Welcome to Bella Family Healthcare

To help us serve you more efficiently, please fill-out, read, sign, and date in the designated areas.

Patient Information

Patient Name ____ I prefer to be called: _____________________________
Last Name First Name MI

Address____ City________________________ State_______ Zip__________

Primary Phone# (_____) ______ - _____________ Cell Phone # (_____) _______ - ________________

Date of Birth _____ / ______/ ________ Age _______ Social Security #__________ - ________ - _____________ (not applicable for minors)

Email Address___________________________________ @ ______________________(used for patient portal)

DEMOGRAPHIC INFORMATION FOR PATIENTS

BIRTH SEX: ___ Male ___ Female Gender Identity: ___ Male ___ Female
RACE: ___ White ___ African American ___ Native American___ Asian ___ Other: _________________________
LANGUAGE ___ English ___ Spanish ___ Russian ___ Indian ___ Other: _______________________
RELATIONSHIP STATUS: ___ Minor ___ Single ___ Married ___ Divorced ___ Widowed ___ In a Partnership ___ Separated

School________________________________ Employer______________________________________ Work Phone: (_____) ________ - _______________

ADDITIONAL FAMILY MEMBERS THAT ATTEND HERE

Patient #2__________________________________ DOB ___ / ___ / ___
Patient #3__________________________________ DOB ___ / ___ / ___
Patient #4__________________________________ DOB ___ / ___ / ___
Patient #5__________________________________ DOB ___ / ___ / ___

PARENT / GUARDIAN INFORMATION FOR MINORS / PRIMARY INSURANCE HOLDER INFORMATION

Name ____ Relationship to Patient: _____________________________
Last Name First Name MI

Address____ City________________________ State_______ Zip__________

Primary Phone# (_____) ______ - _____________ Cell Phone # (_____) _______ - ________________ Work Phone # (_____) _______ - _______________

Sex: ___ Male ___ Female Date of Birth _____ / ______/ ________ Age _______ Social Security #__________ - ________ - _____________

Email Address___________________________________ @ ______________________(used for patient portal)

___ Single ___ Married ___ Divorced ___ Widowed ___ In a Partnership ___ Separated

Employer______________________________________ Work Phone: (_____) ________ - __________ Occupation_______________________________

EMERGENCY CONTACT

Name ____ Relationship to Patient: ___________________________________
Phone #1 (_____) ______ - _____________ Phone #2 (_____) ______ - _____________

*If you would like this party member to have authorization to obtain medical information on patient's behalf or bring them to appointments in your absence, then please include them in the Authorization for Release of Information.

FINANCIAL INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Subscriber Name and DOB ___________________________	Subscriber Name and DOB___________________________
Insurance Company___________________________	Insurance Company___________________________
Subscriber ID#___________________________	Subscriber ID#___________________________
Group # ___________________________	Group # ___________________________
I certify that I, and/or my dependent(s), have insurance coverage with the aforementioned Insurance Company and assign directly to Bella Family Healthcare & aesthetics all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Bella Family Healthcare & Aesthetics may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.	I certify that I, and/or my dependent(s), have insurance coverage with the aforementioned Insurance Company and assign directly to Bella Family Healthcare & Aesthetics all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Bella Family Healthcare & Aesthetics may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Authorization for Release of Information

Please list any person(s) you would like to have access to your medical records, speak with our staff regarding your treatment, make or change appointments, and otherwise act on your behalf. This permission can be revoked at any time.

Name:________________________________ Relationship: ________________________

Name:________________________________ Relationship: ________________________

Name:________________________________ Relationship: ________________________

Financial and Payment Policy

We are committed to the success of your medical treatment and care. Please understand that payment of you bill is part of this treatment and care. Payment is expected at the time of service. As a courtesy to you, we will bill your insurance. Please remember the insurance company's contract is with you. <u>You are responsible for making sure your visit is covered by your insurance plan</u>.

We accept payment by cash, credit card and/or checks. Returned checks will be assessed a $25.00 service charge.

We are contracted with Blue Cross/Blue Shield, Regence, Select Health, United Healthcare, Aetna and Cigna and accept many other insurance plans. Please contact your insurance company to verify that we are in network prior to your appointment.

Your financial responsibility depends on a variety of factors. Please remember you may be responsible for a co-pay as well as a deductible or coinsurance. Remember, all insurance plans require some financial obligation from you. We will make every attempt to keep you current on your obligation, both with statements and on arrival in the office. As a courtesy to you, we will bill your insurance carrier. If no payment is received within 60 days, we will look to you for full payment.

HIPAA Privacy Policy

Uses and Disclosures of Health Information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care you receive. Subject to certain requirements we may use or disclose this health information about you without your authorization for several reasons. Reasons may include public health issues, auditing, and emergencies. We also provide information when other wise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing and identifiable health information about you. Such information may be shared by paper mail, fax, or other methods. Please be aware that we may change our polices at any time. You will be notified of any changes and may request these changes in writing.

Individual Rights

In most cases, you have the right to look at, or get a copy of your health information that we use to make decisions concerning you. If you request copies, we require five working days after your request before this may be processed. Your first copy of your own records will be of no charge, any additional copies of your records will result in a $50.00 photocopy fee. If you are concerned that we have violated your privacy right, or you disagree with a decision we made about access to your records, you may contact us. You may also send a written complaint to the U.S. Department of Health and Human Services. A copy of our Notice of Privacy Practices is available upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide the notice about our information practices, follow the information practices that are described in this notice, and obtain your acknowledgement of receipt of this notice.

Idaho Health Data Exchange

Bella Family Healthcare & Aesthetics has chosen to participate in the Idaho Health Data Exchange (IHDE). If you do not want to participate in the IHDE and you do not want to have your health care information shared with other medical providers involved in your care, you can opt out of the participation. To opt out, you must complete and sign the IHDE “Request to Restrict Disclosure of Health Information” form and mail or fax it to IHDE. You will receive a letter of confirmation upon completion of your request. This will restrict your information from being released through the exchange only (you will need to contact direct any facility you wish to also restrict your information with). This is a secure statewide internet-based health information exchange, with the goal to improve the quality and coordination of health care in Idaho.

Your signature verifies that you have read, understand, and agree to the above financial payment and HIPAA privacy policies. You understand that charges not covered by your insurance company, as well as applicable co-payments and deductibles are your responsibility. You authorize your insurance benefits be paid directly to Bella Family Healthcare & Aesthetics. You authorize Bella Family Healthcare & Aesthetics to release pertinent medical information to your insurance company when requested, or to facilitate payment of a claim.

______________________________	______________________________	__________
Patient and/or Guardian Signature	Patient and/or Guardian Name (Please Print)	Today’s Date

If signing for a minor, what is your relationship to the patient? ______________________________