# BEST CHOICE MEDICAL CLINIC, LLC

6391 Highway 72 Byhalia, MS 38611-9344

Ph (662) 385-4417 Fax (833) 913-2503

***Karen Bolden, FNP-C***


| Todays Date: | | | Please PRINT Clearly |
|---|---|---|---|
| Patients's First Name | Middle Initial: | Last Name: | [ ] Mr. [ ] Miss. [ ] Mrs. [ ] Ms. |
| Is this your legal name? | If not what is your legal name? | Former name: | Birth Date: _____/_____/_____ |
| Sex: [ ] Male [ ] Female | SSN: _____-_____-_____ | Home Phone#: | Cell #: |
| Street Address: | City: | State: | ZIP: |
| Occupation: | Employer: | Employer number: | Race: |
| Chose clinic because because/referred to by: | | | |
| [ ] Family [ ] Friend | [ ]close to home/work | [ ] Doctor | |
| Other family members seen here: | | | |

## INSURANCE INFORMATION

**(PLEASE GIVE INSURANCE CARD TO RECEPTIONIST)**

| | | | |
|---|---|---|---|
| Person responsible for bill: | DOB:____/____/____ SSN: _____ | Address (if different) | City: _____ State:_____Zip:_____ |
| Is this person a patient here? Y/N | Phone: _____ | Occupation: | Employer: |
| Primary insurance: | | Employer Address/Phone: | |
| Subscriber: _____ | Group #: | Policy #: | Co-Payment: $_____ |
| Patient relationship to subscriber: | [ ] Self [ ] Spouse | [ ]Child [ ] Other | Secondary Ins (if applys) |

*Emergency contact: (You must fill this out. If the patient is a minor, this must be filled out with parent/guardian's information)

Name: _____Last Name:_____Phone#_____

Relationship to patient: _____ The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Best Choice Medical Clinic of insurance company to release any information required to process my claims.

Patient/Guardian _____ Date: ____/____/_____


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Ph (662) 385-4417 Fax (833) 913-2505

**Karen Bolden, FNP-C**


Name:_____Birthday:_____Age:_____Date:_____

Allergies: (Food, Insects or Medications):_____

What is the reason for your visit today?_____

List any Medical Problems/Hospitalizations/Surgeries **(Please Include Dates)**

List All Medications Presently Taking **(dosage and how often)**:

| Drug Name | Strength | Frequency Taken |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |

**MEDICAL HISTORY: SELF**

| | | |
|---|---|---|
| ☐ Loss of Bowel or Bladder Control | ☐ High Blood Pressure | ☐ Kidney Problems |
| ☐ Sexual/Menstrual Dysfunction | ☐ Emphysema | ☐ Thyroid/Goiter |
| ☐ Anxiety Disorder | ☐ Gall Bladder Disease | ☐ Vision/Hearing Loss |
| ☐ Dialysis | ☐ Drug or Alcohol Problems | ☐ Allergies/Hay Fever |
| ☐ Heart Attack | ☐ Circulation Problems | ☐ Depression |
| ☐ Heart Pacemaker | ☐ Gastric Reflux Disease | ☐ Hernia |
| ☐ Artificial Heart Valve | ☐ High Cholesterol | ☐ Headaches |
| ☐ Frequent Colds | ☐ Prostate Disease | ☐ Seizures |
| ☐ Venereal Disease | ☐ Skin Problems | ☐ Cancer |
| ☐ Dizziness/Fainting | ☐ Tuberculosis | ☐ Gout |
| ☐ Pneumonia/Bronchitis | ☐ Osteoporosis | ☐ Asthma |
| ☐ Scarlet Fever | ☐ Nervousness | ☐ Stroke |
| ☐ Shortness of Breath | ☐ Hepatitis/Liver Disease | ☐ Arthritis |
| ☐ Back Problems | ☐ Heart Murmur | ☐ Diabetes |
| ☐ Hemorrhoids/Rectal Bleeding | ☐ Blood Clots | ☐ Anemia |

PLEASE LIST ANY PERSON YOU WOULD LIKE FOR US TO RELEASE OR CONTACT ABOUT YOUR PROTECTED HEALTH INFORMATION.

NAME:_____RELATION:_____PHONE:_____

**FAMILY MEDICAL HISTORY**

| RELATION | LIVING? (if no age of death) | SIGNIFICANT HEALTH PROBLEMS |
|---|---|---|
| Maternal Grandmother | Y/N _____ | ☐ Diabetes ☐Stroke ☐Depression☐Cancer ☐Hypertension☐Heart Attack ☐Alcoholism |
| Maternal Grandfather | Y/N_____ | ☐ Diabetes ☐Stroke ☐Depression☐Cancer ☐Hypertension☐Heart Attack ☐Alcoholism |
| Paternal Grandmother | Y/N_____ | ☐ Diabetes ☐Stroke ☐Depression☐Cancer ☐Hypertension☐Heart Attack ☐Alcoholism |
| Paternal Grandfather | Y/N_____ | ☐ Diabetes ☐Stroke ☐Depression☐Cancer ☐Hypertension☐Heart Attack ☐Alcoholism |
| Father | Y/N_____ | ☐ Diabetes ☐Stroke ☐Depression☐Cancer ☐Hypertension☐Heart Attack ☐Alcoholism |
| Mother | Y/N_____ | ☐ Diabetes ☐Stroke ☐Depression☐Cancer ☐Hypertension☐Heart Attack ☐Alcoholism |
| Brother/Sister | Y/N_____ | ☐ Diabetes ☐Stroke ☐Depression☐Cancer ☐Hypertension☐Heart Attack ☐Alcoholism |
| Brother/Sister | Y/N_____ | ☐ Diabetes ☐Stroke ☐Depression☐Cancer ☐Hypertension☐Heart Attack ☐Alcoholism |

**SOCIAL HISTORY:**

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

**Caffeine:** ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
#cups/cans per day?_____

**Alcohol:** Do you drink? Yes /No
If Yes (how many drinks a day_____week_____month____)

**Tobacco:** Do you use Tobacco? Y/N
If not currently, have you ever used tobacco? Y/N
Date Stopped Smoking?_____
☐ Cigarettes (how many packs per day?)_____
☐ Chew (how many packs per day?)_____
☐ Cigars (how many cigars per day?)_____
☐ Vap (how often do you vap?)_____

**Drugs:** Do you currently use recreational or street drugs? Y/N
☐ Marijuana ☐ Cocaine ☐ Extasy ☐ Methamphetamine ☐ Other:_____

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Karen Bolden, FNP-C

## CONSENT FOR TREATMENT

I desire to be seen and treated by Karen R. Bolden FNP-C and Best Choice Medical Clinic and hereby give my consent for the clinic, its physicians, nurse practitioners, employees, and contractors to see and treat me as the deem necessary and appropriate for the diagnosis and treatment. I authorize and consent to examinations, blood tests including blood test for communicable diseases such as hepatitis and AIDS (including testing for health care workers exposed to blood and/or body fluids), laboratory procedures, medications and other services, treatments, and procedures rendered and performed at the Best Choice Medical Clinic or ordered or performed by its physicians, employees, and such as, but not limited to hepatitis and the antibody for the AIDS virus, to the Health Department. I understand that I have the right to ask questions and to receive information regarding my care and treatment and the right to withdraw, in writing my consent to treatment or tests.

## STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for payment for all services rendered to or for me or my family. Although Best Choice Medical Clinic will bill, or arrange for billing to my insurance carrier, I understand and agree that I am responsible for payment of all charges for services provided, regardless of the availability of any insurance coverage(s). I agree to pay all co-payments and deductibles. In the event I fail to pay any charges and the account is turned over to a collection's agency or an attorney, I agree to pay all collection costs incurred, including but not limited to, reasonable attorney fees and court costs.

## RELEASE FROM LIABILITY FOR REFUSING MEDICAL CARE AND LEAVING AGAINST MEDICAL ADVICE

I hereby authorize the release of any and all medical information requested by or otherwise necessary to process my claims with my insurance company, the Social Security Administration and its intermediaries, Medicare, Medicaid, or any other organization responsible for payment of charges for or related to any services provided to me or my family. I hereby assign and authorize payment to the Clinic of any insurance, managed care, or other benefits that are filed by the clinic for services provided for me or my family.

## MEDICARE OR MEDICAID LIFETIME SIGNATURE

I hereby authorize and request payment of authorized Medicare or Medicaid benefits be made to Karen R. Bolden FNP-C or Best Choice Medical Clinic for any services furnished to me.

## ACKNOWLEDGEMENT OF HIPPA PRIVACY POLICY

I acknowledge that I have received a copy of Best Choice Medical Clinic's HIPPA privacy policy.

## WORKMAN'S COMP PERMISSION TO RELEASE INFORMATION

I do hereby give Best Choice Medical Clinic permission to release any medical information needed about my injury to my place of employment which is _____.

Signature: _____ Date:____/____/____

**BEST CHOICE MEDICAL CLINIC, LLC | 6391 HWY 72, BYHALIA, MS 38611-9344**
Phone: (901) 827-1853 | Fax: (833) 913-2503

**A. Notifier:**

**B. Patient Name:** **C. Identification Number:**

# Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

| D. | E. Reason Medicare May Not Pay: | F. Estimated Cost: |
|---|---|---|
| | | |

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**G. OPTIONS:** **Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

**H. Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

| I. Signature: | J. Date: |
|---|---|
| | |

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