Blackhawk
MEDICAL GROUP …a division of BASS Medical Group

Dear New Patient,

Welcome to our practice! Thank you for choosing us as your partner in health and wellness.

In order to make your first visit to our office go as smoothly as possible, we've tried to organize things for you ahead of time.

1. We've created a New Patient Registration packet that you may download, print and complete before you arrive. Click here to get it: https://www.blackhawkmedicalgroup.com/docs/new_patient_information_packet.pdf
2. Please bring your driver's license or passport (photo id) and your current insurance ID card.
3. You will be asked to pay any required copay or identifiable deductible when you check-in for your appointment. We accept cash, check and credit cards.
4. Please arrive fifteen minutes before your scheduled appointment so we can confirm your information and verify your insurance.
5. If you are unable to keep your appointment, please notify us as soon as possible. We do have a 24-hour cancellation policy and No Show or Late Cancelation fees may apply.
6. Our practice uses an electronic medical record system (EPIC). Your record will be established at your first visit. When checking out, you will be given an After Visit Summary (AVS) which will include instructions to create a login to access your personal health records and establish online communication access with our office. Ask at the desk for help if you need it!

If you are enrolled in an HMO insurance program, please be aware that we can only accept HMO insurances through the John Muir Provider Health Network and your card must have one of our Blackhawk Medical Group doctors identified as your Primary Care Provider (PCP). If you are not in John Muir PHN, we will be happy to see you as a self-pay patient, but we cannot bill any other HMOs outside of John Muir.

You can learn more about our Insurance plan participation through this link on our website: http://blackhawkmedicalgroup.com/download/insurance-information/

If you have questions about the practice or your visit, please let us know.

Thank you for choosing Blackhawk Medical Group!

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Practice & Financial Agreements

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 no-showing your appointment creates an undue burden and increases the cost of care to other patients. Please see our fee schedule below as we do reserve the right to charge for no-showing 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 it 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.
- 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 received will be addressed following the delivery of service.
- Many insurance companies have lists of approved drugs they cover. Your provider will prescribe the medication they feel 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 provider with any questions or requests concerning approved medications.
- Disability, FMLA, sports physicals and other form completion requests require an appointment.
- We accept cash, check, and credit cards. 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 a financial aid program 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 they are not a guarantee of payment. You must call your 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 Cancellation Policy
We sincerely request 24-hour notice when cancelling or rescheduling an appointment.

- A **$35.00** NO SHOW/LATE CANCELLATION Fee will be charged for all failed/late cancellations for standard office visits (15 minute appointments)
- A **$75.00** NO SHOW/LATE CANCELLATION Fee will be charged for all physicals and extended visits 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 of Patient or Legal Guardian/Guarantor Date

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Patient Confidentiality Protocol & Notice of Privacy Practices Summary

Purpose: To preserve and protect the privacy and confidentiality of all patient health care information and to prevent civil or criminal prosecution for illegal disclosure of such information.

Policy: It is the right of all patients to receive full consideration of privacy and confidentiality with regard to all information and records about their care. Health plans and reviewers acting as their agents, however, do have certain rights of access to patient medical information for quality-of-care purposes.

Privacy Officer: Lacey Richmond bmglacey@gmail.com 4165 Blackhawk Medical Group, Danville CA 94506 (925)736-7070 x121

Procedure:

1. All employees, contractors, consultants and anyone who may have access to Individually Identifiable Health Information (IIHI) will sign a statement not to disclose or release confidential information for any reason not medically indicated to any persons other than those legally authorized to receive same. (Business Associate Agreement)
2. Except when required in the regular course of business, the discussion, use, transmission, or narration, in any form, of any patient information, which is obtained in the regular course of job functions, is strictly forbidden.
3. Temporary placement of patient records in unattended areas shall be avoided and all records are to be maintained in secured files and in a manner that allows access to authorized individuals only.
4. Facsimile transmission of patient data should be limited to documents necessary for the purpose of completing a transaction or communicating specific patient data to an authorized individual to whom it is addressed.
5. Electronic access to patient data shall be password protected to limit data retrieval to what is needed for job functions.

Health Information Use Acknowledgement

I understand that as part of my healthcare, the providers at Blackhawk Medical Group originate, access and maintain health records describing my health history, examinations and test results, diagnosis, treatment and any plans for future care or treatment.

I understand that the Notice of Privacy Practices Information serves as:

- a basis for planning of my care and treatment
- a means of communication amongst the many healthcare professionals who contribute to my care.
- a source of information applying my diagnosis to my bill.
- a means by which a third-party payer can verify that services billed were actually provided.
- a tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I acknowledge that I will be provided an opportunity to review the Notice of Privacy Practices in full upon request.

Signature: _____ Date: _____

Blackhawk MEDICAL GROUP **…a division of BASS Medical Group** Date:

PATIENT INFORMATION

Patient Name (Last, First, Initial)			**Home Phone #:**	**Cell Phone #:**
Home Address:			**City & State:**	**Zip:**
DOB:	**Gender:**	**Marital Status:** M S W Div	**SSN:** LEAVE BLANK	**DL#:**
Email:		**Your BMG PCP:**		
Employment Status: FT PT Retired Not Working		Employer:		Work Phone #:
Employer Address:			City & State:	Zip:
Emergency Contact Name			**Relationship:**	Phone #:
Preferred Pharmacy Name / Location:			**Phone #:**	**FAX#:**

RESPONSIBLE PARTY/GUARANTOR if different from above or the **patient is a minor.**

Name**:**		Relationship:	Date of Birth:
Address:		City & State:	Zip:
Email Address:		Phone #:	
Primary / Secondary Insurance Information: ***__PLEASE__ provide your most current insurance card at every office visit.**			

Other Required Information:

Religion:	Ethnicity: Non-Hispanic: _____ Hispanic: _____	Preferred Language:	Written Language:
Is an Interpreter Needed : Yes ____ No _____	Race:		

May we text you with appointment reminders? Yes No Cell phone: _____

May we leave messages on your home or cell phone (circle one or both) with results/personal health information or appointment reminders? Yes No (circle one)

Is there someone you would like to authorize to receive messages on your behalf?
Please list name, relationship and phone number:

_____

_____

May we email you with test results or communication re: your health or appointments? Yes No
Email address: _____

I certify that the information I have provided is true and correct:

Signature: _____ Date: _____

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Health History (All information is strictly confidential)

Name _____ Today's Date_____
Age _____ Date of Birth: _____ Date of last physical exam_____
Reason for today's visit? _____

SYMPTOMS Check symptoms 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 in:
- ☐Arms
- ☐Back
- ☐Feet
- ☐Hands
- ☐Hips
- ☐Legs
- ☐Neck
- ☐Shoulders

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

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

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

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

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

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? _____

Number of Children _____

_____
Note:

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

- ☐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
- ☐Liver 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

Health History Continued	**Page Two**	**NAME:**	
MEDICATIONS List current **medications with the dosage**		**ALLERGIES** To medications or substances	

FAMILY HISTORY Fill in health information about your family.

Relation	**Age**	**State of Health**	**Age at Death**	**Cause of Death**	**Check if your first line relatives have had any of the following:**		
						Disease	**Relationship to you**
Mother						Arthritis, Gout	
Father						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease	
Sisters						High Blood Pressure	
						Kidney Disease	
						Stroke	
						Tuberculosis	
						Other	

HOSPITALIZATIONS: Medical Year	**Reason for Hospitalization and Outcome**		**PREGNANCY HISTORY** Year of Birth	Sex of Birth	Complications, if any
HOSPITALIZATIONS:Surgical Year	**Type of Surgery**	**Outcome**			
SERIOUS ILLNESSES	**Date**	**Outcome**			

HEALTH HABITS Check which substances you use and **describe how much you use each week.**				**OCCUPATIONAL CONCERNS** Check if your work exposes you to the following:	
YES	**NO**	Alcohol			Stress
YES	**NO**	Caffeine			Hazardous Substances
YES	**NO**	Drugs			Heavy Lifting
YES	**NO**	Tobacco			Other
YES	**NO**	Other			
Have you ever had a blood transfusion? Yes or NO If yes, please give approximate dates:_____				**Your occupation:**	

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2019 Insurance Update

On January 1, 2016 we affiliated with BASS Medical Group and are now a Division of BASS. Patient services provided by BASS include our claims, billing and collections department. The Billing Department is happy to assist with billing calls and questions and can be reached at (925) 627-3424.

Medical services are provided by Blackhawk Medical Group providers and staff. We are contracted with many of the major insurance plans in the region and the managed care plans available through John Muir Physician Health Network, with the exception of their MediCal plans. For a more thorough list, please see below.

Please remember that your health insurance and the choices you've made regarding premiums, co-pays, co-insurance and deductibles represent your contract with your insurance plan. Please be familiar with your fees and your plan coverage. If required, make sure your primary care provider at Blackhawk Medical Group is named on your card and bring your ID to every appointment please.

We also contract with the insurance companies and our agreement includes collecting your co-pays, co-insurance and deductibles. These fees are due and collected at the time of service. Please come prepared and respect our contract with your insurance company by helping us avoid the expense of billing you later. If we are billing your insurance, and any amount is applied to your deductible or determined to be a non-covered service, please pay your bill upon receipt! Repeatedly invoicing and calling is so unsatisfying for all of us.

If your plan is not listed below, we may be unable to file a claim on your behalf, but we can enroll you as a self-pay patient. Because of the many plan names within the numerous plan networks, we may not have listed your specific insurance, but we may be on their panel. **Please call your insurance company before your appointment to verify that we participate in your plan! Confirm with the BASS Tax ID# 562605608.**

Thank you.

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2019 Update

Accepted Insurance Plans

- Aetna PPO/EPO/POS
- Anthem Blue Cross PPO
- Beech Street PPO (Multiplan)
- Blue Shield PPO
- CalPers Choice/Care Plans
- Cigna PPO/Great West
- Coventry Health Care National Network – PPO
- Covered California
    - Blue Shield
    - Health Net
    - Health Net Pure Care EPO
    - United Healthcare-w500 plan only
    - **We do not participate in Anthem Blue Cross Covered CA/ACA health plans purchased on or off the exchange.**
- Delta Health PPO (Anthem)
- First Health PPO (Aetna)
- Health Net PPO/EPO/POS
- InterPlan/Healthsmart
- Medicare Part B
- Muir Medical Group IPA/John Muir Health
    - Medicare Advantage Plans
        - Humana's Medicare Advantage HMO
        - Health Net Medicare Advantage Seniority Plus HMO (*Group Retirees only*)
        - United Healthcare Signature Value HMO Advantage (West)
    - Commercial HMOs
        - Aetna Select Choice HMO
        - Blue Shield Access+HMO/POS
        - CalPERS (check with your group for our participation)
        - Great-West Healthcare HMO (Cigna)
        - Health Net SmartCare HMO Whole Care Plan (HMO)
        - United Healthcare Signature Value HMO (West)
- Multiplan PPO
- NX Health PPO
- PHCS – Private Health Care System PPO through MultiPlan
- TRICARE West
- United Healthcare PPO (**excludes UHC CORE**)