Welcome

Thank you for choosing Bella Family Healthcare & Aesthetics.
We look forward to helping you meet your healthcare needs.
To help us serve you more efficiently, please fill-out, read, sign, and date in the designated areas.

Patient Information

Patient Name *(Last, First Middle Initial)*	SSN *(Social Security Number)*	DOB *(Date of Birth)*

Race: ☐ White ☐Hispanic ☐African American ☐Native Hawaiian ☐Asian ☐Other _____	Marital Status ☐Married ☐Single ☐Divorced ☐Widow

Sex ☐M*(Male)* ☐F*(Female)* ☐Identify As: _____	Email	Home or Cell Phone

Street Address *(Mailing Address)*	City, State, Zip

When was your last physician visit? *(Date/Dates)*	Physician's Name	Was this an auto accident? ☐Yes ☐No	Work related accident? ☐Yes ☐No	Date of the accident?

Tell Us About Your illness / Injury / Pain	Attorney's Name

Whom may we call in case of emergency?	Relation to you?	Phone

Pharmacy Name and City/Street

Social History

Children or other family living at home	Dates of birth	Are there any issues at home?
1		
2		
3		
4		
5		
6		

Whom may we thank for referring you to our clinic?

☐ Attorney ☐ Billboard/Sign/Location ☐ Doctor ☐ Insurance Provider ☐ Newspaper ☐ Phone Book ☐ Radio

☐ Return Patient ☐ Television ☐ Website ☐ Family or Friend ☐ Other: _____

Insurance - Primary Subscriber

Responsible Party Name or Business Name	Relationship to Patient	Phone

Street Address *(Mailing Address)*	City, State, Zip

Insured Party's SSN *(Social Security Number)*	Insured Party's DOB *(Date of Birth)*	Other Information

Primary Subscriber Employer

Employer's Name	Employer's Phone

Employer's Address	City, State, Zip

Patient Employer

Employer's Name	Employer's Phone

Employer's Address	City, State, Zip

Benefit Assignment/Release of Information

I, undersigned, do hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third-party payers to Bella Family Healthcare, LLC. A photocopy of the assignment is to be considered as valid as the original. I, the undersigned, do hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient and/or Guardian Signature	Patient and/or Guardian Print Name	Today's Date

Financial Policy Statement

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered unless prior arrangements have been made. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full, from you. Any unpaid balance after the first 30 calendar days of treatment accrues 1.5% interest each month thereafter. If your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the remaining difference.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to Bella Family Healthcare, LLC.

The above does not apply for those patients that are treated under Worker's Compensation. However, be advised that if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand that if I am not currently covered by medical insurance, payment is due on the same day as service.

Patient and/or Guardian Signature	Patient and/or Guardian Print Name	Today's Date

Insurance Information

Primary Insurance		Mailing Address *(City, State, Zip)*			Phone
Group and/or Claim #		Member Id #		Adjuster/Case Manager	
Co-Pay or %	Deductible	Amount Met			Effective Date
Secondary Insurance		Mailing Address *(City, State, Zip)*			Phone
Group and/or Claim #		Member Id #		Adjuster/Case Manager	
Co-Pay or %	Deductible	Amount Met			Effective Date

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for Bella Family Healthcare, LLC to furnish medical care and treatment to _____ *(Patient's Name)* as considered necessary and proper in diagnosing or treating his/her physical and condition.

Patient and/or Guardian Signature	Patient and/or Guardian Print Name	Today's Date
Authorized Bella Family Healthcare Representative's Signature	Authorized Bella Family Healthcare Rep's Printed Name	Today's Date