Bellevue Family Practice, P.C.
HIPAA / Notice of Privacy Practices

Patient Name (print):_____ Date of Birth:_____

Address: _____ City: _____ Zip: _____

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of the HIPAA/Notice of Privacy Practices for **Bellevue Family Practice.** I have been given the opportunity to ask any questions I may have regarding the Notice of Privacy Practices for Bellevue Family Practice.

I wish to be contacted at the following numbers:

Home Phone: ( ) - .
- ☐ Ok to leave detailed message
- ☐ Leave call back number only

Cell Phone:( ) - .
- ☐ Ok to leave detailed message
- ☐ Leave call back number only

Business Name: **Business Phone**:( ) -
- ☐ Ok to contact me at this number
- ☐ Do not contact me at this number

Written Communication: (please circle one) YES NO

Email Communication: (please circle one) YES NO _____
Email Address

Bellevue Family Practice now offers a new patient portal.

Whom may we speak with regarding your health information:
(this includes but is not limited to: information regarding lab results, refills, medical instructions, etc)

ONLY INITIAL ONE:

_____ Initial here if you **DO NOT** want BFP to speak with anyone regarding your health information (except for as provided in the Bellevue Family Practice Notice of Privacy Policies.)

OR

_____ Initial here if BFP **IS ALLOWED** to speak with anyone regarding your health information. (Please fill out box below)

Name	Relationship	Phone Number

_____ _____
Signature of Patient or Parent/Legal Guardian Date

For Internal Use Only
Updated in Meditouch ☐

PATIENT INFORMATION

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Last Name:	**First Name:**	**M.I.:**
Street Address:		**Apt#:**
City:	**State:**	**Zip Code:**
Social Security #:	**DOB:**	☐ **Male** ☐ **Female**
Cell Phone:	**Home Phone:**	
Email:		
Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		

EMPLOYMENT INFORMATION

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Full-Time Student ☐ Part-Time Student ☐ Child ☐ Other		
Employer:	**Job Title/Occupation :**	
Phone:	**Ext:**	

RACE/ETHNICITY

Race:	**Ethnicity:**
☐Hispanic ☐Asian or Pacific Islander ☐White ☐ Black ☐American Indian or Alaska Native ☐Native Hawaiian or Other Pacific Islander	☐Hispanic or Latino ☐ Two or More Races ☐Caucasian ☐ American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander
☐ **Prefer not to answer**	

EMERGENCY CONTACT

Name:	Relation:
Home Phone:	Cell Phone:

PREFERRED PHARMACY

Name:	Address:

INSURANCE

Primary:		**Secondary:**	
Insurance Name:	Effective Date:	Insurance Name:	Effective Date:
Policy Holder's Full Name:	Policy Holder's DOB:	Policy Holder's Full Name:	Policy Holder's DOB:

Bellevue Family Practice, P.C.

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Tobacco	☐ Never	☐ Former	☐ Current	How Often?	How Long?	
Alcohol	☐ Never	☐ Former	☐ Current	How Often?	How Long?	
Drug Use	☐ Never	☐ Former	☐ Current	How Often?	How Long?	
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?				☐ Yes	☐ No
	Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

If adopted, please check this box ☐

WOMEN ONLY

Number of pregnancies	Number of live births	Number of Miscarriages?
Date of last Colonoscopy?		
Date of last Mammogram?		
Date of last Bone Density Scan (DEXA)?		
Date of last pap exam?		
Date of last eye exam?		

MEN ONLY

Date of last prostate exam (PSA lab)?
Date of last Colonoscopy?
Date of last eye exam?

Patient Name:_____ **Birth Date:**_____

FINANCIAL POLICY

The following is a statement of our *Financial Policy*, which we require you to read and sign prior to any treatment:

All patients must provide a copy of current insurance card/ photo ID before seeing a provider. This is to insure who we are providing care to and to help prevent insurance fraud. You are responsible for providing updated information as it occurs. Insurance companies have deadlines for filing claims. If the deadline is missed because we do not have updated information, you are responsible for the charges. If no insurance card(s) are provided at time of visit you will be considered a **self-pay**. Self-pay balances are due in full at time of service less a 20% discount. Our billing department is not able to obtain copies of your insurance cards. We have contracts with most commonly used insurance companies. It is your responsibility to check with your insurance company to make sure we are in network. If we do not accept your insurance, you will be treated as a self-pay patient (see above).

Insurance plans where we are a participating provider: All co-pays are due at the time of treatment. Any exceptions must be approved by management. Bills are sent on a monthly cycle and are due in full by the due date. If you are unable to pay the full amount, please contact our billing department when you receive your statement. Accounts that do not have approved payment arrangements may be turned over to an outside collection agency even if you have paid partial payments. Balances that are past due need to be paid prior to receiving new services and refills. Please be aware that some insurance companies, including Medicare, may determine treatment to be non-covered. If such a determination is made after they receive the claim, you will be responsible for the charges. You will be billed and payment is due by the due date of the statement. Some services may be allowed but may go to your deductible/co insurance as determined by your insurance company. We are unable to provide additional discounts other than what is contractual with your insurance company. Because of the number of different insurance companies/plans we are unable to know what your insurance will pay and what you may be responsible for. It is your responsibility to check your coverage with your own insurance company. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the above self-pay policy.

Workers Compensation claims: We will file these claims with your employer or your employer's Workers Compensation carrier. You will need to notify your employer of your injury prior to being seen. You will need to provide us with the information as to where your claims need to be sent. In regards to continuation of care or needed referrals, written or telephone authorization is required from your employer prior to treatment. If prior authorization is not obtained, you are responsible for full payment at the time of service. If your company's Workers Compensation carrier has not paid your account in full within 90 days, the balance will be transferred to you and it will then be your responsibility to pay in full by the statement due date.

Missed appointment: Unless canceled at least 24 hours in advance, you may be subject to a $25-$50 no-show fee at the physician's discretion.

Insufficient Fund Fee: Checks that are returned will be charged a $25 insufficient funds fee.

Collections: Unpaid balances may be turned over to collection agency. If your account is turned over for collections, you will be responsible for paying the collection agency not our office. Future appointment/refills will not be provided until the collection balance is paid in full. If your account is paid and then another balance is sent to collections, you will be dismissed from the practice.

PATIENTS OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the undersigned physician or supplier for services. I authorize Bellevue Family Practice P.C. to release any information acquired in the course of my examination or treatment for insurance and consultation purposes only. I understand that I am financially responsible for the amount of my bill which is not paid by insurance. If I have no insurance coverage, I am fully responsible at the time of service for the entire amount of the bill less a 20% discount. Thank you for understanding our *Financial Policy*. Please let us know if you have any questions or concerns.

I have read the *Financial Policy* and I understand and agree to its provisions.

_____ _____

Signature of patient or responsible party Date

If you wish to obtain a copy of the Financial Policy, Please ask the front desk