Revised November 2017

Blanchard Valley Medical Associates

Patient Last Name: _____ **Patient First Name**: _____ **Middle Initial**:_____

Nickname:_____ **Date of Birth:** _____/_____/_____ **Sex:** *(circle one)* M / F

Marital Status: *(circle one)* M / S / D / W **Employer:**_____

Race: *(circle one)*		**Ethnicity:** *(circle one)*
American Indian/Alaska Native	Black/African American	Hispanic/Latino
Hawaiian/Pacific Islander	Other Race	Not Hispanic/Latino
Asian	White	Decline to Answer
Decline to Answer		

Address: _____ **City / State / Zip**: _____

Home #: ( )_____-_____ **Work #:** ( )_____-_____ **Cell #:** ( )_____-_____

E-Mail:_____ **Preferred Phone Number:** *(circle one)* Home # / Work # / Cell #

Primary Care Provider:_____ **Referring Provider:**_____

If you have an Advance Directive, please submit a copy to us to ensure that it becomes a permanent part of your medical chart.

HIPAA RELEASE & REMINDER COMMUNCIATION

By supplying my home and mobile numbers, email address and any other personal contact information, I authorize BVMA to employ a third-party automated system to use my personal information, the name of my healthcare provider, the time/place of my scheduled appointment(s) and other limited information for the purpose of notifying me of a pending or missed appointment, or any other healthcare-related function. I consent to receiving multiple messages from BVMA, when necessary; and to allowing messages to be left on my voicemail/answering machine or with another individual, if I am unavailable at the numbers provided by me.

People I authorize to receive my medical information ***(list primary EMERGENCY CONTACT first):***

Name:_____ **Relationship:**_____ **Phone:** ( )_____-_____

Name:_____ **Relationship:**_____ **Phone:** ( )_____-_____

Name:_____ **Relationship:**_____ **Phone:** ( )_____-_____

Name:_____ **Relationship:**_____ **Phone:** ( )_____-_____

_____ _____

Patient / Guardian Signature Date

MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf to the Doctor or Group indicated on the claim for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to the above named Doctor or Group any information regarding my Medicare claims under Title XVIII of the Social Security Act.

COMMERCIAL INSURANCE

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM. I understand I am financially responsible for any balance not covered by my insurance carrier. Our practice issues monthly itemized statements to patients/guarantors for services rendered.

I acknowledge and agree that I have received a copy of Blanchard Valley Medical Associates' Notice of Privacy Practices and Financial Policy.

A copy of this signature is as valid as the original.

_____ _____

Patient / Guardian Signature Date