St Bernards HEALTHCARE
The Heart of Great Medicine

PLEASE BRING YOUR INSURANCE CARDS TO ALL APPOINTMENTS

Patient Name: _____ Sex: M F

Mailing Address: _____ City _____ State _____ Zip _____

Home Phone # (____)_____ Work # (____)_____ Cell # (____)_____

Date of Birth _____/_____/_____ Age _____ Social Security # _____

Marital Status: Single _____ Married _____ Widowed _____ Divorced _____ Other _____

Ethnicity: Hispanic or Latino _____ Not-Hispanic or Latino _____ Decline _____

Race: American Indian or Alaskan Native _____ Asian _____ Black / African American _____
Native Hawaiian or Pacific Islander _____ White _____ Decline _____

Preferred Language: _____

Preferred Method of contact: Phone _____ E-Mail _____ Mail _____

Patient's E-mail address _____

Do you approve of healthcare providers sending appointment reminders, lab results, etc. to this e-mail address?
YES _____ NO _____

Preferred Pharmacy _____

PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST

Primary Insurance Coverage with: _____ Policy Holder _____
Policy # _____ Policy Holder DOB: _____

Secondary Insurance Coverage with: _____ Policy Holder _____
Policy # _____ Policy Holder DOB: _____

Patient's Employer (if not applicable, insert "n/a") _____

Spouse or Parent's Name _____ Date of Birth _____/_____/_____

Spouse / Parent's Employer _____ Social Security # _____

Nearest Relative / Friend NOT living with you _____ Phone # (____)_____

Were you referred to our practice by other / physician? YES _____ NO _____

If so, who? _____

ASSIGNMENT OF BENEFITS

I request payments by Medicare, Medicaid, medical insurance companies and other third party payers be made payable to my healthcare providers. I authorize my physicians and healthcare providers to release my Protected Health Information (PHI) to the Healthcare Financing Administration, insurance companies, and other providers of medical services as may be necessary to provide for clinical care and/or to determine my financial benefits or coverages, in compliance with HIPAA and other applicable laws. I hereby acknowledge I have received a Notice of Privacy Practices. I understand and agree I am responsible for any charges not paid for by my insurance.

Name of Patient or Legal Guardian (Please Print): _____

Signature of Patient or Legal Guardian: _____ Date: _____

St. Bernards HEALTHCARE
The Heart of Great Medicine

PATIENT HISTORY FORM

ALLERGIES:
(Are you allergic to any of the following drugs?)

	YES	NO
Penicillin	( )	( )
Sulfa	( )	( )

Other Allergies: (Please List)

_____

_____

Please list all medications you take including over – the – counter & herbal:

_____

_____

_____

_____

In order that we may know more about your medical history, please check yes or no if you have or had any of the following:

MEDICAL:

	YES	NO
Measles	( )	( )
Mumps	( )	( )
Chicken Pox	( )	( )
Whooping Cough	( )	( )
Rheumatic Fever	( )	( )
Diphtheria	( )	( )
Typhoid Fever	( )	( )
Malaria	( )	( )
Pleurisy	( )	( )
Pneumonia	( )	( )
Gallstones	( )	( )
Kidney Stones	( )	( )
Diabetes	( )	( )
Heart Attack	( )	( )
Heart Disease	( )	( )
Epilepsy	( )	( )
Arthritis	( )	( )
High Blood Pressure	( )	( )
Strokes or Paralysis	( )	( )
Ulcers	( )	( )
Cancer	( )	( )

** What kind of cancer? _____

Have any of your blood relative ever had any of the following:

	YES	NO	Relative
Diabetes	( )	( )	_____
Cancer	( )	( )	_____

** What kind of cancer? _____

Tuberculosis	( )	( )	_____
High Blood Pressure	( )	( )	_____
Arthritis	( )	( )	_____
Kidney Disease	( )	( )	_____
Epilepsy	( )	( )	_____
Heart Disease	( )	( )	_____
Heart Attacks	( )	( )	_____
Lung Disease	( )	( )	_____
Strokes	( )	( )	_____
Blood Diseases	( )	( )	_____
Thyroid Diseases	( )	( )	_____

PREVIOUS HOSPITALIZATION OR SURGERY

If you have had a previous hospitalization or surgery, please list the name of the hospital, the year you were admitted and why.

_____

_____

_____

_____

_____

OBGYN (Females only)

No. of Pregnancies _____

Miscarriages _____

Living Births _____

Premature Births _____

Did any child weight over 9 lbs?

Yes _____ No _____

DAILY HABITS:

(Quantity)

Water _____ Per Day

Coffee _____ Per Day

Juices _____ Per Day

Milk _____ Per Day

Soft Drinks _____ Per Day

Alcohol _____ Per Day

Tea _____ Per Day

Sleep _____ Sleep Well? _____

Tobacco _____ How long? _____

Special Diet? Yes _____ No _____

If so, what type of diet?

_____

_____

_____

FAMILY HISTORY

PARENTS

Name	Living / Deceased	State of Health

SIBLINGS

Name	Living / Deceased	State of Health

CHILDREN

Name	Living / Deceased	State of Health

Patient Name: _____

Patient Signature: _____ Date : _____

St. Bernards HEALTHCARE
The Heart of Great Medicine

THIRD PARTY ACCESS FORM

Patient Name _____ Date of Birth ____/____/____

Patient Address _____

Chart # _____ Social Security # _____

I AUTHORIZE THE RELEASE OF MY PROTECTED HEALTH INFORMATION (PHI) TO THE FOLLOWING:

SPOUSE: Name: _____ Phone # _____

CHILDREN: Name: _____ Phone # _____

CHILDREN: Name: _____ Phone # _____

FAMILY MEMBER: Name: _____ Phone # _____

EMPLOYER: Name: _____ Phone # _____

If any of these individuals contact us, they will be asked to provide your social security number. Please make sure they know this information. Anyone who is not named above or who cannot provide your social security number will be denied access to your Protected Health Information.

* I understand information disclosed pursuant to this authorization may be re-disclosed to additional parties and is no longer protected.
* I understand I may revoke this authorization at any time by signing the revocation section of this form and returning it to the address above. I further understand any such revocation dose not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.
* I understand I am under no obligation to sign this authorization. I further understand my ability to obtain treatment will not depend in any way on whether or not I sigh this authorization.
* I understand I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.
* I understand the clinic named above will not receive compensation for the uses and disclosures I have authorized.

Note: After the initial completion of this form, any additions or deletions must be given to the healthcare provider in writing.

Name (Please Print): _____

Signature: _____ Date: _____

****

REVOCATION SECTION

I hereby revoke this authorization: _____ _____
Signature Date

Revocation received by the clinic: _____ _____
Signature Date

St. Bernards HEALTHCARE
The Heart of Great Medicine

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of the clinic's Notice of Privacy Practices.
(Patient Name – Please Print)

_____ _____
Signature of Patient or Legal Guardian Date

If not signed by the patient, please indicate relationship:

( ) Parent or guardian of minor patient
( ) Guardian or conservator of an incompetent patient
( ) Beneficiary or personal representative of deceased patient

I would like to receive a copy of any amended Notice of Privacy Practices. Yes No (Please Circle)

****

For Office Use Only:

( ) Signed form received by: _____

( ) Acknowledgment refused:

Efforts to obtain:

_____

_____

Reason for refusal:

_____

_____

Patients Date of Birth: _____ / _____ / _____

Patient's chart Number: _____

St. Bernards HEALTHCARE
The Heart of Great Medicine

Payment Policy

Thank you for choosing First Care. We are committed to providing you with high quality, convenient, and affordable health care. We have developed this policy to answer our patients' questions regarding patient and insurance payment responsibilities for services rendered. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a health insurance plan that will pay us directly, payment in full is expected at the time of each visit. We accept personal checks, cash, Master Card, Visa, and Discover. If you are insured by a plan that will pay us directly, but you don't have an up-to-date insurance card, payment in full for each visit is required until we may verify your coverage.

2. Co-payments, deductibles and non-covered medical services. All co-payment, deductibles and non-covered medical services must be paid for at the time of service. Your agreement to pay these expenses is a part of your contract with your insurance company. Failure on our part to collect these co-payments and deductibles would be a violation of our contract with your insurance company (and may be considered fraud). Please help us to both comply with our contracts and the law by paying your portion of these expenses at the time of each visit.

3. Non-covered services. We would like to take this opportunity to remind you that some of the medical services you receive may not be paid for by your insurance company or Medicare. Please plan to pay for these services when they are provided.

4. Proof of insurance. All patients are asked to complete our patient information form before seeing the doctor. We must obtain a copy of a photo I.D. and current insurance card in order to obtain proof of insurance. If you do not provide us with correct insurance information, you will be asked to pay for your medical services at the time the services is rendered.

5. Claims submission. We will submit your claims to your insurance carrier and otherwise assist you in any way we reasonably can in order for your medical services to be paid by your insurance company. Your insurance company may need you yo provide certain information directly to them. Your insurance policy is a contract between you and your insurance company.

6. Coverage charges. If your insurance coverage changes, please notify us prior to seeing the doctor so we may make the appropriate changes to our records and assist you in receiving your maximum benefits. If your insurance company does not pay your claim in 60 days, the balance will be billed to you.

7. Nonpayment. If your account is 60 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless you call our business office at (870) 931-6472 in order to make other arrangements. Please be aware that if a balance remains unpaid, we mat refer your account to a collection agency and you and your immediate family members mat be discharged from this practice. If discharge is to occur, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing high quality, convenient, and affordable health care to our patients. Our fees are representative of the usual and customary charges for medical services in our area.

Thank you for understanding out payment policy. Please let use know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of Patient or Responsible Party Date