



Confidential Patient Information Application

650 W. Maryland Ave Suite #1
Phoenix, Arizona 85013
602-240-2401
www.bellawomenscare.com

500 W Thomas Rd #480
Phoenix, Arizona 85013
602-264-1771
www.bellawomenscare.com

51 E Monterey Way
Phoenix, Arizona 85012
602-240-2401
www.bellawomenscare.com

Last Name: _____ First: _____ Middle: _____

Birthdate: ____/____/____ Ethnicity: Black/White/Hispanic/Asian/Arab, Middle-Eastern, Choose to not answer

How did you hear about us? Friend-Who can we thank? _____ Internet/ Website/ Physician/ Other _____

Address: _____ Unit # _____ City _____ State _____ Zip _____

Phone () _____ - _____ EMAIL: _____ @ _____ . _____

Emergency Contacts 1. _____ Relationship: _____ Phone: _____

2. _____ Relationship: _____ Phone: _____

Primary Insurance: _____ Telephone: _____ Policy # _____

Policyholder Name: _____ Birthdate: _____ Group# _____

Secondary Insurance: _____ Telephone: _____ Policy # _____

Policyholder Name: _____ Birthdate: _____ Group# _____

Employment Status: FT/PT/Unemployed/Retired/Active Military/Self-Employed/Minor Child

Employer Name: _____ Address: _____ Zip _____ Phone: _____

Pharmacy Name: _____ Address: _____ Zip _____

Your Primary Care Physician Name: _____

Facility: _____ Address: _____

City _____ State: _____ Zip _____ Telephone: _____

I certify that I have read and understood the above information to the best of my knowledge. I have completed this form with accurate information. I authorize Bella Women's Care to use or disclose any information for treatment, payment and healthcare operations. I also authorize Bella Women's Care to release any medical information necessary to process Medicare and/or any insurance claims. I authorize payment of medical benefits to Bella Women's Care. I also understand that regardless of my insurance status I am responsible for any due balances on my account for medical services rendered to me. I understand that I am responsible for any deductible, co-pays or co-insurance amounts not covered by my insurance carrier. I also understand that any collection or attorney fees will be my responsibility.

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Bella Women's Care, PC as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that have been or will be rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Provider. A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Patient Signature _____ Date: _____

Legal Guardian: _____ Date: _____ Relationship: _____

Patient Account #: _____

Patient Medical History

Patient Name: _____ Date of Birth: _____

Pharmacy Name: _____ Phone Number: _____

Medication Allergy List

Medication	Reaction	Medication	Reaction	Medication	Reaction

Medical Problems

1	2	3	4
5	6	7	8

Medications

Medication Name	Strength	Quantity	Frequency
1			
2			
3			
4			
5			
6			
7			

Advance Directives

	On File Date
Advance Directive	
Do Not Resuscitate	
Living Will	
Durable Power of Attorney	
Health Care Surrogate	
Other (Please specify)	

Receipt of Privacy Notices/Health Insurance Portability and Accountability Act (HIPAA)

I acknowledge that I have received a copy of Bella Women's Care Notices of Privacy Practices.

Patient/Legal Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship: _____



IT IS THE OFFICE POLICY OF BELLA WOMEN'S CARE AND STAFF NOT TO DISCLOSE CONFIDENTIAL AND/OR UNAUTHORIZED INFORMATION TO INDIVIDUALS OTHER THAN THE PATIENT.

I _____ AUTHORIZE BELLA WOMEN'S CARE AND/OR THEIR STAFF TO LEAVE MEDICAL INFORMATION PERTAINING TO MY CARE BY THE FOLLOWING METHODS AND WILL ASSUME RESPONSIBILITY TO NOTIFY THEM WHENEVER THIS INFORMATION CHANGES.

HOME TELEPHONE	YES _____	NO _____
ANSWERING MACHINE	YES _____	NO _____
WORK TELEPHONE	YES _____	NO _____
VOICEMAIL	YES _____	NO _____
CELL PHONE	YES _____	NO _____

FAX MEDICAL RECORDS TO PRIMARY CARE PHYSICIAN OR OTHER MEDICAL PROVIDERS YES _____ NO _____

IF YOU WOULD LIKE TO HAVE ANY INFORMATION RELEASED TO SOMEONE OTHER THAN YOURSELF PLEASE COMPLETE THE FOLLOWING

NAME AND RELATIONSHIP OF AUTHORIZED PEOPLE TO RELEASE INFORMATION TO:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PATIENT/GUARDIAN SIGNATURE _____ DATE _____