

WEST FLORIDA MEDICAL ASSOCIATES, P A

BELLAM MEDICAL CLINIC

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

11011 N. Williams Street
Dunnellon, FL 34432
Phone: (352) 465-1199

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

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

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

- | | | |
|---|---|-----------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart disease/Stroke | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Mental illness | <input type="checkbox"/> 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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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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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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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