MedFirst Primary Care
BHS PHYSICIANS NETWORK

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____ Marital Status: _____

Sex: _____ Date Of Birth: _____ SS#: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Street Address: _____ City: _____State: _____ Zip: _____

Patient Referred By:_____ Patient Primary Care Physician: _____

Email address: _____

Preferred Pharmacy: _____ Phone: _____

Preferred Laboratory: _____

Preferred Language: _____

Race:

☐ Arab ☐ Black or African American ☐ White ☐ Other ☐ Declined

Ethnicity:

☐Central America ☐Cuban ☐Dominican ☐Hispanic or Latin ☐Latin America/Latin ☐Not Hispanic or Latino
☐Puerto Rican ☐South American ☐Spaniard ☐Declined

Advance Directive: Do you have an advanced directive (living will/power of attorney)?____Yes ____ No; If yes, please provide a copy

How did you hear about us?

☐Physician ☐Internet Search ☐ Newspaper ☐Television ☐Hospital Partner ☐BHS Screening Bus
☐Baptist Community Event ☐Website ☐Insurance Company ☐Baptist Emergency Hospital ☐Friend/Family
☐Employer ☐Other _____

Guardian Information

Last Name: _____ First Name: _____ Middle Initial: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Employer Information

Employer Name:_____ Employer Phone: _____

Street Address:_____ City: _____ State _____ ZIP: _____

Insurance Information:

Plan Name: _____Claims Address_____City: _____ State: ____ Zip: _____

Phone: _____ Policy ID #: _____Group #: _____ Effective Date: _____

Relation to Policy Holder_____Policy Holder Name: _____

Injury and Workman's Compensation Information

Is Injury Related to: ☐Work ☐Auto Accident ☐ Other Date of Injury: _____

Work Comp Claim Number: _____ Claims Adjuster: _____ Claims Adjuster Phone: _____

NEW PATIENT HEALTH QUESTIONNAIRE

SURGICAL HISTORY

Surgery / Procedure	Year	Provider / Hospital

ALLERGIES

Drug/Allergen	Reaction	Onset Date

MEDICATIONS

Please list all medications or pills that you take, that you do not utilize your insurance to obtain or that are not prescribed by a physician. Please include all vitamins, herbal supplements, and/or over the counter medications.

Medicine or pill name	**Dose**	**Why do you take this?**

PAST MEDICAL HISTORY

Have you ever been told you had one of the following? Please check Yes if you have now, or have had in the past.

	Yes	No		Yes	No		Yes	No
Allergies	☐	☐	DM 1	☐	☐	Lung Disease	☐	☐
Anemia	☐	☐	DM2	☐	☐	Mental Illness	☐	☐
Anxiety	☐	☐	Diabetic Complications	☐	☐	Movement Disorder	☐	☐
Arthritis	☐	☐	Endocrine Disease	☐	☐	Nerve Disease	☐	☐
Asthma	☐	☐	Eye Problems	☐	☐	Osteopenia/Osteoporosis	☐	☐
Autoimmune Disease	☐	☐	Gastritis/Ulcer	☐	☐	Overweight/ Obesity	☐	☐
Back/ Neck Pain	☐	☐	GERD/ Acid Reflux	☐	☐	Pneumonia	☐	☐
Blood Disorder	☐	☐	Headaches/ Migraines	☐	☐	Prostate Disorder	☐	☐
Bowel Disease	☐	☐	Hearing Loss			Spine Disease	☐	☐
CAD	☐	☐	Heart Rhythm Disorder	☐	☐	Stroke/ TIA	☐	☐
CHF (Congestive Heart Failure)	☐	☐	Heart Disease	☐	☐	Thyroid Disease	☐	☐
Cancer	☐	☐	High Blood Pressure	☐	☐	Tuberculosis	☐	☐
Dementia	☐	☐	High Cholesterol	☐	☐	Urinary Problems	☐	☐
Developmental	☐	☐	Kidney Disease	☐	☐	Viral Disease	☐	☐
Depression	☐	☐	Liver Disease	☐	☐	Other: _____		

FAMILY HEALTH HISTORY

Relation		Age of Onset		Significant Health Problems
1. _____		_____		_____
2. _____		_____		_____
3. _____		_____		_____
4. _____		_____		_____
5. _____		_____		_____

Education:

☐ Less than 8th grade ☐ High School ☐ 2 Year College ☐ 4 Year College ☐ Post Graduate ☐ Other: _____

Tobacco:

Do you currently use tobacco? ☐ Yes ☐ No Did you use tobacco in the past? ☐ Yes ☐ No How long?: _____

☐ Cigarettes___/day ☐ Chew ___/day ☐ Cigars ___/day

Caffeine: ☐None ☐ Occasional ☐ Moderate ☐ Heavy # cups/cans per day _____

Drugs : Do you currently use recreational or street drugs? ☐ Yes ☐ No

Sexually Active ☐ Yes ☐ No Are you interested in being screened for STD's? ☐ Yes ☐ No

(WOMEN ONLY) - OBSTETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date: _____

Last Mammogram Date: _____

Date of last menstrual period or menopause: _____

Number of pregnancies: _____

FINANCIAL POLICY AND AUTHORIZATIONS

We are happy that you selected BHS Physicians Network for your healthcare needs and look forward to working with you. To help you understand your financial responsibilities in relation to your medical care, we would like to briefly outline our financial policies.

Patients are expected to provide identification and if insured, a current insurance card(s) at time of service. Patients are financially responsible for all services provided and are expected to pay for services at time of service, including any past due balance from a prior date of service. If the patient is a minor child, the parent or other adult accompanying the child will be financially responsible regardless of legal guardianship. Returned checks will be subject to fees.

Medicare: The office will bill the Medicare intermediary. Patients are responsible for the following: • Annual Medicare deductible • All applicable co-pays of the allowed charge • Any non-covered services • Any covered service ordered by the physician which does not meet Medicare's medical necessity and for which the beneficiary signed an Advanced Beneficiary Notice (ABN).

Medicare Supplemental and Secondary Insurances: The Practice will bill both Medicare and secondary insurances.

Medicaid: Patients must provide the Practice with a current Medicaid card at each visit. Medicaid patients are responsible for applicable co-pays and for all non-covered services. Medicaid patients are responsible for securing necessary referrals from their primary care physicians.

HMOs and PPOs, Commercial Insurance Plans: Patients are responsible for payment of the co-pay, co-insurance and/or deductible, or non-covered amounts at the time of service as well as for any charges for which the patient failed to secure prior authorization, if authorization is necessary. Insurance is filed as a courtesy and benefits are authorized to be paid directly to the Practice. Patients are responsible for the balance in full if not paid by the insurance within 30 days. If the patient is not prepared to pay the co-pay or deductible, a member of the clinical staff will determine if it is medically necessary for the patient to see the physician. If the patient's condition allows, the appointment will be rescheduled.

Self-Pay: Patients are responsible for payment in full at the time of services for all services rendered.

Worker's Compensation: Employer authorization must be obtained before treatment is rendered or the patient will be responsible for payment in full at the time of services for all services rendered. Once authorized, patients are not responsible for any charges unless the workers compensation case is dismissed or denied.

Personal Injury/Motor Vehicle Accidents and Other Third Party Liability: The patient is responsible for the balance in full at the time of service. Any settlement you receive from your insurance company or other third party will be handled by you, your insurance company, and/or your attorney.

Out of State Insurance: If the patient presents with an out of state HMO/PPO insurance card, we will need to verify the patient's benefits for out-of-state or out-of-network benefits. The patient may be required to make payment in full or pay any co-pay, co-insurance or deductible.

AUTHORIZATION AND CONSENTS

ASSIGNMENT AND RELEASE: I hereby assign my insurance or other third party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid for claims). I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

ELECTRONIC CHECK CONVERSION: When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account the same day.

CONSENT FOR TREATMENT: I hereby authorize the physicians, midlevel providers, nurses, medical assistants, and other Practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable. I authorize BHS Physicians Network to download medication history via the pharmacy benefit managers database.

NO SHOW POLICY: I understand if I fail to come for a scheduled appointment or cancel at least 24 hours prior to the appointment, I will be considered a "no show" and may be subject to a "no show" charge per occurrence. Ongoing occurrences of no shows may result in dismissal from the Practice.

I understand the Financial and No Show Policies, Authorizations and Consent for Treatment, and hereby agree to them:

Patient or Parent/Guardian if Minor:_____
Date of Birth_____ Date:_____

CONSENT TO CONTACT

A federal law was passed in 2014 and became effective on September 30, 2014, governing how we may contact you via telephone, text, and email. Listed below are some of the reasons we may need to contact you via telephone, text, or email:

- Appointment reminders
- Follow up with test results
- Reminder calls about annual preventive care due
- Email or fax with patient forms to complete prior to your appointment
- Notification of medication renewals
- Notification of surgery time and date
- Notification of prepayments for surgeries and procedures
- Follow up calls after surgeries or procedures Consent to Contact

By providing a telephone number, I expressly consent and authorize the physician practice, any practitioner or clinical provider as well as any of their related entities, agents, or contractors, including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with me and obtained through any source including, but not limited to, any number I am providing today, have provided previously or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number, I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with, me and obtained through any source including, but not limited to, any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical and educational information including exchange news, changes to health care law, health care coverage, care follow up, and other healthcare opportunities, goods and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C.§ 7701, et seq. By providing an email address, I represent I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a phone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or utilizing the opt–out method that will be identified in the applicable communication.

I have read and understand the above and consent to contact as described:

Patient Name: _____Date of Birth: _____

Signature: _____ Date: _____

***Minors or Users Requiring Caregivers – Acknowledgement of Consent to Contact**

Name: _____ Relationship to Patient: _____
Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A Notice of Privacy Practices (NPP) is provided to all patients and explains: (1) how your Protected Health Information (PHI) may be used or shared; (2) your rights to access or amend your PHI, request information on disclosures of your PHI, and request additional restrictions on our uses and disclosures of PHI; (3) your rights to complain if you believe your privacy rights have been violated; and (4) our responsibilities for maintaining the privacy of your PHI.

I acknowledge that I have read the foregoing and received a copy of the "Notice of Privacy Practices" (Version 3 August 2013 dated 09/23/2013) that explains when, where, and why my Protected Health Information (PHI) may be used or shared.

I authorize BHS Physicians Network to furnish complete information, including Protected Health Information, requested by my insurance carrier or its intermediaries regarding services rendered. I hereby authorize my insurance carrier to furnish to BHS Physicians Network any information obtained in the adjudication of any claim for services furnished to me by BHS Physicians Network.

I acknowledge that BHS Physicians Network, the physicians, the nurses, and other staff may obtain and share any or all of my Protected Health Information, including prescription history, with other health care professionals in order to treat me, coordinate my care, and/or in order to arrange for payment of my bill and respond to any issues related to my care.

I acknowledge that I have the right to request additional restrictions on the use and disclosure of my PHI if I so choose.

Printed Name of Patient: _____ Date of Birth:_____

Signature of Patient/Guardian: _____ Date: _____

Printed Name of Guardian: _____ Relationship to Patient: _____

FOR INTERNAL USE ONLY

Name of Employee: _____

Signature of Employee:_____

If applicable, reason patient's written acknowledgment could not be obtained:

- Patient was unable to sign.

• Patient refused to sign.
• Other: _____

PATIENT COMMUNICATION CONSENT

We may need to contact you regarding your medical care, appointments, test results, referrals, or any other reason. This is to acknowledge that you authorize BHS Physicians Network to contact you and how you wish to be contacted (check all that apply):

Preference	Order of Preference	Permission to Leave Voice Mail	Phone Number
Home Phone	1 / 2 / 3 / 4 / 5	Yes or No	_____
Cell Phone	1 / 2 / 3 / 4 / 5	Yes or No	_____
Work Phone	1 / 2 / 3 / 4 / 5	Yes or No	_____
Alternate Phone	1 / 2 / 3 / 4 / 5	Yes or No	_____
Patient Portal & Secure Email	1 / 2 / 3 / 4 / 5	Yes or No	Email Address_____

_____ None of the above

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize BHS Physicians Network to disclose your PHI to the following individuals (check all that apply):

Name: _____ Relationship to Patient:_____Telephone:(____)_____

Type Of Information	Permission to Contact via:
_____ Appointment Reminders	_____ Telephone
_____ Results (Lab Tests. X-Rays, etc)	_____ Leave a Voice Mail Message
_____ Financial	_____ Patient Portal & Secure Email
_____Other:_____	_____ Other:_____

Name: _____ Relationship to Patient:_____ Telephone:(____)_____

Type Of Information	Permission to Contact via:
_____ Appointment Reminders	_____ Telephone
_____ Results (Lab Tests. X-Rays, etc)	_____ Leave a Voice Mail Message
_____ Financial	_____ Patient Portal & Secure Email
_____Other:_____	_____ Other:_____

_____ None of the above

Patient Signature: _____ Date:_____