PATIENT FINANCIAL RESPONSIBILITY & ACKNOWLEDGEMENT FORM

Bristol Health Medical Group

I acknowledge that (as an adult patient or as the parent/guardian of a pediatric patient):

- I will provide a copy of my photo ID and insurance card today and at all BHMG visits
- Some/all portions of the bill are my responsibility & collected at the time of service, including but not limited to:
    - Co-pays, annual deductibles and cost sharing coinsurance
    - Amounts applied to my high deductible health plan (minimum $100 payment to be applied toward deductible amount)(including health savings account (HSA) compatible plans)
    - Amounts not covered by my benefits plan and/or any outstanding prior BHMG balances

I request that payment of authorized benefits be made to me or on my behalf to Bristol Health Medical Group, Inc. for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents, or any other supplier of medical benefits, any information needed to determine those benefits, or the benefits for the related services. If for some reason my insurance company denies my claim, BHMG has the right to appeal on my behalf. I understand it is my responsibility to pay my bill regardless of my insurance coverage. I understand not all services are covered by Medicare or other insurance and acknowledge I am responsible to pay for those services. I agree to pay all costs of collection, including reasonable attorney's fee incurred in the collection of any amounts not paid, as required above.

PRIVACY POLICY:	The Bristol Health Notice of Privacy Practices (subject to change) was made available to me. I may obtain a copy at any BHMG office or online via the Bristol Health website.
MULTIDISCIPLINARY APPROACH:	Bristol Health provides a range of services all utilizing the same electronic medical record. Medical information is shared among these practices.
NOTIFICATIONS:	I agree to receive voice and text notifications from BHMG practices, including appointment reminders, billing alerts/updates and other health reminders or information. I agree to receive text notifications regarding BHMG balances that may be owed. Should you choose to opt out and NOT receive any text messages, please initial here _____.
HEALTH INFORMATION EXCHANGE:	I consent to BHMG sharing my protected health information (PHI) with providers involved in my care via a health information exchange (HIE). Should you choose to opt out and NOT participate in a HIE, you may do so by calling 1.866.987.5514 or completing and submitting an opt-out form to Connie by mail, fax or through their website at www.conniect.org.
APPOINTMENT/CANCELLATION:	I agree to confirm appointments promptly, arrive on time and notify the office a minimum of one day prior should I need to reschedule. A combination of three (3) or more no shows and/or same day cancellations in a calendar year may result in discharge from a practice. A $30 fee may be charged for missed appointments or late cancellations.
PRESCRIPTION REFILLS:	I will call my pharmacy to request routine prescription refills and understand the pharmacy will contact BHMG directly to obtain continuation authorization, unless a visit to your provider is warranted. Providers may consult my prescription history prior to issuing scripts.
REFERRALS:	It is my responsibility to contact my insurance company to see if a referral from my Primary Care Provider (PCP) is required to see a specialist.

Printed Name: _____ Patient Signature: _____ Date: _____

Updated 9/2023

Bristol Health Medical Group

Today's Date_____

PATIENT HISTORY INFORMATION

NAME: _____ Date of Birth _____

DRUG ALLERGIES _____

_____

Occupation_____ Marital Status _____ Living Will/Healthcare Directive? Y / N

PERSONAL HEALTH - Circle all that apply

AIDS	Cancer _____	Gout	Lyme Disease	Rheumatic Fever
Alcoholism	Cataracts	Heart Disease	Murmur, Heart	Scarlet Fever
Anemia	Chicken Pox	Hepatitis	Measles	Stroke
Anorexia	Drug Dependency	Hernia	Migraines	Suicide Attempt
Anxiety	Depression	Herpes	Mononucleosis	Thyroid problem
Arthritis	Diabetes	High Cholesterol	Multiple Sclerosis	Tuberculosis
Asthma	Diverticulitis	High Blood Pressure	Osteoporosis	Ulcers, stomach
Bleeding Disorders	Emphysema	HIV Positive	Pacemaker	Vaginal Infection
Blood Clots in legs	Glaucoma	Kidney Disease	Pneumonia	Venereal Disease
Bronchitis	Goiter	Kidney Stones	Prostate Problems	Other _____
Bulimia	Gonorrhea	Liver Disease	Psychiatric Care	Other _____

MEDICAL HISTORY - List illness/surgery and dates

OTHER CHRONIC ILLNESSES, HOSPITALIZATIONS OR MAJOR SURGERIES & Dates	

FAMILY HISTORY	AGE IF LIVING	AGE AT DEATH	PRESENT CONDITION(s) OR CAUSE OF DEATH
FATHER			
MOTHER			
BROTHERS			
SISTERS			
CHILDREN			

HAS ANY PARENT/SIBLING HAD THE FOLLOWING:

- ❑ Alcoholism _____
- ❑ Alzheimer's _____
- ❑ Anemia/Low Blood Count _____
- ❑ Lung Problems _____
- ❑ Cancer, Breast _____
- ❑ Cancer, Colon _____
- ❑ Cancer, Prostate _____
- ❑ Cancer, Other _____
- ❑ Heart Disease _____
- ❑ Depression _____
- ❑ Bipolar Disorder _____
- ❑ Diabetes _____
- ❑ Blood Clots _____
- ❑ Hearing Loss _____
- ❑ High Blood Pressure _____
- ❑ High Cholesterol _____
- ❑ Osteoporosis _____
- ❑ Stroke _____
- ❑ Other _____

IMMUNIZATIONS/VACCINATIONS (dates)

Flu _____ Tetanus _____ Pneumonia _____ COVID _____
Other _____

SOCIAL HISTORY

Exercise:
Type/frequency_____
_____
_____

Smoking:
Packs/day _____
# of years _____
Year stopped _____

Alcohol:
Drinks/day _____
Drinks/week _____

Recreational Drugs:
Type/frequency _____
_____

NAME: _____ Date of Birth _____

PLEASE LIST CURRENT PRESCRIPTION MEDICATIONS, OVER THE COUNTER & HERBAL SUPPLEMENTS:

Medication Name	Medication Dose	# Times per Day	Who Prescribed Med

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We at Bristol Health care about you and our community. Please take a moment to answer these questions. Resources may be available.

What is your living situation today?
____ I have a steady place to live ____ I am worried about losing my housing ____ I do not have a steady place to live

Do you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc?
____ I don't need any help ____ I could use help (please describe) _____

Do you need assistance with transportation to get to and from medical appointments, work or getting things needed for daily living? ___Yes ___No

Would you like someone to contact you for further assistance with these social needs? _____ Yes _____ No