Patient Information Today's Date____/____/_____

Last Name _____ First Name _____ MI _____ Suffix_____

Referred by:_____

Date of Birth____/____/_____ Gender (circle one) Male Female

Address _____ City_____ State_____ Zip_____

Home Phone_____-_____-_____ Work Phone_____-_____-_____ Cell Phone_____-_____-_____

Email_____

Marital Status (circle one) Single Married Separated Divorced Ethnicity_____

Spouse/ Partner Name_____ Spouse/ Partner Gender Male Female

Do You Have Children? (circle one) Yes No If Yes, How Many?_____

Patient Employer/School Name_____

Emergency Contact Name_____ Emergency Contact Phone_____-_____-_____

Preferred Pharmacy Name & Location_____

Pharmacy Phone_____-_____-_____ Does Insurance Require Referrals (circle one) Yes No

Financial Policy

This office is committed to providing cost effective, high quality healthcare to our patients. With so many insurance plans and options to choose from, it is essential that you understand which services, procedures, restrictions and limits are covered by your particular policy. It is your responsibility to know what is covered. We will bill your primary and secondary insurances for you. You are responsible for all co-pays, deductibles, co-insurance amounts and non-covered services. Please let us know if there is a change in your insurance status. Payment is required at the time of service. If your insurance company deems a service medically unnecessary, you agree to pay for the services. We will make every effort to inform you in advance. For your convenience, we accept cash, checks, Visa, MasterCard and Discover. We understand there are times when your healthcare is an unplanned event and we will attempt to accommodate your needs. Patients who do not have insurance or who choose to pay for their services, will need to pay at the time of service. For any questions, please call our billing department. There is a $30.00 fee for returned checks. If you request a copy of your own chart, you may receive the first copy at no charge. There will be a charge for all additional copies.

Signature_____ Date _____/_____/_____

Preventive Care

Your health plan may not cover preventive services. It is your responsibility to know what is covered. We suggest you check with your plan to determine if you are offered benefits for this service. If additional complaints/ requests are made at your Preventive visit, additional charges may be incurred and may not be covered by your insurance. I agree to pay these charges.

Signature_____ Date _____/_____/_____

Electronic Prescriptions

For your convenience, we are able to send most prescriptions electronically to your pharmacy. I agree to this prescribing method and hold harmless Bel-Red Internal Medicine, PLLC and its providers from any misuse or privacy breach.

Signature_____ Date _____/_____/_____

Cancellation Policy

Please give 24 hours notice of a change in your appointment. There is a $100 charge for missed/late cancelled physical appointments and a $50 charge for all other missed/late cancelled appointments. This policy includes same day appointments.

Signature_____ Date _____/_____/_____

Private Healthcare Information

Please provide contact information where we may leave private healthcare information. Bel-Red Internal Medicine, PLLC makes every attempt to notify you of all lab results, however, if you have NOT been notified, it is your responsibility to call and obtain any results.

Phone Number_____-_____-_____ Phone Number_____-_____-_____

Other: Name of Person_____ Phone Number_____-_____-_____

Signature_____ Date _____/_____/_____

Bel-Red Internal Medicine, PLLC recognizes you, the patient, as your own healthcare advocate and will respect your healthcare decisions. As such, I hold harmless Bel-Red Internal Medicine, PLLC, Teresa Girolami, MD, Cheryl Allen, ARNP and all employees and associates for any decisions I make against medical advice that may result in harm to me.

Signature_____ Date _____/_____/_____

Notice of Privacy Practices Acknowledgement

Bel-Red Internal Medicine, PLLC keeps a record of the health care services provided to you. You may ask to see and copy that record. You may also ask to correct that record. Bel-Red Internal Medicine, PLLC will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Privacy Officer. Out notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge that I have received a copy of the Notice of Practices:

Signature_____ Date _____/_____/_____ Time _____:_____AM PM