Allyson Bagenholm, MD

INTAKE FORM

PLEASE PRINT

Date: __________________ Sex: ( ) Male ( ) Female S.S.#: ______________________

Patient Name: _____________________ *Preferred Name:* _____________ Date of Birth: __________

Local Address: ____

City: ____________________________________ State: ________ Zip: _______________

Permanent Address: ____

City: _____________________________________ State: ________ Zip: _______________

Local Phone #: _______________________________ Cell Phone #: _______________________

Preferred Contact: ( ) Local Phone ( ) Cell Phone May we leave a voicemail?: ( ) Yes ( ) No

Email: _____________________________Marital Status: Single Married Divorced Widowed

Occupation: ______________________ Business Phone #: ________________________

Name of Emergency Contact: ______________________Phone #______________________

Relationship of Emergency Contact: Spouse ( ) Next of Kin ( ) Other:_______________

May we discuss results/information with this person ( ) Yes ( ) No > *Initial here:* _________

Referred by: ___________________________

Pharmacy: Name_______________ Location: ________________ Phone Number: ______________

(It is extremely important for you to provide our office with copies of these legal documents so that we may have them on file in case of emergency – (Power of Attorney, DNR and/ or Living Will)

Please list any individual(s) or Power of Attorney on your behalf that our office can contact/speak with regarding your medical care, test results and appointments:

Name: ________________________________ Relationship: ___________________________

Name: ________________________________ Relationship: ___________________________

Patient Signature: ____ Date: ___________

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to the quality of your medical care, while maintaining your privacy and confidentiality. Please understand that payment of your bill is considered a part of our medical treatment. The following is a statement of our financial policy, which I require that you read and sign prior to any treatment.

All patients must complete this registration form before any medical care is rendered.

Payment is due at the time of service. We accept cash, checks, and credit cards.

Your insurance policy is a contract specific to you and your insurance company. Each and every plan and policy are different. Please make sure you are familiar with the specifics of your contract. As a patient, you will be responsible for your annual deductible, co-payments, coinsurance, and charges for non-covered services. Your co-pay is due at the time of service. All other charges will be sent to your insurance company first and the balance will then be billed to you in a monthly statement. We may order tests/procedures that are medically necessary but may not be covered by your insurance company. The financial responsibility for these non-covered tests belongs to the patient. If this is a concern, please check with your insurance company before proceeding with these tests/procedures.

It is the patients' responsibility to inform the office of all insurance changes, authorization, and referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

As a courtesy to our patients, we try our best to remind our patients of their appointment the day before. But, it is ultimately the patients' responsibility to arrive at their scheduled time. If you cannot make your appointment, we ask that you please give us a minimum of 24 hours advance notice so that we may fill your slot. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. For this reason, the office of Dr. Allyson Bagenholm reserves the right to charge a fee of $50.00 for all missed appointments and appointments which, absent of a compelling reason, are not cancelled with a 24 hour advance notice.

These fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "No Shows" may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

Past due accounts of 90 days or more are subject to outside collections. We will make an attempt to call and speak with you first to set up a payment arrangement. If no cooperation is received, we will send your account to collections. A fee will be added onto your balance for this collection.

I have read the Financial Policy. I understand and agree to this Financial Policy.

______________________________ ______________________

Signature of Responsible Party Date

______________________________ ______________________

Signature of Co-Responsible Party Date

CONSENT FOR TREATMENT, USE, AND DISCLOSURE OF HEALTH INFORMATION
HIPAA COMPLIANCE FORM

Section A: Patient Giving Consent

Name: ____

Address: ____

Telephone: ________________________ **Social Security #** _____________________

Section B: To the Patient – Please read the following statements carefully.

Purpose of Consent - By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment and healthcare operations. You give permission to Dr. B Medical PLLC to administer medical treatment. You understand that the physical examination may include a medically appropriate examination of your pelvic area, and you consent to such examination. (Must be signed by parent/guardian if patient is a child under 18 years of age).

Notice of Privacy Practices - You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised notice.

Right to Revoke - You will have the right to revoke Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action that we took before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, ______________________, have had full opportunity to read and consider the contents of this consent
(Please Print)
form and your Notice of Privacy Practices. I understand that, by signing this Consent Form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

Signature: ________________________________ Date: _______________________

CONSENT FOR TELEHEALTH VISITS

1. I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that Dr. B Medical PLLC- will take steps to make sure my health information is not seen by anyone who should not see it. I understand that telehealth may involve electronic communication of my personal medical information to other health practitioners engaged by Dr. B Medical PLLC that may be located in other areas, including out of state.

2. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

3. I understand that I may or may not be covered under my current health insurance plan for telehealth services. Insurance coverages have been changing rapidly due to multiple factors. Your insurance or you (self-pay) will be billed at our usual rates for office visits and you are responsible for payment; copays or deductibles. I agree to pay any costs I incur for the visit.

Patient Informed Consent

I have carefully read this form and fully understand its contents, including the risks and benefits of the telehealth services. I hereby give my informed consent to participate in a telehealth consultation under the terms described herein. By checking the box associated with “Telehealth Informed Consent”, I acknowledge that I understand and agree with the above and hereby consent to receive Dr. B Medical PLLC’s telehealth services:

☐ Accept, by checking the Box for this “Telehealth Informed Consent”, I hereby state that I have read, understand and agree to the terms of this document.

___________________________	___________________________________	______________
Patient’s Name	Patient’s Signature	Date

If signing on behalf of a minor:

_______________________________	____________________________________	______________
Parent/Legal Guardian’s Name	Parent/Legal Guardian’ Signature	Date

Dr. B Medical PLLC
1905 Clint Moore Road Suite 202
Boca Raton, FL 33496

***** IF NO RECORDS, PLEASE INDICATE HERE AND FAX BACK***

☐

CONSENT TO RELEASE / OBTAIN MEDICAL RECORDS

Allyson Bagenholm, M.D

Diplomate American Board of Family Medicine

Date: _________ **Patient Name:** _________________________ **Date of Birth:** __________

(Print Name)

I hereby authorize Dr. B Medical PLLC:

_________To **RELEASE** copies of my medical records to:

_________To **RECEIVE** copies of medical records from:

Dr./Clinic ____

Address____

Phone______________________________ **Fax**______________________________

Send only the following records:

☐ _____________ **Visit Notes** ☐ **Lab Results** ☐ **EKGs** ☐ **Other Testing/Pathology Reports**

Other: ____

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Patient Signature ______________________________

1905 Clint Moore Road, Suite 202, Boca Raton, FL 33496

Phone: (561) 757-5530 Fax: (561) 430-3590

Patient Name: ____________________

Physician List

Physician's Name	Address	Specialty	Phone Number/Fax Number

Please provide us with the physicians and/or facilities that you would like us to obtain records from.

Dr. B Medical PLLC

1905 Clint Moore Road, Suite 202
Boca Raton, FL 33434

561-757-5530

Fax: 561-430-3590