

BMG PATIENT UPDATE

DUE TO THE CONSTANT CHANGES IN THE MEDICAL INDUSTRY AND MEDICAL INSURANCE IT IS THE POLICY OF BEAVER MEDICAL FOR OUR PATIENTS TO COMPLETE IN FULL A YEARLY PATIENT UPDATE. IF YOU HAVE COMPLETED AN UPDATE BUT KNOW THAT YOU HAVE PERTINATE INFORMATION THAT HAS CHANGED PLEASE NOTIFY THE FROM DESK. THANK YOU MANAGEMENT

LAST (patient)		FIRST	M	DOB	SS#
MAILING ADDRESS		CITY		ST	ZIP
PHONE HOME	WORK	CELL		EMAIL	
MARITAL STATUS Married Divorced Separated Widowed Long Term Partner					
PATIENT EMPLOYER		EMPLOYER ADDRESS			PHONE
PATIENT INSURANCE		ID#		GROUP#	
POLICY HOLDER		RELATIONSHIP		DOB	SS#
POLICY HOLDER EMPLOYER		ADDRESS		CITY	PHONE
SECONDARY INSURANCE		ID#		GROUP#	
POLICY HOLDER		RELATIONSHIP		DOB	SS#
PHARMACY		ADDRESS		PHONE	
EMERGENCY CONTACT		RELATIONSHIP		PHONE	

AUTHORIZATION OF RELEASE OF HEALTHCARE INFORMATION

*****If you would like anyone other than yourself to have access to your health record or financial information please list that person below and what their relationship is to you.**

NAME	RELATIONSHIP

NOTICE OF PRIVACY

I HAVE REVIEWED Beaver Medical Group's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document at no cost to me.

Patient requested copy: Yes No

ADVANCED DIRECTIVES

Advance directives are legal documents that allow you to convey your decisions about end of life care ahead of time. They provide a way for you to communicate your wishes to family, friends and health care professionals. An Advance Directive tells how you feel about care intended to sustain life.

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|---|---|
| <input type="checkbox"/> I would like information regarding Advance Directives. | <input type="checkbox"/> I do not wish to have information provided to me at this time. |
| <input type="checkbox"/> I already have an Advance Directive. | <input type="checkbox"/> I do not have an Advance Directive |

Name of Patient	Signature of Patient or Legal Guardian	Relationship to Patient	Date
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Beaver Medical Group, PLLC would like to welcome you to our office. We appreciate the opportunity to serve you. The following information is provided for your benefit so that we may better serve you. Please read, initial and sign at the bottom.

- _____ 1. **PAYMENTS:** All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your appointment. We accept cash, checks, Visa, Mastercard, Discover or American Express. There will be a charge for all non-sufficient fund/returned checks billed directly to you by our recovery agency.
- _____ 2. **APPOINTMENT TIME:** We ask that our patients arrive for their appointment on time; this will facilitate our ability to see you as scheduled. Patients arriving past their appointment time may need to be rescheduled. **Please note that we strictly enforce a (\$25.00/ \$50.00 No Show Fee); depending on the type of appointment that is scheduled. This is enforced if you do not show up for your appointment or you do not cancel 24 hours prior to your appointment.**
- _____ 3. **WEIGHT LOSS POLICY:** All *weight loss* services (Phentermine refill/ Lipo-b injections) are considered cosmetic and (*non-billable to insurance*). These appointments are separate from a sick visit appointment. For your convenience you may be seen by the provider for a *weight loss* visit at the same time as a sick visit (congestion, sinusitis, lab follow-up) but it will still be considered a *separate (non-billable to insurance)* visit and you will be charged at the rate of **(\$85.00 for a New Weight Loss and \$55.00 for an established Weight Loss patient)**. **If you have been a previous weight loss patient but have not been seen for weight loss program for more 1 year you will be considered a New Weight Loss Patient.**
- _____ 4. **CHANGE OF INFORMATION:** Please provide us with any change regarding your address, phone numbers or Insurance information as soon as possible.
- _____ 5. **MEDICATION REFILL REQUESTS:** We request that you contact your pharmacy first. They will call our office with the necessary information to refill your medication. No refills will be done after hours. Please request refills 1 week prior to your running out. **Please allow 24 to 48 hours for your refill request to be processed.**
- _____ 6. **LAB AND X-RAY RESULTS:** Please allow 7 – 10 days for results. A member of our staff will contact you as soon as we receive and review your results.
- _____ 7. **INSURANCE VERIFICATION:** This office will verify your benefits to the best of our ability once you supply your correct insurance information. Verification of coverage **DOES NOT** mean that all services rendered will be covered during your visit; however, any uncovered services, supplies and/or treatments will be your responsibility to pay.
Please Note: If the services performed at Beaver Medical Group are not paid by your insurance due to information that has not been provided to our office by you (the patient) the balance will become that patients' responsibility. It is the patients' responsibility to keep our office informed of any changes in your insurance.
- _____ 8. **REFERRALS TO SPECIALISTS:** Please allow our staff 7 – 10 days to process your referral. **If you are unable to make a scheduled appointment with your specialist, it is your responsibility to reschedule.** Please be advised that some insurance companies extend referrals for a certain period. If you cannot make it within your appointed time frame, there may be a charge for a repeat authorization.
- _____ 9. **DRUG TESTING:** It is the policy of Beaver Medical Group that every new patient and/or anyone on a narcotic or antidepressant will be drug tested at the providers discretion. Drug testing refusal will result in dismissal from the practice.
- _____ 10. **MEDICATION MANAGEMENT:** All patients on a medication management protocol must be seen by provider once Every 6 months; (i.e., diabetes, cholesterol, testosterone, hormones, COPD etc.
- _____ 11. **NARCOTIC PAIN MEDICATION:** Our office will prescribe pain medication as needed for acute pain and only for a short duration of time. If the patient suffers from chronic pain and needs further observation for possible long-term use of prescription narcotics, we will refer the patient to a pain management center. We will not prescribe narcotic pain medication and controlled substances if they are obtained from multiple physicians and/or pharmacies. **(Every patient that we prescribe narcotic medication to must be seen by the provider every 3 months for follow-up and refills and is subject to a drug test at the provider's discretion).**
- _____ 12. **FORMS:** We will be happy to fill out any forms and/or letters that the patient may require. However, there will be a charge per document up to \$25.
- _____ 13. **LABS** We collect lab specimens (blood) here in our office as a convenience to our patients; the fee for this is \$15.00. If you do not want to pay the convenience fee, we will be happy to give you a requisition for your labs and you may utilize any facility of your choosing.

I, being a patient of Beaver Medical Group agree to the above policies as set forth by Beaver Medical Group.

Patient Name _____ Signature _____ Date _____