appreciate your cooperation and anticipate your understanding of this policy.

Prescription Refills: We will accept requests for prescription refills on maintenance medications only. It is not the practice of this office to phone in prescriptions for antibiotic medications. All written prescriptions require a minimum of 24 hours notice for refills and are usually available the next business day for pick-up. All other medications should be available at your pharmacy after 5:00 p.m. on the day of request.

Referrals: Many insurance programs require a referral authorization from the primary care physician to see a specialist. If this is true for your insurance plan, please allow 48 hours notice to our office for such referrals, otherwise you may have to endure a long delay at your scheduled appointment. Worse yet, you may not be able to be seen at your scheduled time or you may have to pay for the entire visit yourself. These delays can be avoided by simply notifying our office of your need for a referral at least 48 hours in advance.

Insurance: We accept most health insurance and will be glad to verify insurance coverage and submit your claims for you. Your insurance carrier will determine final reimbursement. This service is provided as a courtesy and does not provide guarantee of insurance payment. The patient or responsible party assumes complete responsibility for payment on their account. We do require you to present your insurance card at each office visit.

Payment Policy: Monthly statements will be mailed to you after insurance has processed your claims. Payments must be made on any balance due. If there is no activity on your balance due for a period of 30 days you must call our office to make payment arrangements. If you do not make payment arrangements and keep regular scheduled monthly payments, your account will be subject to a service charge. In addition, after 90 days of non-payment activity, you will be subject to dismissal from the practice.

Non-Discrimination Policy Statement: It is the policy of our office to provide services to all persons without regard to race, color, national origin, religion, sex, age or disability. No person shall be excluded from participation in, or be denied the benefits of any service, or be subject to discrimination because of race, color, national origin, religion, sex, age or disability.

Complaint Procedure: If you believe you have been denied a benefit of service because of your race, color, national origin, religion, sex, age, or disability, you may file a Complaint of Discrimination with the Office or Business Manager, either verbally or in writing. If you choose to file your complaint in writing, please include your name, address, telephone number and a brief description of what occurred which led you to believe you were discriminated against. In this way the appropriate person may respond to your complaint. You may also file a Complaint of Discrimination by contacting either of the external agencies listed below:

Department of Social Services	Department of Health and Human Services
Office for Civil Rights	Office for Civil Rights
PO Box 1527	601 East 12th Street
Jefferson City, MO 65102	Kansas City, MO 64106
(573) 751-9092 or (800) 776-8014	(816) 426-7277

By signing this form I am stating that I have read, understand, and accept these policies.

Name: _____ Date: _____ Signature: _____

DAVID J. STANSFIELD, D.O., LLC

PATIENT INFORMATION

LAST NAME: _____ FIRST: _____ MIDDLE INITIAL: _____ NICKNAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____ - _____ CELL PHONE: (_____) _____ - _____ WORK PHONE: (_____) _____ - _____

E-MAIL ADDRESS: _____

DATE OF BIRTH: _____/_____/_____ SEX: □ F □ M SOCIAL SECURITY #: _____/_____/_____

MARITAL STATUS: □ SINGLE □ LEGALLY SEPARATED □ MARRIED (SPOUSE NAME _____)
□ DIVORCED □ WIDOWED □ PARTNER

EMPLOYMENT STATUS: □ FULL TIME □ NOT EMPLOYED □ RETIRED
□ PART TIME □ SELF EMPLOYED □ ACTIVE MILITARY

EMPLOYER: _____ ADDRESS: _____

STUDENT STATUS: □ FULL TIME □ PART TIME □ NOT A STUDENT

RACE: □ AMERICAN INDIAN □ ASIAN □ AFRICAN AMERICAN □ NATIVE HAWAIIAN □ WHITE □ HISPANIC
□ OTHER PACIFIC ISLANDER □ OTHER RACE □ REFUSE TO REPORT

ETHNICITY: □ HISPANIC □ NON HISPANIC □ REFUSE TO REPORT

GUARANTOR/RESPONSIBLE PARTY: □ SELF □ GUARANTOR RELATIONSHIP TO PATIENT: _____

NAME: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT:

LAST NAME: _____ FIRST: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____ - _____ WORK PHONE: (_____) _____ - _____ EXT: _____

LOCAL PHARMACY: _____

MAIL ORDER PHARMACY: _____

DO YOU HAVE AN ADVANCE DIRECTIVE: □ YES □ NO IF YES: □ LIVING WILL □ POWER OF ATTORNEY

I AUTHORIZE DR. DAVID STANSFIELD TO ACCESS MY EXTERNAL PRESCRIPTION HISTORY : □ YES □ NO

ASSIGNMENT/AUTHORIZATION

Assignment of Benefits: I hereby authorize direct payment of surgical/medical benefits to David J. Stansfield, D.O. for services rendered by him or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization to Release Information: I hereby authorize David J. Stansfield, D.O. to release any information acquired in the course of my examination or treatment to 1) my insurance company of record, 2) any physician who has participated in my health care, and 3) any physician to whom I may be subsequently referred.

Signature: _____ Date: _____

CONSENT OF PRIVACY PRACTICES FOR PURPOSES OF PROTECTED HEALTH INFORMATION
FOR USE, DISCLOSURE, TREATMENT, PAYMENT, AND/OR HEALTHCARE OPERATION

I, _____, consent to the use or disclosure of my Protected Health Information by David J. Stansfield, D.O., LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations by David J. Stansfield, D.O. LLC. I understand that diagnosis or treatment of me by my physician may be conditional upon my consent as evidenced by my signature on this document. The release of Protected Health Information with regard to my medical treatment may be sent by fax, telephone, mail or e-mail to other physicians, healthcare facilities or insurance companies.

I understand I have the right to request a restriction as to how my Protected Health Information is used or disclosed to carry out treatment, payment or healthcare operation of this practice. David J. Stansfield, D.O., LLC is not required to agree to the restrictions that I, the patient, may request if the restriction falls within the exceptions to confidentiality by law. However, if David J. Stansfield, D.O., LLC agrees to a restriction that I request, the restriction is binding on my treating physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that David J. Stansfield, D.O., LLC has taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health insurance plan, my employer or a health care clearinghouse. This relates to any past, present or future physical or mental health condition that may identify me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review and request a copy of David J. Stansfield, D.O., LLC's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information that will occur in my treatment, payment of my bills or in the performance of health care operations of David J. Stansfield, D.O., LLC. The Notice of Privacy Practices for David J. Stansfield, D.O., LLC is posted in the waiting room area. This Notice of Privacy Practices also describes my rights and David J. Stansfield, D.O., LLC's duties with respect to my Protected Health Information.

I have the right to request and be provided with a description of the procedures for exercising the following with respect to your Protected Health Information:

1. Inspecting and copying;
2. Amending or correcting; and
3. An accounting of the disclosures of such information by David J. Stansfield, D.O., LLC.

David J. Stansfield, D.O., LLC may change its policies and procedures relating to Protected Health Information at any time. Should the Protected Health Information policies change, a revised notice will be available at David J. Stansfield, D.O. LLC's office. If you believe that there has been a violation of your Privacy Rights, a complaint may be filed with David J. Stansfield, D.O., LLC, by contacting Tricia Green, Privacy Official, 10279 Business 21, Hillsboro, MO 63050 or at 636-789-3941. Further, a complaint may be filed with the U.S. Department of Health and Human Services.

□ I have read and received a copy of the Notice of Privacy Practices.

□ I have read and refuse to accept a copy of the Notice of Privacy Practices.

Signed this _____ day of _____, 20_____.

_____
Patient/Guardian Signature

Test results may be left on answering machine: Home: □ Yes □ No Work: □ Yes □ No

Name(s) and relationship of person(s) authorized by this form to use and disclose the patient's Protected Health Information; i.e.; spouse, child, parent.

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____