PATIENT INFORMATION:

Name: ____ Date of Birth: ____________________ Gender: M F

Address: ____ Social Security #: __________________________________

City, State, Zip: ____________________________________ Marital Status: M S D W Other

Phone: Home _____________________________________ Referring Physician: _______________________________

Phone: Cell _______________________________________ Primary Physician: ________________________________

Email: ____ Race: _________________Ethnicity: __________________

Resident of Skilled Nursing Facility? Yes No Preferred Language: _____________Religion___________

EMPLOYMENT INFORMATION:

_____Employed _____Unemployed _____Student _____Disabled _____Retired

Employer: _______________________________________ Work Phone: ______________________________________

If retired, retirement date: _________________________ Was Medicare notified? Yes No

GUARANTOR/PERSON RESPONSIBLE FOR ACCOUNT:

Name: ____ Date of Birth: ____________________________________

Address: ____ Social Security: ___________________________________

City, State, Zip: ____________________________________ Phone: ____

Employer: ____ Employer Phone: __________________________________

PRIMARY INSURANCE:

Insurance Co: ______________________________________ Subscriber Phone #: ________________________________

Subscriber: ____ Social Security #: __________________________________

Date of Birth: _______________________________________ Insured ID #: ______________________________________

Relationship to patient: ______________________________ Group #: ____

SECONDARY INSURANCE:

Insurance Co: ______________________________________ Subscriber Phone #: ________________________________

Subscriber: ____ Social Security #: ________________________________

Date of Birth: _______________________________________ Insured ID #: ______________________________________

Relationship to patient: ______________________________ Group #: ____

EMERGENCY CONTACT

Name: _____________________________________ Phone: _________________________ Relationship: __________________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I understand that if I am a resident of a nursing facility, BASS Medical Group cannot bill my insurance company for some services and that I will be responsible for any balance. I authorize BASS Medical Group and/or my insurance company to release any information necessary and/or required to process my claims. **By signing this form, I acknowledge that I have reviewed a copy of the Patient Consent for Use or Disclosure of Protected Health Information form and a copy of the Financial Policy and Advanced Beneficiary Notice and Missed Appointment Fee Notice on the back of this form.**

Patient / Guardian Signature: ____ Date: ______________________

PATIENT CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for BASS Medical Group (BASS) to use and disclose protected health information to carry out treatment, payment and healthcare operations. (BASS's Notice of Privacy Practices provides a more complete description of such uses and disclosures).

With this consent, BASS may call my home or other alternative locations and leave messages on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. With this consent , BASS may mail to my home or other alternative locations any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that BASS Medical Group restrict how it uses or how it discloses my protected health information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I have the right to review the Notice of Privacy Practice prior to signing this consent. BASS reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to BASS's Privacy Officer at 3250 Beard Road, Napa, CA 94558.

By signing this form, I am consenting to BASS Medical Groups' use to disclosure of my protected health information to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, BASS Medical Group may decline to provide treatment to me.

FINANCIAL POLICY AND ADVANCED BENEFICIARY NOTICE

Verification of insurance coverage is performed at the time of visit. If your insurance indicates that you have a co-pay, it will be required at the visit. BASS Medical Group will be happy to bill all insurance companies, however if we are not a provider in your insurance network, you will be responsible for any amount your insurance does not pay. **If you have an unmet deductible and are having an elective procedure, you will be required to pay your deductible to our office (equivalent to the cost of surgery) prior to scheduling**. If you have unmet deductibles, please plan accordingly. You are responsible for obtaining any referrals that may be required for processing of your claim. For non-covered items, payment is expected at the time of service. For scheduled surgeries of non-covered items, we expect ½ of the charge at the time of scheduling surgery and the remainder 2 days prior to the procedure. **Patients with Medi-Cal, Partnership, CMSP, and Partnership Advantage:** Insurance will be verified the date of the visit, if you are not eligible (even if you provide proof of Medi-Cal application) you will be accepted as a cash-pay patient. If you are seen on a cash basis and obtain retroactive eligibility for Medi-Cal, *no retroactive refunds will be given.*

If you do not have insurance, we will be happy to see you as a patient. Payment in full is required at the time of service. If you should need to have surgery, ½ of the charge is due at the time of scheduling and the remaining ½ is due 2 days prior to the scheduled surgery. All accounts are due and payable within 30 days of statement receipt. We accept credit cards, cash and checks as payment.

As a healthcare provider, we believe in offering essential items to patients that we sometimes are not able to bill for with your insurance company. This notice is to advise you that items such as catheters, drainage bags, leg straps, etc. will not be billed to your insurance company. Payment for these items is expected at the time of service.

Missed Appointment Fee Notice – for appointments not cancelled with 24 hours notice, or for not showing up for an appointment, a $50.00 charge will be applied to your account.

PHARMACY:___________________________ **ADDRESS OF PHARMACY**:___________________________________

***PAST* MEDICAL HISTORY: Please CIRCLE if YOU have had any of the following diseases or conditions:**

Anemia
Angina
Arrhythmia
Aortic Aneurysm
Atrial Fibrillation
Bleeding Disorder
Deep Venous Thrombosis
Heart Attack
Heart Disease
Hypertension
Stroke
HIV
Diabetes
Gout
Thyroid Disorder
Constipation
Crohn's Disease
GERD
Hemorrhoids
Hepatitis B C
Hernia
Irritable Bowel Syndrome
Peptic Ulcer
Kidney Disease
Kidney Infection
Prostatitis
Glaucoma
Arthritis
Fibromyalgia
Herniated Disc
Osteoporosis
Alcoholism
Alzheimer's
Anxiety
Depression
Epilepsy
Migraine
Asthma
COPD
Emphysema
Tuberculosis
Transplant Recipient Type: __________________
Cancer Type: __________________

OTHER: ____

SURGICAL HISTORY: Please CIRCLE if YOU have had any of the following surgeries and date of surgery:

Angioplasty
Aortic Aneurysm Repair
Carotid Artery Surgery
Heart Bypass Surgery
Pace Maker
Brain Surgery
Skin Grafting
Appendectomy
Bowel/Colon Resection
Colostomy
Gall Bladder Surgery
Hemorrhoidectomy
Hernia Repair
Laparoscopy
Liver Surgery
Lysis Adhesions
Splenectomy
Stomach Surgery
Bladder Surgery (Type): ________________
Brachytherapy
Circumcision
Cystoscopy
Epididymectomy
Kidney Stone Shockwave
Hydrocelectomy
Laser Prostatectomy
Meatotomy
Nephrectomy
Penile Implant
Prostate Biopsy
Prostate Microwave Therapy
Prostate Removal
Spermatocelectomy
Testicle Removal
Ureteroscopy
Varicocelectomy
Vasectomy
Breast Surgery
Deliveries (Type): __________________
Hysterectomy
Ear Surgery
Eye Surgery
Nasal Surgery
Sinus Surgery
Tonsil Surgery
Thyroid Surgery
Amputation
Back Surgery
Carpal Tunnel Surgery
Foot Surgery
Hand Surgery
Hip Surgery
Knee Surgery
Rotator Cuff Surgery

OTHER: ____

FAMILY HISTORY: *CIRCLE* the illness AND which FAMILY MEMBER (Mother, Father, Sister, Brother, Daughter, Son) has had the following:

Bedwetting	M F S B D S	Heart Disease	M F S B D S	Prostate Cancer	M F S B D S
Bladder Cancer	M F S B D S	Hypertension	M F S B D S	Stroke	M F S B D S
Diabetes	M F S B D S	Kidney Cancer	M F S B D S	Tuberculosis	M F S B D S
Gout	M F S B D S	Kidney Stones	M F S B D S		

OTHER: ____

CIRCLE: Marital Status: Single Married Separated Divorced Widowed Partner **# DEPENDENTS:** _________

Tobacco: No Yes Occasional Packs/day ___ If stopped, when?_____ **Alcohol:** No Yes Occasional Drink(s)/day ___

Caffeinated beverages: No Low Moderate High/Excessive **Recreational Drugs:** No Yes: _____________

CURRENT SYMPTOMS: Please CIRCLE if you CURRENTLY have any of the following symptoms:

Appetite Decreased
Chills
Fatigue
Fever
Headache
Insomnia
Night Sweats
Food Allergies
Seasonal Allergies
Blurred Vision
Cataracts
Ear Infection
Sinus Problems
Sore Throat
Asthma
Frequent Cough
Pneumonia
Shortness of Breath
Wheezing
Arrhythmia
Chest Pain/Angina
Edema/Swelling
Heart Murmur
High Blood Pressure
Leg Pain While Walking
Abdominal Pain
Bloody Stools
Bloody Vomit
Constipation
Diarrhea
Indigestion
Nausea/Vomiting
Bedwetting
Blood in Urine
Incontinence
Loss of Libido
Painful Urination
Urinary Frequency
Urinary Hesitation
Arthritis
Back Pain
Gout
Joint Pain
Muscle Cramps
Muscle Weakness
Neck Pain
Spinal Disease
Dizzy Spells
Fainting Spells
Memory Loss
Numbness/Tingling
Paralysis/Weakness
Tremors
Hair Growth or Change
Rash
Boils
Blood Clotting Problem
Easy Bleeding
Sickle Cell
Swollen Glands
Thyroid Disease
Anxiety
Depressed
Nervousness

OTHER: ____

MEDICATION LIST

NAME: ____ D.O.B.:______________________________________

REASON FOR VISIT: ____

HOW LONG HAVE YOU HAD THIS PROBLEM? ____

HAVE YOU TRIED MEDICATION/TREATMENT FOR THIS PROBLEM? ____

PLEASE LIST ALL DRUG ALLERGIES: OR NONE

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MEDICATION	STRENGTH	TIMES PER DAY
___________________________	___________________________	___________________________
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