BASS MEDICAL GROUP

Patient Information

Last Name: _____ First Name: _____ Middle: _____

SSN#: _____ DOB: _____ Gender: _____

Marital Status: _____ Emergency Contact & Relationship: _____ Emergency Contact Phone: ( ) _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) - _____

Email Address: _____

By checking this box, you are authorizing us to send you statements, payment receipts or other billing information related to today's services:
☐ Yes ☐ No

Primary Care Physician Name: _____ Primary Care Physician Phone Number: _____

Employer: _____ Is the visit related to a work related injury? _____

Ethnicity (White, Black/African American, American Indian, Asian, Hispanic/Latino, Native Hawaiian, other): _____ Language and Religion: _____

Primary Insurance

Insurance Company: _____ ID#: _____ Group#: _____

Subscriber or Responsible Party Name: _____ DOB: _____ Relationship to Patient: _____

Secondary Insurance

Insurance Company: _____ ID#: _____ Group#: _____

Subscriber or Responsible Party Name: _____ DOB: _____ Relationship to Patient: _____

SELF PAY OPTION: Please initial if you have health insurance but you do not want your insurance billed and instead opt to pay out of pocket as self-pay

BASS
MEDICAL GROUP

FINANCIAL POLICY

- I, the responsible party, certify that the above information is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges regardless of delays in insurance payment or denial of insurance coverage.
- It is my responsibility to verify with my insurance if BASS Medical Group is a contracted provider. BASS and/or its representatives will make every effort to assist you, but BASS will not be held accountable for understanding every insurance plan.
- I hereby authorize BASS Medical Group to apply for benefits and receive payments directly on my behalf for covered services rendered. They may also disclose any or all parts of my clinical record to any insurance company covering services for the purpose of satisfying charges billed.
- I authorize the release of any medical or other information necessary to process claims for payment.
- I further agree to pay all collection costs, attorney fees and any other collection costs that may be incurred in the attempt to collect outstanding patient responsibility amounts.
- I also understand, that if any insurance payments are sent directly to me, it is my responsibility to send these monies directly to BASS Medical Group. immediately upon receipt.
- I understand that I will be billed for any amounts due by me (co-payments/co-insurance amounts/deductibles) and that I have a financial responsibility to pay these amounts.
- I understand that I will be provided with at least 2 statements for any balance due after insurance payment. Payment in full is due within 30 days of your first statement unless other arrangements have been made. I further understand that if I have not made payment prior to the third statement being mailed, the third statement will be a final notice and may result in my account being sent to an outside collection service if I still do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with those collection efforts.
- I, the patient, or the patient's representative, understand that all medical doctors at BASS Medical Group are licensed and regulated by the Medical Board of California. I can verify this by contacting the Medical Board at (800) 633-2322 or via the internet at their website: www.mbc.ca.gov.
- Lab services: I understand some or all laboratory tests may be sent to an outsourced lab for processing when necessary.
- Imaging Services: Attention Medicare patients only, if you are referred by a chiropractor for radiology services, please note, Medicare will not cover the billed charges.

My signature below confirms that I have read these billing policies and my financial obligations as pertains to the laboratory department of BASS Medical Group.

Signature of Patient, Parent or Legal Guardian	Relationship to Patient	Date

HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM - Page 1 of 3

We are required by law to keep health information confidential. Authorization for the disclosure of health information to someone who is not legally required to keep it private may cause the information to no longer be protected by state and federal confidentiality laws. In accordance with state and federal patient privacy laws, including HIPPA (the Health Insurance Portability and Accountability Act of 1996) this Notice describes how your health information may be used or disclosed and how you, the patient, can get this information. Please review this Notice carefully.

PERMITTED USES & DISCLOSURES: The law permits us to use or disclose your health information to the following:

- Another specialist or physician who is involved in your care.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff, for the purpose of entering your information into our computerized system
- Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent via fax which is a permitted use allowed by law. We have on file with these sources, verification for the confidentiality of the fax used and its limited access by authorized personnel.
- If this practice is sold, your health information will become the property of the new owner.
- We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Federal and state law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations. We also use a shared Electronic Medical Record that allows both our physicians and staff access to our patients' health information. The purpose for this access is to expedite the referral of patients within the BASS Medical Group, other providers, and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the BASS Medical Group only with the patient's express authorization or as otherwise specifically permitted or required by law.

PATIENT RIGHTS: The law also establishes patient rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses or disclosures we make with your health information beyond the normal uses referenced above.
- You have the right to limit the use or restrict the use disclosure of your health information. Our office will follow any restrictions notated by you on page 2 of this Form.
- You have the right to request in writing to inspect and/or receive a copy of your health information.* Our office may charge a reasonable fee to cover copying and mailing of these records to you. Some releases of your health information may require the completion and submission of a separate request or form from this one, as our Privacy Officer may determine.

HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM - Page 2 of 3

- You have the right to request an alternate means or location to receive communications regarding your health information.* Otherwise, such communications will be mailed to the home address in your medical or billing record and/or sent to the alternative address and/or by the alternative means of communication(s) you designate below (E.g., via telephone text or email).

- You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.

  *Conditions and limitations may apply; obtain additional information from our Privacy Officer.

- We may use your information to contact you. For example, we may use the U.S. Mail, the telephone, a Text message, or email to remind you of an appointment or call you with information regarding your care. If you are not at home, this information may be left on your answering machine, voicemail, sent via Text, via email, or with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care.

- **MINORS:** We take patient privacy laws very seriously. The State of California limits what type of health information we can share with the parents or legal guardians of minor teenage children between the ages of 12 and 17. Accordingly, we will maintain an exclusive phone number and/or email address for minors in this age range, as they may designate.

  IF PATIENT IS A MINOR, PLEASE STATE AGE: _____ **AND DATE OF BIRTH:** _____

- **WHOM I DESIGNATE: Please designate who our offices CAN disclose your health information to, including, but not limited to correspondence, test results, prescriptions, medical records, or billing information, who are 18 years or older, by checking the boxes below and signing below:**

  This authorization to Release Health Information is voluntary.

  ☐ **OK to Spouse: Please list name. alternative address. phone number. & email address of Spouse. as applicable:**

  _____

  ☐ **OK to Family Members: Please list name(s). alternative address. phone numbers. & email addresses of Family Member(s). as applicable:**

  _____

  ☐ **OK to Other (E.g., Attorney, Accountant, Financial Advisor, Legal Guardian, Conservator, or other legally authorized agent or representative). Please list name(s). alternative address. phone numbers. and email addresses of authorized person(s) or entities:**

  _____

BASS MEDICAL GROUP

HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM - Page 3 of 3

☐ **OK to leave health information on answering machine, voicemail, telephone text, or email.**

☐ **DO NOT RELEASE AND SEND ANY INFORMATION to anyone other than myself (the Patient). Please send my information to my home address or the alternative address, phone number, and email address I list here:**

Address: _____ **Phone:** _____

Email address:

IF PATIENT IS A MINOR, PLEASE STATE AGE: _____ **AND DATE OF BIRTH:** _____

☐ **DO NOT RELEASE TO:** _____
[Please list names, as applicable].

We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and our office will notify you of the changes in writing.
You have the right to file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at (925) 627-3424.

ACKNOWLEDGEMENT, AUTHORIZATION, & CONSENT
This acknowledges that you have received and read a copy of our Privacy Practices Notice and Consent to the disclosure of your health information to the person(s) or entities you have designated above. This document will remain as part of your medical and billing record.

Signature: _____ Date: _____

Patient's Name: _____ Date of Birth: _____

If person signing is not patient, please provide name and identify the relationship to the patient and in what capacity you/ they are signing (E.g., parent, guardian, conservator):

Name: _____

Capacity and/or Relationship to patient: _____

This authorization/consent may be revoked at any time prior to the release of the requested information. The revocation must be in a writing, signed by the patient or their authorized representative, and delivered to BASS at their address referenced below.

Patient's authorized representative is entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION/CONSENT: Unless otherwise revoked, rescinded, revised, updated, or changed by you in a writing signed by you, this Authorization & Consent shall not expire and will last indefinitely.

MORGAN HILL
Family Medicine
A division of BASS Medical Group

Health History (all information is strictly confidential) Page 1 of 4

Name _____ Today's Date _____

Age ____ Date of Birth _____ Date of last physical exam _____

Reason for today's visit? _____

SYMPTOMS Check symptom's you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain/weakness/numbness:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

MEN ONLY

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision- Flashes
- ☐ Vision - Halos

WOMEN ONLY

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period: _____

Date of last Pap Smear: _____

Date of last mammogram: _____

Are you pregnant? Yes / No

Number of Children: _____

Notes:

MORGAN HILL
Family Medicine
A division of BASS Medical Group

Health History (all information is strictly confidential) Page 2 of 4

CONDITIONS Check conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

OTHER CONDITION not listed above:

MEDICATIONS you are currently taking	**ALLERGIES** to medications or substance

Pharmacy Name: _____ Pharmacy Location: _____

Pharmacy Phone: _____ Pharmacy FAX: _____

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Health History (all information is strictly confidential) Page 3 of 4

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age of Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check if your first line relatives have had any of the following:

Disease	Relationship to you
☐ Arthritis/Gout	
☐ Asthma/Hay Fever	
☐ Cancer	
☐ Chemical Dependency	
☐ Diabetes	
☐ Heart Disease or Stroke	
☐ High Blood Pressure	
☐ Kidney Disease	
☐ Tuberculosis	
☐ Other	

HEALTH HABITS Check which substances you use and describe how much you use.

Substance		How much?			
☐ Caffeine	—	☐ Daily	☐ Weekly	☐ Monthly	☐ Rare Occasions
☐ Tobacco	—	☐ Daily	☐ Weekly	☐ Monthly	☐ Rare Occasions
☐ Drugs	—	☐ Daily	☐ Weekly	☐ Monthly	☐ Rare Occasions
☐ Other	—	☐ Daily	☐ Weekly	☐ Monthly	☐ Rare Occasions

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Health History (all information is strictly confidential) Page 4 of 4

Have you ever had a blood transfusion? Yes / No

If yes, when? _____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

HOSPITALIZATIONS

REASON	YEAR

OCCUPATIONAL CONCERNS Check if your work exposes you to the following:

What is your occupation: _____

☐ Stress
☐ Hazardous Substances
☐ Heavy Lifting
☐ Other _____

PREGNANCY HISTORY

BABY GENDER	YEAR OF BIRTH	COMPLICATIONS, if any

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PRACTICE & FINANCIAL AGREEMENTS (PG 1 OF 2)

We appreciate the opportunity to serve you and pledge to provide you our best medical care in a safe environment with compassion and attention to detail. In order to make our relationship with you the best it can possibly be, please be familiar with the following policies:

Administrative Policies

- We promise to inform you at check-in if your doctor is running late.
- We promise to treat you with respect & dignity in a professional and caring manner. In return we expect you to refrain from using verbally abusive language, threatening any employee or provider or otherwise hostile behavior. Using such is cause for immediate termination from this practice.
- Many appointments require collection of a urine sample so please check with the front desk upon arrival before going to the bathroom.
- To respect other patients, we ask that cell phones be turned on vibrate mode while in our office and that you step out of the waiting room if you must take a call. Please let us know if you step outside.
- Missing or not showing up for your appointment, whether in-office or telehealth, creates an undue burden and increases the cost of care to all patients. Please see our fee schedule below as we do reserve the right to charge for No-Shows and last minute cancellations. Missing three appointments without notice will result in dismissal from this practice.
- If you are 15 minutes late, we reserve the right to reschedule your appointment.

Insurance & Billing Policies

- If you have insurance, please bring your card to every appointment; without current insurance cards we cannot bill your carrier.
- We are required to collect co-payments and co-insurance and reserve the right to re-schedule or cancel appointments to comply with insurance company agreements and our practice policy.
- Your health insurance policy is an agreement between you and your insurance carrier. You are responsible for understanding your own coverage. Your insurance company makes the determination of your eligibility. You authorize your insurance benefits to be transferred directly to the rendering provider and acknowledge you are financially responsible for paying any co-insurance amounts. You agree to pay for services rendered within the limits of this care provisions policy.
- If you do not have insurance or choose not to file a visit with your insurance, a minimum payment of $100 at time of service is required. The remaining balance for services provided will be addressed following the delivery of service and will be due upon appointment completion.
- Many insurance companies have lists of approved drugs that they cover. Your provider will prescribe the medication s/he believes will best address your needs. We will do our best to respond to prior-authorization requests from your insurance company, but this process may delay your prescription. You are responsible for contacting your insurance carrier with any questions or requests concerning approved or disapproved medications.
- Disability, FMLA, sports physicals and other form completion requests require an appointment and in some cases a $35 payment for the administrative service outside of an appointment.
- We accept cash, check, and credit cards. We do not keep change in the office so please come prepared for your co-payments and any outstanding balances due.

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PRACTICE & FINANCIAL AGREEMENTS (PG 2 OF 2)

• Payment in full is due within 30 days of your first statement unless other arrangements have been made. We send two statements at 30-day intervals. You understand and agree that if we are forced to send your account to collections, a fee of 35% of the unpaid balance will be added. This amount shall be in addition to any other cost incurred directly or indirectly to collect amounts owed under this agreement. We offer payment plans to patients who meet the criteria.

• If you need an in-office surgical procedure, our coordinators will assist you in scheduling. Although we seek prior authorizations, insurance carriers state that does not a guarantee payment. You must call our insurance carrier to verify they will cover your procedure.

• If you get lab or imaging tests as part of your appointment remember some tests/labs are performed by outside parties; in such cases they bill separately. If you know your insurance carrier only covers certain labs or facilities, please notify our office in advance.

Non-compliant policy penalties:

No Show and Late Cancellation Policy

• A **$35.00** NO SHOW/LATE CANCELLATION Fee will be charged for all failed/late cancellations for standard office visits and telehealth appointments. (15 minute appointments)

• A **$75.00** NO SHOW/LATE CANCELLATION Fee will be charged for all physicals and extended visits including telehealth appointments not cancelled more than 24 hours in advance. (30 minute or longer time slots.)

Returned Check Fee

• A **$35.00** fee will be charged for all checks returned from the bank for Non-Sufficient Funds.

Insurance Rebill Fee

• A **$20.00** fee will be charged if current insurance information is not provided thereby causing a delay in payment and requiring a 2nd insurance claim to be processed.

By signing below you agree to the terms of service provided herein.

_____

Signature

_____

Date

MORGAN HILL
Family Medicine
A division of BASS Medical Group

OPEN PAYMENTS DATABASE NOTICE

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at openpaymentsdata.cms.gov

The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals.

My signature below confirms that I have read and understand that notice above.

_____
Patient Name

_____
Patient Representative Name

_____
Signature

_____
Date