PATIENT DISCLOSURE PREFERENCES

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

I have read and understand the Hippa/ Notice of Privacy Policies for **Bellevue Family Practice**. I have been given the opportunity to ask any questions I may have regarding the Notice of Privacy Policies for Bellevue Family Practice.

I wish to be contacted in the following manner: (please circle all that apply)

Home Phone: _____

It is ok to leave a detailed message with medical information. YES NO
Leave a message with a call back number only. YES NO

Cell Phone: _____

It is ok to leave a detailed message with medical information. YES NO
Leave a message with a call back number only. YES NO

Business Phone: _____

It is ok to leave a detailed message with medical information. YES NO
Leave a message with a call back number only. YES NO

Written Communication: (please circle one) YES NO

Who are we allowed to speak to about your health information: (this includes but is not limited to, information regarding lab results, refills, medical instructions, etc.)

Name	Relationship	Phone Number

_____**Do NOT speak with anyone regarding my health information (except for as provided in the Bellevue Family Practice Notice of Privacy Policies.)**

Signature_____ Date_____

PATIENT INFORMATION

FULL NAME (LAST, FIRST, MIDDLE)_____ DATE OF BIRTH_____

CURRENT ADDRESS_____ YEARS THERE_____

CITY_____ STATE_____ ZIP_____

HOME PHONE_____ CELL PHONE_____

SOCIAL SECURITY NO._____ REFERRED BY_____

PRESENT EMPLOYER_____ TITLE_____

WORK PHONE_____ x_____ ADDRESS_____

EMERGENCY CONTACT_____ PHONE_____

a copy of your insurance card will be needed at the front desk

POLICYHOLDER INFORMATION

FULL NAME (LAST, FIRST, MIDDLE)_____ DATE OF BIRTH_____

CURRENT ADDRESS_____ YEARS THERE_____

CITY_____ STATE_____ ZIP_____

HOME PHONE_____ CELL PHONE_____

SOCIAL SECURITY NO._____

PRESENT EMPLOYER_____ TITLE_____

WORK PHONE_____ x_____ ADDRESS_____

EMERGENCY CONTACT_____ PHONE_____

PATIENT'S 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.

SIGNED (GUARDIAN IF MINOR) _____ DATE_____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services.

SIGNED (GUARDIAN IF MINOR) _____ DATE_____

AUTHORIZATION TO RELEASE INFORMATION I hereby 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.

SIGNED (GUARDIAN IF MINOR) _____ DATE_____

FINANCIALLY RESPONSIBLE I understand that I am financially responsible for the amount of my bill which is not paid by my insurance. If I have no insurance coverage I am fully responsible at the time of service for the entire amount of the bill.

SIGNED (GUARDIAN IF MINOR) _____ DATE_____