Buellton Medical Center

Family Practice

PATIENT INFORMATION (PLEASE PRINT)

PATIENT'S NAME: _____
LAST FIRST MIDDLE

BIRTHDATE: _____ GENDER: _____

SSN#: _____ PREFFERED LANGUAGE: _____

HOME ADDRESS: _____
STREET ADDRESS CITY STATE ZIP CODE

MAILING ADDRESS: _____
P.O. BOX CITY STATE ZIP CODE

HOME PHONE#: _____ WORK#: _____ CELL#: _____
PREFFERED PHONE # TO BE REACHED? *(CIRCLE)* HOME WORK CELL

EMPLOYER: _____ OCCUPATION: _____

E-MAIL: _____
(ONLY FOR OFFICE USE, WILL NOT BE SOLD TO OTHER COMPANIES)
*BY PROVIDING THIS EMAIL YOU AUTHORIZE BUELLTON MEDICAL CENTER'S EHR (ADVANCEDMD) TO SEND YOU NOTIFICATIONS SUCH AS PATIENT PORTAL ACCESS, PATIENT FORMS, APPOINTMENT REMINDERS, ETC...

EMERGENCY CONTACT NAME: _____

RELATION: _____ PHONE: _____

REFFERED BY: _____
(ONLINE, FAMILY, FRIEND, DOCTOR, ETC...)

BILLING INFORMATION:

RESPONSIBLE PARTY: _____ RELATION: _____

NAME OF INSURANCE: _____

POLICY HOLDER: _____ RELATION: _____ DATE OF BIRTH: _____

PLEASE INITIAL BELOW:

_____ I, AUTHORIZE THE PROVIDERS AND STAFF OF THIS CENTER TO ADMINISTER NECESSARY TESTS AND TREATMENTS ON **(CIRCLE)** MYSELF/CHILD FOR WHICH I/THEY HAVE BEEN CONSULTED ON.

_____ BMC WILL SUBMIT A CLAIM FOR THE PATIENT TO CONTRACTED PPO INSURANCE CARRIERS, **HOWEVER, ANY SERVICES NOT COVERED BY THE PATIENT'S INSURANCE WILL BE THE RESPONSIBILITY OF THE PATIENT.**

_____ I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BUELLTON MEDICAL CENTER OR SUPPLIER FOR SERVICES.

_____ I AUTHORIZE BMC TO RELEASE MY PHI (PROTECTED HEALTH INFORMATION) WHEN REFERRED TO AN OUTSIDE PROVIDER.

_____ I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES (HIPAA) FOR BMC.

_____ I UNDERSTAND THERE WILL BE A $40 CHARGE FOR RETURNED CHECKS.

_____ I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR A $45 FEE FOR MISSED APPTS.

_____ AS OF 01/01/14 BMC WILL BE CHARGING A $55 FEE FOR MISSED APPOINTMENTS OR CANCELATIONS WITHOUT 24 HR. NOTICES WITH OUR SPECIALTY DOCTORS.

_____ FOR CENCAL PATIENTS- I UNDERSTAND THAT IF I HAVE 3 UNEXCUSED NO SHOWS, I WILL BE REMOVED FROM THIS PRACTICE AND REASSIGNED TO ANOTHER PRACTICE.

SIGNATURE: _____ DATE: _____