

NEW PT PAPERWORK



Bloom Health Services for Women

1200 North State Street, Suite 430 Jackson, MS 39202

Phone: 601-487-7141 Fax: 601-487-7140

Welcome to Bloom Health Services for Women!

The Nurse Practitioners are registered nurses who have an advanced education and clinical experience in women's health care. As specialists, the Nurse Practitioners deliver comprehensive health care to women throughout their lifespan, with an emphasis in reproductive and gynecologic health needs. The Nurse Practitioners are well qualified to provide well-woman care, prenatal and postpartum care, care for women who are experiencing episodic acute or chronic illnesses, as well as care to men who have selected reproductive health needs or problems.

Our Nurse Practitioners are NOT physicians, The work collaboratively with Norman Connell MD, if physician services are needed or desired.

Thank you for lending Bloom your trust for your healthcare needs.

I have read the above and acknowledge that Kimberly Bartels, Grace Ann Mayne and Ashley Boyte are nurse practitioners and not physicians.

Patient Signature: _____ **Date:** _____

Bloom Health Services for Women

Full Name: _____ Date: _____

Address: _____

City: _____

State: _____ Zip: _____

Email: _____

Home Ph. # _____ Cell # _____

Best Number where you can be reached: _____

Social Security Number: _____

Sex: _____ Male _____ Female

Marital Status: Single Married Divorced

Age: _____ Date of Birth: _____

Race or Nationality: _____

Primary Insurance:

Insurance Name: _____

Name of Policy Holder: _____

Identification # _____ Group # _____

Date of Birth of Policy Holder: _____

Name of Pharmacy: _____

I acknowledge that failure to provide correct information could result in denial of insurance claims. I understand that I am financially responsible for all charges that are incurred because of Missing or incorrect information.

Patient Signature: _____ Date: _____

LIST ALL Current Medications: Prescription and Non-Prescription (over-the-counter)
*****Existing patients, please only list anything new or medications you have stopped*****

Medications	Dose	How Often Taken

List any drug allergies:

Surgeries and Hospital Stays since last visit:
*****Existing patients, please only list anything new*****

Surgery and Hospital Stays	Date

Obstetrical History List all pregnancies, miscarriages and abortions
*****Existing patients, please only list anything new*****

Month/Year	Length of Preg	Hospital	Complications	Birth Wt	Sex of Baby

Bloom Health Services for Women

HIPAA Privacy Notice Consent Form

I understand and have been provided with **Bloom Health Services Notice of Privacy Practices** that provides a more complete description of information uses and disclosures. Bloom Health Services reserves the right to make changes to their Privacy Notice and revised copies are available at the front desk. By signing this form, I acknowledge that I have been afforded the opportunity to consider Bloom Health Services Notice of Privacy prior to signing and making healthcare decisions.

I authorize **Bloom Health Services** to release medical and financial information, including any or all reports, records, bill for services rendered or opinions found in my medical chart, with respect to treatment to any alternative healthcare giver.

Boom Health Services maintains patient medical records on electronic media which may be accessible to any healthcare provider participating in my current or future care. Medical records are disclosed according to applicable MS State guidelines.

HIPAA AUTHORIZATION TO DISCUSS YOUR MEDICAL INFORMATION

Patient Only **OR**

You may disclose my medical information to:

Name: _____

Relationship: _____

Phone Number: _____

Emergency Contact: (Medical information is NOT released to this person. However, this person can be the same as your HIPAA Authorized Contact.)

Name: _____

Relationship: _____

Phone Number: _____

I acknowledge that I have received a copy of Bloom Health Services Notice of Privacy Practices (available at front desk window).

Patient Signature: _____ **Date:** _____

Bloom Communications/HIPAA Consent

Name: _____ DOB: _____

This consent form allows Bloom Health Services to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment, or health care operations.

Bloom Health Services has provided me with a Notice of Privacy Practices, which completely describes uses and disclosures. Bloom provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

Communication between Bloom and patients is often necessary outside of the clinic setting.

Discussing lab results, appointment reminders and returning calls of patient concerns are examples of reasons Bloom may try and contact you. Please initial below the permissible methods that we may contact you.

_____ Text Message

_____ Personal Email

_____ Personal Cell Phone

_____ United State Postal Service (paper mail) This option will be utilized if other methods of communication fail after three attempts.

I understand that it is MY responsibility to **notify** Bloom of any email, phone or address change.

I acknowledge that all statements will be delivered electronically by text and email. We do NOT routinely send paper statements. If you opt out of electronic statements, you will be charged \$1.00 postage and handling for your paper statement. Please initial below your preference and permissions:

_____ I give my permission to receive electronic statements.

_____ I ONLY want paper statements, and I agree to a \$1.00 postage and handling fee with each statement sent.

I give permission for Bloom to disclose my medical information to:

Name _____ Phone: _____

Name _____ Phone: _____

(if you wish to add more recipients write their name and phone number on the back of this form)

Patient Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Bloom Health Services for Women

No Show and Cancellation Policy

We schedule our appointments so that each patient is given the right amount of time to be seen by our nurse practitioners and staff. That's why it is very important that you keep your scheduled appointment with us and arrive on time. As a courtesy and to help patients remember their scheduled appointments, Bloom Health Services for Women sends text message reminders in advance of the appointment time. If your schedule changes and you cannot keep your appointment, please contact us immediately so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the nurse practitioner, please give us at least 24 hours' notice. If you do not cancel or reschedule your appointment with at least 24 hours' notice, we will collect by your credit card on file **\$95.00** "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. If your credit card declines, this fee will be collected prior to making any future appointments. After three consecutive no-show appointments, our practice may decide to terminate its relationship with you.

I understand the "no-show" policy of Bloom Health Services for Women and agree to provide a credit card number, which may be charged \$95.00 for any no-show of a scheduled appointment with a nurse practitioner. I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a no-show charge to the credit card provided.

Credit Card Number: _____

Exp: _____

Code: _____

Billing Zip: _____

Patient Signature: _____ Date: _____

Bloom Health Services for Women

Initial Laboratory Services

Because of the extensive lab work on your first visit to Bloom, we ask for payment in full and do not file this with insurance for the following reasons:

- BCBS of Mississippi and other commercial carriers do not recommend laboratory testing that is not clearly indicated for a particular diagnosis.
- Surveying health through laboratory panels is discouraged by insurance and results in provider reprimand if used routinely.
- If billed through insurance, the likelihood of denial of coverage is strong and often results in high laboratory bills that far exceed the discounted self-pay price of \$499.00.
- The lab work collected through Bloom's custom panel allows your nurse practitioner to see "the big picture" of what is going on with you hormonally, metabolically, genetically and systemically. We encourage this panel and believe the cost is exceptionally low for the results it provides.

Please indicate below how you wish to proceed with your laboratory testing:

___ I wish to have Bloom's custom panel collected today (\$499.00). I understand that this panel is a thorough cardiovascular, metabolic and hormonal assessment. I understand that I will pay for this lab in full today. I understand that these labs will NOT be billed to insurance.

___ I wish to have Bloom only collect labs according to the policies of my medical insurance and the laboratory will bill my insurance for only those labs that are specific to current diagnosis or current symptoms or problems. I will receive a bill from the laboratory that will reflect the residual cost after my insurance has determined benefits. I understand that deductibles and copays apply to laboratory services. Bloom has no business affiliation with Lab Corp Laboratories.

Patient Signature: _____ **Date:** _____

**Bloom Health Services for Women
Insurance Attestation Form**

Patient Name: _____ **DOB:** _____

Name of Insurance: _____

Is this insurance your **ONLY** policy? **YES** **NO** (circle one)

(Failure to disclose all policies is insurance fraud and may be subject to prosecution)

If **NO**, what other policy do you have? _____

Are you aged 26 or younger? **YES** **NO** (circle one)

If **YES**, are you on your parent's insurance policy? **YES** **NO** **NOT SURE** (circle one)

If **YES**, Name of Insurance: _____

I attest that the above information is true and correct. I understand that if my insurance changes, it is my responsibility to notify Bloom Health Services for Women immediately. I understand that I am financially responsible for all charges incurred due to incorrect, non-disclosed or inaccurate information regarding my insurance.

Patient Signature: _____ **Date:** _____

Office use only:

Employee has verified insurance including TPL coverage _____ (employee initials)