

FINANCIAL RESPONSIBILITY FORM

I acknowledge that:

- I will provide a copy of my photo ID and insurance card today at all BHMGM 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
 - Any outstanding prior BHMGM balances are due and payable in full

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 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, BHMGM has the right to appeal on my behalf. I understand that it is my responsibility to pay my bill regardless of my insurance coverage. I understand that 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 a reasonable attorney's fee incurred in the collection of any amounts not paid, as required above.

PRIVACY POLICY: A Notice of Privacy Practices (subject to change) is available in each practice. A Privacy Officer is available at (860) 585-3223.

MULTIDISCIPLINARY APPROACH: BHMGM provides a range of services all utilizing the same electronic medical record. Medical information is shared among these practices. This form applies to all offices within the BHMGM network.

NOTIFICATIONS: I agree to receive voice and text notifications from BHMGM practices.

HEALTH INFORMATION EXCHANGE: I consent to BHMGM sharing my protected health information (PHI) with providers involved in my care via the health information exchange (HIE).

APPOINTMENT/CANCELLATION: I agree to confirm appointments promptly, arrive on time for scheduled appointments 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 failure to cancel an appointment with 24 hr notice or missing an appointment.

PRESCRIPTION REFILLS: I will call my pharmacy to request routine prescription refills and understand the pharmacy will contact BHMGM 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: _____

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	HAS ANY PARENT/SIBLING HAD THE FOLLOWING:
				<input type="checkbox"/> Alcoholism <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Anemia/Low Blood Count <input type="checkbox"/> Lung Problems <input type="checkbox"/> Cancer, Breast <input type="checkbox"/> Cancer, Colon <input type="checkbox"/> Cancer, Prostate <input type="checkbox"/> Cancer, Other <input type="checkbox"/> Heart Disease <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Blood Clots <input type="checkbox"/> Hearing Loss <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Other
FATHER				_____
MOTHER				_____
BROTHERS				_____
SISTERS				_____
CHILDREN				_____

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

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