DRUG ALLERGIES

CHART NUMBER

BLACK RIVER HEALTH SERVICES, INC

Patient Information

Name _____ Date of Birth _____ Sex: ☐ M ☐ F
FIRST MI LAST

Marital Status : ☐ S ☐ M ☐ W ☐ D ☐ SEP SS# _____ Living Will? ☐ Yes ☐ No

Mailing Address_____City _____ State ____ Zip _____

Physical Address_____City _____ State ____ Zip _____

County _____ Phone (Home/Cell) _____ Phone (Alt.) _____

Occupation/Employer _____

Spouse's Name _____ Date of Birth _____ Phone _____

Emergency Contact (Other than spouse) _____Phone _____

Email Address _____

HITECH Act

Race : ☐ Asian ☐ Black ☐ White ☐ Native American ☐ Hispanic ☐ Other ☐ More than one

Ethnicity : ☐ Hispanic ☐ Non-Hispanic ☐ All Other

Language : ☐ English ☐ Spanish ☐ Other _____

Smoking Status : ☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoked

Mothers maiden name (pediatric patients only) : _____

Collection of this information is a requirement of the "Health Information Technology for Economic and Clinical Health Act" or the "HITECH Act" through use of Certified Electronic Health Records.

If Under 18 years of age:

Mother's Name _____ Father's Name _____

Social Security Number _____ Social Security Number _____

Phone _____ Phone _____

Address _____ Address _____

City/State/Zip_____ City/State/Zip _____

Insurance & Billing

Insurance Company _____ Secondary Insurance _____

Subscriber Name_____ Subscriber Name_____

Date of Birth _____ Date of Birth _____

Subscriber ID # _____Group#_____ Subscriber ID#_____Group#_____

BLACK RIVER HEALTH SERVICES, INC.

Insurance/Medicare/Medicaid Assignment of Benefits & Information Release

I hereby authorize direct payment of surgical/medical benefits to Black River Health Services, Inc. for services rendered. I understand that I am financially responsible for any balance no covered by my insurance.

I request payment of authorized Medicare/Medicaid benefits on my behalf for any services furnished me by Black River Health Services, Inc. I authorize any holder of medical and other information about me to release to Medicare/Medicaid and its agents any information needed to determine these benefits for related services.

I authorize Black River Health Services, Inc. to release or receive any medical or incidental information about me that may be necessary for either medical care or processing of insurance claims.

Initial _____

Parental Consent for Minors Younger than 18 Years

I hereby grant permission for my child to be evaluated by the provider and receive appropriate treatment including sutures and medications as deemed necessary (in my absence).

Initial _____

Payment/Collection Policies

1. Full payment for services is expected at the time of the visit unless insurance will cover the charges for the day.
2. If the service is covered by insurance, the deductible and co-insurance payment is expected at the time of the visit. If an insurance payment is not received 90 days after insurance is filed, the patient will be held responsible for the charges.
3. Patients with insurance are responsible for paying for those services not covered by insurance.
4. If we contract with your insurer, the practice will file claims on behalf of the patient.
5. Patients are given the option of paying for services in cash, by check or by credit card.
6. There will be a $25.00 fee for processing non-sufficient fund (NSF) checks. Additional checks will not be accepted until the NSF check and related fees have been paid.
7. All Patients with outstanding balances will be billed monthly. Payment of the portion of the bill for which the patient is responsible is due upon receipt of the patient statement.
8. Patients who have difficulty paying off their account in full upon receipt of the billing statement must contact the practice to make payment arrangements. The practice has special payment provisions for persons who need health care but who are without means of paying for services. However, those persons must qualify for assistance by means of an approved application.
9. Patients who make no effort to pay off their outstanding balances on a timely basis and who do not contact the practice to make payment arrangements will be subject to a progressive collection system.
10. After three billing cycles, patients who do not make an attempt to clear their accounts or make payment arrangements will be subject to a collection agency and, ultimately, denied services from the practice.

If you are having trouble reading or understanding these policies,
please ask the receptionist for assistance.

_____ _____

Patient or Authorized Signature **Date**