Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____/____/_____

[ ] I authorize the release of information including diagnosis, records, examination rendered to me and claims information. This information may be released to:

Name: _____

Phone: _____

Relation: _____

Name: _____

Phone: _____

Relation: _____

Name: _____

Phone: _____

Relation: _____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Signed: _____ Date: ____/____/_____

Witness: _____ Date: ____/____/_____

Brookhaven Health and Wellness
1005 West Congress Street
Brookhaven, MS 39601
601.833.9388 – Office
601.833.9495 – Fax

Brookhaven Urgent Care
430 Highway 51 North
Brookhaven, MS 39601
601.990.4303 – Office
601.990.2282 – Fax

McComb Health and Wellness
521 Marion Avenue
McComb, MS 39648
601.600.2053 – Office
601.600.2360 – Fax

Wesson Health and Wellness
1096 Beech Street
Wesson, MS 39191
601.990.4308 – Office

Bridging Community with Healthcare

Brookhaven Health & Wellness Center
BHWC Urgent Care
McComb Health & Wellness Center

Patient Name:			**SSN #:**	Sex: Male Female
MAILING Address:			**Date of Birth:**	Age:
City:	**State:**	**Zip Code:**	Marital Status: (_) Single (_) Married (_) Widowed (_) Divorced (_) Separated	
Street Address if different:		City, State, Zip	**Race:**	**Ethnicity:**
			(_) White	(_) Hispanic or Latino
			(_) American Indian	(_) NOT Hispanic or Latino
			(_) Asia, India, Pakistan	
Home Phone:	**Cell Phone:**		(_) Black/African American	Language Preference:
			(_) More than one race	(_) English
Work Phone:	**Email Address:**		(_) Decline to report	Specify if not English
			(_) Other: _____	
Employer:		Full time	**Retired:**	**Date of Retirement:**
Phone:		Part Time	Yes No	
Parent/Legal Guardian:			**Relation to Patient:**	
Address:			(_) Spouse (_) Parent (_) Grandparent (_) Other	
			DOB: SSN:	
Phone:			Cell Phone:	

Emergency Contact/May release medical/billing information to:	**Relation to Patient:**
Name:	(_) Spouse (_) Parent (_) Child (_) Other
Address:	Phone:
Pharmacy:	

PRIMARY INSURANCE: (Copies of cards MUST be provided)		
Insurance Company:		
Policy Holder:	Date of Birth (Policy Holder)	Social Security Number:
Relationship to Insured: __ Spouse __ Parent __ Other		
SECONDARY INSURANCE:		
Insurance Company:		
Policy Holder:	Date of Birth (Policy Holder)	Social Security Number:
Relationship to Insured: __ Spouse __ Parent __ Other		

Authorizations, Medical Records Release, Assignment of Benefits:

Please initial at each line and sign at the bottom.

(____) 1. Treatment Authorization: I authorize you to give me reasonable and proper medical care by today's standards.

(____) 2. Patient Rights/Privacy Notice: I have received and understand my patient rights, responsibilities, and privacy notice.

(____) 3. Release of Information: I authorize release of my medical records to Bridging Community with Healthcare, and from Bridging Community with Healthcare to other healthcare providers as necessary for continued medical care, to obtain insurance reimbursement, or to comply with the utilization review. I authorize this office to obtain previous medical records from other physicians and/or medical facilities. A faxed copy of this authorization can serve as an original.

(____) 4. Medicare Lifetime Signature on File(if applicable): I request that payment of authorized Medicare benefits be made to Bridging Community with Healthcare for any services furnished me by a member of this group. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services any information needed to determine these benefits or benefits payable for related services.

(____) 5. Assignment of Benefits: I request that payment of authorized insurance benefits be made on my behalf to Bridging Community with Healthcare for any services furnished to me.

(____) 6. Financial Responsibility: I understand that Bridging Community with Healthcare will file my insurance as a courtesy to me and that I remain responsible for payment of copays, coinsurance, deductibles, non-covered services, and any other charges not paid by insurance within 45 days.

Signature:	**Date:**

PAYMENT POLICY

Thank you for choosing ***Bridging Community with Healthcare***. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan, we do business with, payment in full is expected at each visit. If you are insured by a plan, we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Bridging Community with Healthcare is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date