**WEST FLORIDA MEDICAL ASSOCIATES, P A**

**BELLAM MEDICAL CLINIC**

RAJENDRA P. BELLAM, M.D
**Diplomate, American Board of Internal Medicine**

CRYSTAL VAN LEEUWEN, ARNP-C
Board Certified, American Academy of Nurse Practitioners

11707 N. Williams Street
Dunnellon, FL 34432
Phone: ( 352) 465-1199

41 N. Inglis Avenue
Inglis, FL 34449
Phone: (352) 447-3031

**PATIENT INFO**

DATE: ________ /________ /__________

NAME: ______________________________________________ D.O.B: ______ / _____ / ________ AGE: _________

ADDRESS: ____________________________________________________________________________________

CITY: ______________________________________________ STATE: ___________________ ZIP: ________________

PHONE: ( _____) _______-- __________ SSN # _________ -- ________ -- ____________ GENDER: ________________

**EMERGENCY CONTACT NAME, ADDRESS & PHONE#** & **RELATION**: _________________________________________

_______________________________________________________________________________________________

ARE YOU ALLERGIC TO ANY FOOD?____________________________________________________________________

ARE YOU ALLERGIC TO ANY MEDICATIONS: _____________________________________________________________

**INSURANCE INFO**

MEDICARE ID# ________________________________________ MEDICAID ID# _______________________________

BCBS ID# ____________________________________________ GROUP# ____________________________________

UNITED HEALTHCARE ID# GROUP# ___________________________________________________________________

OTHER INS. NAME & ID# __________________________________________________________________________

_______________________________________________________________________________________________

**SELF PAY: YES________ NO _________**

**CIRCLE HOW YOU WILL BE PAYING FOR TODAY'S VISIT: CASH CREDIT/DEBIT CHECK**

Guarantor Name: _________________________________
Guarantor D/O/B: _________________________________
Relationship: [ ] Self [ ] Spouse [ ] Child

**PLEASE PRESENT YOUR INSURANCE CARDS & PHOTO ID AT THE FRONT DESK.**

Name: ___________________________________________ Date of Birth:__________________________

Are you allergic to any medication? _________ Yes ________ No
If Yes, please list: _________________________________________________________________________

__________________________________________________________________________________________

Do you smoke cigarettes? ________ Yes _______ No
If Yes, how many daily: _______ less than one pack __________one pack ________ more than one pack
Smokeless Tobacco __________ Yes __________ No
Are you exposed to any second hand smoke ____________ Yes _______ No
Are you sexually active: _____________ Yes __________ No
Are you at risk for HIV: ___________ Yes ___________ No
Do you use any recreational Drugs: ___________ Yes _________ No
If Yes, What kind and how frequently? : _______________________
Do you drink alcohol-containing beverages: _______ Yes _________ No
If yes, How many per week____________________
Are you a victim of Domestic Violence _______________ Yes _________ No

**MEDICAL HISTORY**

Do you have any conditions for which you are under a Doctor's care? _______ Yes ______ No
If yes, give details:

_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

**SURGICAL HISTORY**

Have you ever had a surgery? ___________ Yes ____________ No
If yes, give details: ________________________________________________________________________

__________________________________________________________________________________________

FAMILY HISTORY

Check if any of the following occurred in your parents, aunts/uncles, brothers/sisters

| | | |
|---|---|---|
| ☐ Diabetes | ☐ Hypertension | ☐ Cancer |
| ☐ Tuberculosis | ☐ Heart disease/Stroke | ☐ Asthma |
| ☐ Arthritis/Gout | ☐ Mental illness | ☐ Seizures |

If any of the above has been checked, give details:

__________________________________________________________________________________________
__________________________________________________________________________________________

**REVIEW OF SYSTEMS**

| Do you have any problems with the following? | Yes | No |
|---|---|---|
| Heart | ______________ | _______________ |
| Lungs | ______________ | _______________ |
| Digestive tract | ______________ | _______________ |
| Thyroid/Glands | ______________ | _______________ |
| Joints/Bones | ______________ | _______________ |
| Kidneys | ______________ | _______________ |
| Nervous System | ______________ | _______________ |

If any of the above been checked, Please explain on the back of this sheet.

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## CONSENT FOR TREATMENT & BILLING OF INSURANCE

I RECOGNIZE AND ACDEPT FULL RESPONSIBILITY FOR ALL SERVICES RENDERED AND AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY CLAIM AND ASSIGN REQUEST PAYMENT DIRECTLY TO THE PROVIDER.

I CONSENT FOR EXAMINATION AND TREATMENT.

SIGNATURE: ____________________________________________________

DATE: _______________________________________

## ATTENTION MEDICARE PATIENTS

Bellam Medical Clinic has been approved as a Rural Health clinic and Medicare claims are processed by BCBS of Tennessee. In order for us to file with BCBS of Tennessee, they require that a signature from you signifying that you re allowing us to file Medicare claims for you and request payment to us. Your signature will allow us to release any medical information that Medicare may need to process your claim.

### PLEASE READ AND SIGN THE FOLLOWING TO PERMIT PAYMENT OF MEDICARE BENEFITS TO RURAL HEALTH CLINIC

I request payment of authorized Medicare benefits on my behalf of any services furnished to me by BELLAM MEDICAL CLINIC. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits for related services.

____________________________________________________________________________________________________

**Patient signature/Medicare number**

Date: ___________________________________

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## Patient Acknowledgment of understanding of Bellam Medical Clinic's Privacy Practices.

Patient's name: ____________________________________________________________
Date of Birth: ______/________/_____________ Social security # ________ / _______ / ____________
Previous Name: ________________________________________________________

I understand that the [patient's health information is private and confidential. I understand that Bellam Medical Clinic works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information. I understand that Bellam Medical Clinic may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operation. (In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are unusual. One example would be if a patient threatened to hurt someone.)

Bellam Medical Clinic has a detailed document called the "Notice of Privacy practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this acknowledgment. I understand that I have the right to read this "Notice" before signing this Acknowledgment.

Bellam Medical Clinic may update this Acknowledgment and "Notice of Privacy Practices", if I ask; I will be provided with a copy of the most current' Notice of Privacy Practices".

Within this "Notice" is contained a complete description my Privacy/ confidentiality rights. The rights include, but are not limited to, access to my medical records, restrictions on certain uses receiving and accounting of disclosures as required by law; and, requesting communication be by, specified methods of communications or alternative location.

Bellam Medical Clinic has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgment, and authorizations, reasonable time frames for requesting information; charges for copies and non-routine information needs etc. I will assist Bellam Medical Clinic by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicated that I have given the chance to review a current copy of Bellam Medical Clinic's "Notice of Privacy Practices".

_______________________________________________________________

**Patient or legally authorized individual signature/relationship to patient**

Date and Time: ______________________________________

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## AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: ________________________________________ D/O/B: _________________ SSN # __________________

I authorize the use or release of me above named individual's health information as described below:

The following individual or organization is authorize to release information

NAME: ________________________________________________________________________________
ADDRESS:______________________________________________________________________________
_______________________________________________________________________________________
Phone: _________________________________ FAX: ___________________________________

The type and amount of information to be used or released is as follows:

**Emergency Dept**: ____________ **Radiology:** _____________________ **Consultation**: _______________
**Pathology**: _________________ **Entire record**: __________________ **Other:** ____________________

I understand this information may include records related to sexually transmitted disease, AIDS/HIV, behavioral or mental health services, or treatment for alcohol or drug, abuse.

This information may be released to and used by the following individual or organization:

NAME: ________________________________________________________________________________
ADDRESS:______________________________________________________________________________
_______________________________________________________________________________________
Phone: _________________________________ FAX: ___________________________________

I understand I may revoke this authorization at anytime. I understand it must be in writing and present my revocation to the Medical Records Dept. I understand the revocation will not apply to information that has already released in response to this authorization unless otherwise revoked this authorization will expire on the following date ________ / ________ / _________. If I fail to specify expiration date this authorization will expire in 60 days.

I understand that authorizing the release of this health information is voluntary. I understand I can refuse to sign this release. I need not to sign this form in order to assure treatment. I may inspect this form or copied information to be released as provided in 45 CFR 164.524. I understand any release of information carries with it the potential for re-release by the recipient and may not be protected by the Privacy Laws. If I have any questions I may direct them to the Office Manger.

**Signature of Patient of Legal Representative:** ____________________________________________________________

**If signed by Legal Representative, Relationship to Patient:** ____________________________________________________

**Date:** _______ / ______ / ___________ **Signature of Witness:** __________________________________________

**Date Faxed :** _______ / _______ / _____________ **Faxed By:** ______________________________________

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**Patient Name:** ______________________________________________________ **DOB:** ____________________

## ADVANCED DIRECTIVES

(For Compliance with the Patient Self-Determination Act of Florida Statutes Chapter 765)

Have you executed an advanced directive? YES ______ NO ______

If YES, is this directive in the form of:

____ A Living Will

____ A Durable Power of Attorney

____ A Health Care Surrogate

____ A DO NOT RESUSCIATE ORDER (SIGNED BY YOU)

Have you provided this office with a copy of Advanced Directive? YES _____ NO _____

I have been provided with information regarding the "PATIENT SELF-DETERMINATION ACT"

Signature of patient or representative Date

Please provide us with the following information:

| **Race** | **Ethnicity** | **Language** |
|---|---|---|
| ____ White | ____ Non-Hispanic | ____ English |
| ____ African American | ____Hispanic | ____ Spanish |
| ____ Asian | ____ UNKNOWN | ____ Indian (Hindi, Gujarathi etc) |
| ____ Native American/ESKIMO | | ____ Other |
| ____ Pacific Islander/Native Hawaii | | |
| ____ Other | | |
| ____ UNKNOWN | | |

______________________________________________________________________

Signature of patient or representative Date