Bristol Health
Medical Group

Welcome to our practice.

We strive to make the registration process go as quickly for you as possible on the day of your appointment with

_____for_____/_____/_____at_____in_____
(Provider name) (date) (time) (location)

In order to help us achieve this, please:

1. Complete the enclosed patient information form and health questionnaire. It will save time if you complete the enclosed and bring these forms with you when you come in for your appointment.

2. Bring your insurance card(s) and a photo ID with you.

3. Bring a list of the medications/vitamins you are taking. Also, any recent lab, x-ray reports or records.

4. **All** copays are due at the time of visit. If you have a high deductible insurance, and your deductible has NOT been met, a required payment of $100 is due at the time of visit. Patients who do not have insurance coverage will be expected to pay in full at the time of service.

5. Plan to arrive 15 minutes before your appointment time.

We look forward to serving all of your healthcare needs in our practice which is part of the Bristol Hospital Multi Specialty Group. Please do not hesitate to call us if you have any questions regarding these instructions.

We utilize an automatic calling system that will call you 48 hrs in advance of your appointment. We do understand that in today's busy world occasionally situations come up that are beyond your control. In those instances, we do request you extend us the courtesy of a 24 hr notice for cancellations. This courtesy allows us to continue to operate efficiently and use the time that was reserved for you to help other patients in need. It is our policy that if you miss or call within 24 hr appointment time three times within a one year period, you may be discharged from our practice.

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PATIENT INFORMATION: Primary Care Provider: (PCP)__ _____

Patient Name:_____
(Last name) (First name) (Middle initial)

Address:_____
(Street) (Apt) (City) (State) (Zip code)

☐ Home Phone: (_____)_____-_____ ☐ Cell Phone: (_____)_____-_____ ☐ Work Phone: (_____)_____-_____
(Please check box for preferred phone)

Date of Birth:_____/_____/_____ Age_____ Male or Female Marital Status: S M D W (Circle one)

Ethnicity: Caucasian Hispanic African American Asian Middle Eastern Pacific Islander Native American Other: _____ (circle one)

Race:_____ Do you have an advance directive (living will)? Yes_____ No_____

EMAIL ADDRESS: _____

EMPLOYER INFORMATION:

Employer Name/Address: _____Phone: (_____)_____-_____

Spouse's Name:_____ DOB: _____/_____/_____

Spouse's Employer Name/Address_____ Phone: (_____)_____-_____

INSURANCE INFORMATION:

Primary Insurance:_____ Secondary Insurance:_____

Subscriber's Name_____DOB___/___/___ Subscriber's Name:_____DOB___/___/___
(The person employed by the company) (The person employed by the company)

WHOM MAY WE CONTACT IN CASE OF EMERGENCY?_____(_____)_____-_____
(Name) (Relationship) (Phone)

Signature on File
Please read carefully and sign:
I request that payment of authorized benefits be made to Bristol Health Medical Group, Inc. for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to HCFA 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, the office/billing department has the right to appeal on my behalf. I understand that regardless of any insurance coverage I may have, it is my responsibility to pay my bill. I further understand that my insurance is designed to reimburse me for covered expenses. I understand further that not all services are covered by Medicare or other insurance and acknowledge that I am responsible and will pay for those services. I agree to pay all costs of collection, including a reasonable attorney's fee incurred in the collection of any amounts not paid, as required above.
If you fail to give 24 hour notice to cancel an appointment you may be subject to a $30 No-Show Fee.

_____ _____/_____/_____
(Signature-Patient or Responsible Party) (Date)

Bristol Health
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Financial Responsibility Form

I am visiting a provider at Bristol Health Medical Group, Inc. (Group).

I acknowledge that:

- I will provide a copy of my insurance card today and during each subsequent visit. In addition, I will supply my driver's license and pay any copays.
- As a courtesy, the Group will submit demographic, protected health information and billing information to my health plan for the purpose of determining eligibility, covered benefits, payment and for the coordination of care such as authorizations for tests, services, home care and hospitalizations.
- Payments available under my plan will be paid directly to Group, or if payment is denied, the Group may elect to appeal the denial on my behalf.
- Some portions, or all portions of the bill may be my responsibility including, but not limited to:
    - Office Copays
    - Annual Deductibles
    - Cost Sharing Coinsurance
    - Amounts applied to my high deductible health plan (including health savings account (HSA) compatible plans)
    - Amounts not covered by my benefit plan
- Group may request that some portions of the patient responsibility be collected at time of service including:
    - Copays as indicated on your insurance card, and
    - some portion of the amounts that will be applied to a deductible (minimum $100 payment to be applied toward deductible amount).
    - Any outstanding prior BHMG balances are due and payable in full.

  Failure to pay fees at the time of visit will result in a service charge of $15 due to the additional expense of statement processing.
- Group may assign uncollected balances to a credit reporting Collection Agency.

Printed Name_____

Patient Signature_____Today's Date:_____/_____/_____

Thank you for reviewing patient forms that are pertinent to your visit to BHMG

HEALTH HISTORY

Name:_____ Today's Date _____/_____/_____

Age:_____ Date of Birth _____/_____/_____ Date of last physical _____/_____/_____ by Dr._____

MEDICAL HISTORY: Circle all conditions that you have or have had in the past. OR SINCE LAST PHYSICAL

AIDS	Cancer_____	Gout	Murmur, Heart	Scarlet fever
Alcoholism	Cataracts	Heart Disease	Measles	Stroke
Anemia	Chicken Pox	Hepatitis	Migraines	Stomach Ulcer
Anorexia	Drug Dependency	Hernia	Mononucleosis	Suicide attempt
Anxiety disorder	Depression	Herpes	Multiple Sclerosis	Thyroid problems
Arthritis	Diabetes	High Cholesterol	Osteoporosis	Tuberculosis
Asthma	Diverticulitis	High BP	Pacemaker	Ulcers, stomach
Bleeding Disorders	Emphysema	HIV positive	Pneumonia	Vaginal infection
Blood clots in legs	Glaucoma	Kidney disease	Prostate problems	Venereal disease
Bronchitis	Goiter	Kidney stones	Psychiatric Care	Lyme disease
Bulimia	Gonorrhea	Liver Disease	Rheumatic Fever	Other

PAST SURGERY : CIRCLE ALL THAT APPLY

Cataract	Appendectomy	Bladder Suspension	Hip replacement
Tonsils	Gallbladder	Prostate Surgery	Knee replacement
Cardiac Bypass	Hysterectomy	Neck Surgery	Other
Angioplasty	C-Section	Back Surgery	

FAMILY HISTORY: Please fill in all that apply

	Age, if alive	*Age at death, if deceased*	*Cause of death*	***MEDICAL PROBLEMS: Circle all that apply***
Father				***Asthma Diabetes High BP High Cholesterol Stroke Heart problems Cancer***
Mother				***Asthma Diabetes High BP High Cholesterol Stroke Heart problems Cancer***
Brothers				***Asthma Diabetes High BP High Cholesterol Stroke Heart problems Cancer***
				Asthma Diabetes High BP High Cholesterol Stroke Heart problems Cancer
				Asthma Diabetes High BP High Cholesterol Stroke Heart problems Cancer
Sisters				***Asthma Diabetes High BP High Cholesterol Stroke Heart problems Cancer***
				Asthma Diabetes High BP High Cholesterol Stroke Heart problems Cancer
				Asthma Diabetes High BP High Cholesterol Stroke Heart problems Cancer

CURRENT MEDICATIONS: List all prescribed medications as well as vitamins and dietary supplements

MEDICATION	DOSE(mg)	Frequency

MEDICATION	DOSE (mg)	Frequency

ALLERGIES:

_____

_____

_____

SOCIAL HISTORY:

Do you smoke? Yes ○ No ○ ___Pks/P/D ___# of Years

Alcohol: Yes ○ No ○ ____Drinks per/wk Drugs: ○ Yes ○ No

Single ○ Married ○ Divorced ○ Widow(er) ○

Children: Yes ○ No ○ How many? _____

Signature: _____ Occupation: _____

Bristol Health
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Medical Record
Restriction & Sharing

I allow Bristol Hospital Medical Group staff to share and discuss (or restrict) my health information with:

Spell Name	Circle One
Other BHMG Offices where I seek care.	SHARE
And	
Spouse Name_____	Share or Restrict
Phone:_____	
Significant Other_____	Share or Restrict
Phone:_____	
Parent Name(s)_____	Share or Restrict
Phone:_____	
Child (ren) _____	Share or Restrict
Phone:_____	
Sibling(s) _____	Share or Restrict
Phone:_____	
Friend _____	Share or Restrict
Phone:_____	
Caregiver_____	Share or Restrict
Phone:_____	

***PATIENT SIGNATURE*_____*DATE:*_____/_____/_____**

Thank you for reviewing patient forms that are pertinent to your visit to BHMG

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To begin your BHMG electronic medical record, we ask that each patient review and sign the following:

Privacy Policy	A Notice of Privacy Practices has been made available in the waiting room. I acknowledge that the policy may change and that I may read updated copies at subsequent visits. I currently have no questions about the policy. A Privacy Officer is available at (860 585-3425)
Request for Sharing & Restrictions	I may identify people who may access my record, and I may identify others for whom BHMG should limit information.
Multidisciplinary Approach	I understand that BHMG provides a range of services in the Greater Bristol community and that if I access other sites, my BHMG EMR will be made available for my appointments. I acknowledge that the forms signed today will apply to other offices within the network. I understand that I may visit Med-Help Medical Center for an acute illness visit at the cost of a Primary Care Physician visit. My provider will have access to these findings.
Medical Record Release	I will request and sign a release any time that I want my records sent to a provider outside the BHMG network.
Financial Responsibility	I have reviewed and signed the BHMG financial responsibility form.
Cancellation Policy	I agree that I may be charged $30 for either (a) failure to cancel an appointment with a 24 hr notice or (b) missing an appointment.
Patient Responsibility	I agree to optimize the delivery of care to me by providing a complete medical history.
Prescriptions	Refills: I will call my pharmacy to request a routine refill on my prescriptions and understand that the pharmacy will contact BHMG directly to obtain authorization for continuation. History: I authorize the provider office to review my prescription history.
Referrals	If I have an appointment with a **Specialist**, it is my responsibility to contact my insurance company to see if an insurance referral from my Primary Care Physician (PCP) is required.

Patient Name: _____ Patient Signature: _____

Today's Date: _____/_____/_____

Bristol Health Medical Group

Patient Rights & Responsibilities

Bristol Health Medical Group (BHMG) is committed to providing you with the highest quality medical care. Our health care providers and staff are dedicated to helping you achieve and maintain your health goals in a safe, respectful and supportive environment. We encourage you to speak openly with your health care providers and to be involved in your health care. We are committed to honoring these patient rights and equally expect responsible behavior from our patients.

Patient Rights - You have the right to:

- ★ Receive considerate, respectful and compassionate care in a safe setting regardless of age, gender, race, national origin, religion, sexual orientation, gender identity or disabilities. BHMG does not discriminate, treat differently or exclude treatment to anyone for reasons including and beyond those identified here.
- ★ Be treated with professionalism and courtesy in a clean and safe environment
- ★ Know the names and titles/roles of everyone involved in your care
- ★ Receive the information necessary to actively participate in your health care decisions
- ★ Full information regarding your diagnosis, prognosis, treatment benefits/risks and expected outcomes
- ★ Have access to resources that facilitate effective communication with your healthcare provider
- ★ Informed consent prior to any non-emergency procedure
- ★ Have a chaperone present for intimate/invasive appointments, or as requested
- ★ Refuse treatment as permitted by law and be informed of effect(s) this may have on your health
- ★ Respectful protection of your personal privacy in accordance with HIPAA guidelines, including access to our Notification of Privacy Practices upon request
- ★ Expect all communication and records about your care be kept confidential and not disclosed unless permitted by law. You also have the right to request in writing and receive a copy of your medical records.
- ★ Receive information regarding charges relative to the care you have received
- ★ Voice your concerns about the care you receive. If you have an issue, concern or complaint, you may discuss with your healthcare provider or practice management.

Patient Responsibilities - You are expected to:

- ➔ Treat BHMG staff with respect, courtesy and consideration for the needs and rights of other patients
- ➔ Confirm appointments promptly, arrive on time for your scheduled appointments and notify the office a minimum of the day prior to your appointment should you need to reschedule. Patients with a combination of three (3) or more no shows and/or same day cancellations in a calendar year may be discharged from the practice.
- ➔ Provide complete and accurate demographic and insurance information including relevant phone numbers/emails so we may communicate with you. You are also expected to provide both photo identification and your insurance card at each visit.
- ➔ Provide complete, honest and accurate information about your health and medical history, including present or past medical conditions, medications, and any other details to the best of your ability
- ➔ Ask questions if you are not sure or do not understand your diagnosis, treatment, prognosis or other instructions
- ➔ Follow directions concerning medications, follow up care, referrals and notify your health care provider if you feel you cannot follow your treatment plan
- ➔ Receive a referral from your primary care physician before specialty care may be obtained, if required by your insurance company
- ➔ Pay for copays or deductibles as arranged at the time of each visit
- ➔ Assume responsibility for any charges billed to you as a result of receiving services within BHMG

Patient Signature: _____ Date: _____