**General Information** –Please answer **all** questions below:

**First Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **MI:** \_\_\_\_\_\_  **Last Name:**

**First Name Used:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Previous Last Name(s):**

**Mailing Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_\_ **Zip:**

**Physical Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_\_ **Zip:**

(Y/N) **Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Y/N) **Cell Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Y/N) **Work Phone:**

**May we leave a message?** Yes No  **If yes, on your:** Home Phone Cell Phone Work Phone

**How would you like to be notified about your appointments?**  Call Text Both

**Birthdate:** \_\_\_\_\_/ \_\_\_\_\_\_ / \_\_\_\_\_\_ **Social Security #:** \_\_\_\_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_

**Sex Per Birth Certificate:** Female Male **Marital Status:** Married Single Widowed Divorced Separated

**Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Occupation** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Full-Time Part-time Unemployed Retired

Are you an employee or dependent of employee of BVHC? Yes No **If yes, name of Employee**

**Current Primary Care Provider/Location:**

**What Country are you from:**  United States Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Choose not to answer

**Preferred Language:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Translator Needed:**  Yes No

**Agricultural worker:**  Yes No Decline **Are you a Student?** Yes No If yes, Full-time / Part-time

**Homeless status:**  Yes No Decline

**Veteran status:** If you served in the active military, naval, or air service, which includes full-time service in the Air Force, Army, Coast Guard, Marines, Navy, or as a commissioned officer of the Public Health Service or National Oceanic and Atmospheric Administration or served in the National Guard or Reserves on active duty status, **choose:**  Yes No Decline

|  |  |  |
| --- | --- | --- |
| **Race/Ethnicity**  Hispanic or Latino  Non-Hispanic  (Circle **ALL** that apply)  American Indian/Alaskan Native  White/Caucasian  Black/African American  Native Hawaiian  Asian  Other Pacific Islander  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Sexual Orientation**  Straight (heterosexual)  Lesbian/Gay (homosexual)  Bisexual  Something Else  Don’t Know  Choose not to answer | **Gender Identity**  Male/Man  Female/Woman  Transgender Man/Male  Transgender Woman/Female  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Choose not to answer |

**Emergency Contact Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship:**

**Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone:**

* Same as patient

**Responsible Party**

Individual Responsible for Bill: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_ Zip:

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone:

**Preferred Pharmacy/Location:**

**Do you currently have Medical Insurance?** **Yes No**

|  |  |
| --- | --- |
| **Primary Insurance:** | **Secondary Insurance:** |
| **ID/Subscriber #:** | **ID/Subscriber #:** |
| **Group #:** | **Group #:** |
| **Policy Holder:** | **Policy Holder:** |
| **Policy Holder DOB:** | **Policy Holder DOB:** |
| **Policy Holder SSN:** | **Policy Holder SSN:** |
| **Policy Holder Phone #:** | **Policy Holder Phone #:** |

**Do You Currently have Dental Insurance? Yes No If yes, please provide information below:**

**Dental Insurance Provider:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ID #**

**Please circle the RANGE which corresponds to your household size** *(how many people live in your home)* **and income** *(your total income before tax):*



If more than 8 people, what is the patient’s family size? \_\_\_\_\_\_\_\_\_\_ and income $

**DO YOU WISH TO APPLY FOR THE SLIDING FEE DISCOUNT? YES NO \*If yes, please fill out HSP application\***

**Online Patient Portal Authorization**

We encourage the use of our Online Patient Portal where you can access your chart to see your information such as lab and x-ray results, current medication list & communicate with your provider via a secure email.  Often, this secure email is the fastest way to communicate with your provider.

Do you wish to sign up?  **Yes No**

**Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgement of Consumer Bill of Rights:** I acknowledge receipt of the Consumer Bill of Rights. \_\_\_\_\_\_\_\_\_\_\_\_\_ **(Initial)**

**Acknowledgement of Privacy Practices**: I acknowledge receipt of the Notice of Privacy Practices. \_\_\_\_\_\_\_\_\_\_\_\_\_ **(Initial)**

**Acknowledgement of Payment Policy**: I understand the Payment Policy and agree to abide by it. \_\_\_\_\_\_\_\_\_\_\_\_\_ **(Initial)**

**Authorization for Verbal Release of Personal Health Information**

Would you like to designate a family member or other individual with whom the provider may discuss your medical condition? **No Yes** If yes, whom?

|  |  |  |
| --- | --- | --- |
| **Name** | **Relationship** | **Contact Number** |
|  |  |  |
|  |  |  |

Patient/Representative may revoke or modify this authorization in writing at any time.

|  |  |
| --- | --- |
| Patient Name (Print) | Signature (Patient/Personal Representative) |
|  |  |
| Date | Relationship to Patient |
|  |  |

Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

***Thank you for taking the time to provide this most useful information!***

**Consent and Assignment:**

I consent to integrated medical, mental health, behavioral health and dental services for me or the individual for whom I am the personal representative and hereby accept responsibility to pay for such services. I know that it is my choice to have services and can change my mind about receiving services at BVHC.

In the event I receive family planning services, I understand that such family planning services are provided on a voluntary basis and are not a pre-requisite to eligibility for, or receipt of, any other services or programs of BVHC. Individuals 18 years of age and younger may consent to the receipt of family planning services, without parental notification or consent. All information as to personal facts and circumstances obtained by BVHC staff will be held strictly confidential and will not be disclosed without your written consent, except as necessary to provide services to you or as required by law, with appropriate safeguards for confidentiality.

I understand that I have the right to receive free language interpreter services. I understand that I must tell the staff if these services will be helpful to my understanding of the written or spoken information given during my health care visits.

I hereby designate BVHC as my lawful agent and assign to BVHC any benefits for medical, dental, behavioral health, mental health, or any other services I receive from BVHC which I may be entitled to. You may ask for a copy of this form or any form that you sign.

|  |  |
| --- | --- |
| Patient Name (Print) | Signature (Patient/Personal Representative) |
|  |  |
| Date | Relationship to Patient |
|  |  |

I further consent to receive the services described above via telehealth if it is necessary or appropriate for the current situation. Telehealth uses electronic communications, such as real time audio, video, and data communications, so health care providers at different locations can share a patient’s health information to diagnose, consult, and/or treat the patient. To protect the privacy and security of patient health information, all electronic communications used for telehealth comply with network and software security protocols. As with any health care service, there are benefits and possible risks with the use of telehealth. The benefits of using telehealth include improved access to health care and the expertise of providers and/or specialists who are not physically located in the geographic area. Possible risks of using telehealth include possible delay in diagnosis or treatment due to technical difficulties with equipment; information being sent is not sufficient to allow for a complete medical exam by the offsite provider; information may be lost when being sent due to technical failures; and despite security protocols being in place, the privacy of patient health information may be compromised when sent electronically. If I participate in a telehealth session where I am located outside of the clinic, I understand that there is potential for other people to overhear sessions if I am not in a private place.  In such cases, I understand that it is my obligation to take reasonable steps to ensure my privacy. I have the right to withhold or withdraw my consent to the use of telehealth without affecting my right to future care or treatment. By signing in the space below, I consent to receive services via telehealth.

|  |  |
| --- | --- |
| Patient Name (Print) | Signature (Patient/Personal Representative) |
|  |  |
| Date | Relationship to Patient |
|  |  |