PATIENT INFORMATION

Name: _____
First Middle Last

Date of Birth_____ Social Security_____ Male____ Female____

Mailing Address_____
City State Zip Code

Home Phone_____ Mobile Phone_____ Alt Phone_____

Email Address_____ Pharmacy_____

Marital Status: Single Married Separated Divorced Widowed
(Please circle one)

Employer: _____ Phone_____ Occupation_____

BILLING INFORMATION

Guarantor (Person Responsible for paying bill) please circle:
Patient Parent Spouse Other

Name (if not patient)_____

Address (if different than above)_____

Phone _____

INSURANCE INFORMATION

PRIMARY INSURANCE

_____
Policy name Address Phone#

Subscriber ID_____ Group #_____

Subscriber Name_____ Subscriber DOB_____

SECONDARY INSURANCE

_____
Policy name Address Phone#

Subscriber ID_____ Group #_____

Subscriber Name_____ Subscriber DOB_____

IN CASE OF EMERGENCY

Name_____ Phone_____ Relationship_____

FINANCIAL POLICY

We strongly feel all patients deserve the very best care that we can provide. Everyone benefits when financial arrangements are agreed upon. We have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, not the insurance company. Payment for treatment is your responsibility, not the insurance company.

FINANCIAL AGREEMENTS

Initial

_____ I have no insurance coverage. I understand that I am responsible for payment of services rendered to myself or dependents at the time of service.

_____ I understand that if I fail to pay amounts owed, the clinic has the right to secure an outside collection agency and or attorney to collect unpaid debt and to report the unpaid debt to a credit reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency, including reasonable attorney's fees.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Initial

_____I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made for services rendered.

_____I understand I am responsible at the time of service for paying any required co-payment and deductible.

MEDICARE/MEDIGAP

For Medicare Patients only _____ Medicare Number

_____I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Finance Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 112813 of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information. Regulations pertaining to Medicare assignment of benefits also apply.

Medigap Authorization Statement _____
Policy Number

There will be a $25.00 charge on all returned checks

Patient/Parent/Guardian signature_____ Date_____

Printed name_____ relationship _____

I will be paying by (please circle) Check Cash Credit/Debit card

BIG BEND REGIONAL HEALTH CENTER

Consent for Medical Treatment

I/ we voluntarily consent to medical treatment and diagnostic procedures provided by Big Bend Regional Health Center and its associated physicians, clinicians and other personnel.

I /we voluntarily request a physician, nurse practitioner, and other health care providers or designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.

I/we consent to lab testing including, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician.
I/we give consent to be given medication and/or procedural care while in the office if clinically advised.

I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

I understand that clinical photographs may be taken and used for medical purposes only as part of my medical record.

_____ Date_____

Signature of Patient / (Parent, Guardian or Legally Authorized Representative)

_____ Date_____

Signature of Witness

Patient Consent to E-Prescribe (Electronic Prescribing)

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see tis protected health information.

I have been provided the Electronic Prescribing Notice.

Parent, Patient's signature or Legal Representative				Date	Time
Relationship to Patient			interpreter, if Utilized	Date	Time
Witness Signature	Date	Time	if Telephone Consent, Second Witness Signature	Date	Time

Notice of Privacy Practices:

As required by the Health Insurance Portability and Accountability Act of 1196 (HIPAA), I acknowledge that I was provided a copy of the Facility's Notice of Privacy Practices.

Parent, Patient's signature or Legal Representative				Date	Time
Relationship to Patient			interpreter, if Utilized	Date	Time
Witness Signature	Date	Time	if Telephone Consent, Second Witness Signature	Date	Time

Patient Consent and Agreement:

- I consent to participation in the facility Patient Portal (Portal), and understand that my personal health and individually identifying information is made available to me in the Portal.
- I understand that the use of the Portal is for non-emergency purposes.
- I understand that I have the ability to provide Portal access to my Authorized Representatives (Representatives), and that those Representatives may have the ability to perform all of the functions I am able to perform, including viewing, downloading and transmitting my health and individually identifying information.
- I understand there are risks associated with web-based applications and that I am responsible for safeguarding my access information.
- I understand that my e-mail address is required to initiate Portal access, and will be used for communications related to the Portal. I agree to communicate my e-mail address changes.
- I have read and understand the Terms and Conditions of Use, and I have been provided with an opportunity to ask questions.
- I understand that my access to the Portal requires my acceptance of the Terms and Conditions of Use. If I refuse to sign at this time, I understand that I may change that decision in the future and can contact the Facility to obtain access to the Portal.
- I understand that failure to follow the Terms and Conditions of Use may result in termination of access to the Portal.

Patient Name	Email Address	
Patient Signature	Date	Time
☐ Patient Refused Access to the Portal		
Clinical Staff Signature (witness to refusal)	Date	Time

Patient Label

Patient History

Date: _____

Name: _____ Date of Birth: _____ Age: _____ SSN: _____

Past Medical Surgical History/Family Medical History

	Self	Family (relationship)		Self	Family (relationship)
High Blood Pressure			Learning Difficulties		
Heart Disease			Eye Problems		
High Cholesterol			Congenital Problems		
Heart Failure			Failure to Thrive		
Diabetes			ADD/ADHD		
Thyroid Problems			Heart Murmur		
Cancer			Asthma		
Anemia			Menstrual Problems (LMP)		
Bowel Disorders			Pregnancies (number)		
Migraines/Headaches			Gall Bladder Surgery		
Kidney Disease			Appendectomy		
Hepatitis (type)			Hernia Repair		
Liver Disease			Tonsillectomy		
Arthritis			Joint Surgery (type)		
Anxiety/Depression			Thyroid Surgery		
Blood Transfusion			C Sections (number)		
Epilepsy			Tubal Ligation		
Menopause (LMP)			Hysterectomy		
STDs			Cervical Procedures (type)		
Other:			Other:		
Other:			Other:		

Allergies _____

Immunizations (circle and indicate year, children include shot record)

Tetanus _____ Flu _____ Hep B _____ Hep A _____ Pneumonia _____ Meningitis _____ Pertussis _____

Habits: Tobacco (Amount & Years of Use) _____

Alcohol (Amount & Years of Use) _____

Have you ever had shakes or seizures when off of alcohol? _____

Drugs (type and route) _____

Exercise: _____

Living Situation: _____