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 ____ Preferred Name ____________________
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 the patient portal)

Birth Sex _____ Male _____ Female Gender Identity _____ Male _____ Female

Race/Ethnicity (not required) _____ White _____ Black/African American _____ Native American _____ Asian

_____ Hispanic/Latino _____ Pacific Islander _____ Other ______________________

Preferred Language _____ English _____ Spanish _____ Russian _____ Indian ___ Other ________________

Relationship Status _____ Single _____ Married _____ Divorced _____ Widowed _____ In a Partnership _____ Separated

School ________________________ School Phone (______) _________ - _____________

Employer ____________________________ Work Phone (______) _________ - _____________

ADDITIONAL FAMILY MEMBERS THAT ATTEND HERE

Name ______________________________________

DOB _____ / _____ / _____ Relationship to you ____________

Name ______________________________________

DOB _____ / _____ / _____ Relationship to you ____________

Name ______________________________________

DOB _____ / _____ / _____ Relationship to you ____________

Name ______________________________________

DOB _____ / _____ / _____ Relationship to you ____________

PARENT / GUARDIAN INFORMATION FOR MINORS or 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 _____ / _____/ _______ Social Security # _________ - _______ - ___________

Email Address ____(used for patient portal)

Relationship Status _____ Single _____ Married _____ Divorced _____ Widowed _____ In a Partnership _____ Separated

Employer ____________________________ Work Phone (______) _________ - _____________

EMERGENCY CONTACT

Name ____ Relationship to Patient ______________________________

Phone # (_____) ______ - _____________

FINANCIAL INFORMATION

PRIMARY INSURANCE

Subscriber Name ____________________________________

DOB ____________ Relationship to patient _______________

Insurance Company___________________________________

Subscriber ID#_______________________________________

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 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 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.

SECONDARY INSURANCE

Subscriber Name ____________________________________

DOB ____________ Relationship to patient _______________

Insurance Company___________________________________

Subscriber ID#_______________________________________

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 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 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 to patient ______________________________

Name ____ Relationship to patient ______________________________

Name ____ Relationship to patient ______________________________

FINANCIAL AND PAYMENT POLICY

We are committed to the success of your medical treatment and care. Please understand that payment of your 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 and for any amount left by your insurance to your financial responsibility</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 multiple 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. Depending on your policy, you may be responsible for a co-pay as well as the deductible or coinsurance. Please note it is possible that your insurance may not cover portions of your treatment, including your annual wellness exams. Any services not covered by your insurance will be your responsibility We will make every attempt to inform you of your outstanding balance and keep you current on your obligation with monthly statements. Outstanding balances that are not resolved may be sent to collections.

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 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 authorizes your consent to be treated and 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 to be paid directly to Bella Family Healthcare. You authorize Bella Family Healthcare to release pertinent medical information to your insurance company when requested, or to facilitate payment of a claim.

____ ____

Signature | Printed Name

____ ____

Date | Relationship to the patient