Bon Secours
Medical Group

Place patient label inside box (if no patient label, complete below)

Name: _____

DOB: _____

MR #: _____

PRACTICE NAME: _____

PATIENT INFORMATION

PATIENT NAME: _____
Last First Middle

HOME ADDRESS: _____

ZIP CODE: _____ CITY: _____ STATE: _____

MAILING ADDRESS: (☐ same as above) _____

ZIP CODE: _____ CITY: _____ STATE: _____

HOME PHONE: (____)_____ WORK PHONE: (____)_____ CELL PHONE: (____)_____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

MARITAL STATUS: _____ CONTACT PREFERENCE: _____

GENDER: _____ RACE: _____ ETHNICITY: _____

LANGUAGE: _____ RELIGIOUS PREFERENCE: _____

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

EMPLOYER: _____ PHONE #: (____)_____

EMAIL: _____ ☐ No E-Mail ☐ Declines to Provide

HOW DID YOU HEAR ABOUT US? _____

GUARANTOR INFORMATION *(name of person to whom financial statements are sent)*

GUARANTOR NAME: _____
Last First Middle

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: (____)_____ DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

INSURANCE POLICY INFORMATION

PATIENT RELATIONSHIP TO POLICY HOLDER: (circle one) SELF SPOUSE CHILD OTHER

PRIMARY POLICY HOLDER DATE OF BIRTH: _____

SECONDARY PATIENT RELATIONSHIP TO POLICY HOLDER: (circle one) SELF SPOUSE CHILD OTHER

SECONDARY POLICY HOLDER DATE OF BIRTH: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP: _____

HOME PHONE: (____)_____ CELL PHONE: (____)_____

PATIENT OR LEGAL
REPRESENTATIVE SIGNATURE: _____ DATE: _____

BON SECOURS MEDICAL GROUP
Bon Secours Richmond Health System

Permission to Disclose Private Health Information (PHI)

Patient Name: _____ DOB: _____

By signing this paper below, I give permission to the person(s) listed in the table documented to receive Private Health Information or other authorization as listed in the comments section. I understand this form is legally binding and that I may revoke my authorization at any time by submitting by request to change, add, or terminate such permission in writing.

Date of Permission	Name of Individual	Comments/Instructions (i.e.; may pick up meds)	Parent/ Guardian Initials	Date Permission Revoked	Parent/ Guardian Initials	Telephone Number

In order to obtain information by telephone, the party calling the practice must be able to share the patient identifier/password with the staff.

Patient Identifier/Password: _____

Signature of Patient or Legal Guardian _____ Date _____ Time _____

Printed Name of Patient or Legal Guardian _____ Relationship (if not self) _____

Bon Secours
Medical Group

Practice Name: _____

Place patient label inside box (if no patient label, complete below)

Name: _____

DOB: _____

MR #: _____

BON SECOURS RICHMOND HEALTH SYSTEM
NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Bon Secours Richmond Health System "Notice of Privacy Practices". Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information, as well as your rights with respect to your protected health information. We encourage you to read it in full.

Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our website at http://richmond.bonsecours.com/, or by asking for a copy of the Notice at your next visit to our facility.

_____ _____

[Signature of patient or legal representative] [Date of Receipt]

_____

[Printed Name of patient or legal representative]

If signed by someone other than the patient, indicate relationship to the patient: _____

For Office Use Only:
Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained.

Good faith efforts. Please describe:

Reasons why acknowledgement was not obtained:

- ☐ Patient/legal representative refused to sign this acknowledgement even though the patient/legal representative was asked to do so and the Notice of Privacy Practices was provided to the patient/legal representative.
- ☐ Signature not obtained due to patient incapacitation/emergency situation.
- ☐ Other. Please describe:

I personally delivered the Notice of Privacy Practices to the patient listed above. A written acknowledgement of receipt by the patient was not obtained as noted above.

_____ _____

[Signature of Staff Member] [Date of Receipt]

_____

[Printed Name of Staff Member]

Bon Secours
Medical Group

Place patient label inside box (if no patient label, complete below)

Name: _____

DOB: _____

MR #: _____

Practice Name: _____

Authorization for Treatment

- I hereby authorize medical treatment by the physician, the clinical staff and technical employees assigned to my care.
- I authorize my treating providers to order any ancillary services, such as laboratory or radiology tests, or any other services or treatments deemed necessary for my care and safety.
- I understand that I have the right and the opportunity to discuss alternative plans of treatment with my physician or other healthcare provider and to ask and have answered to my satisfaction any questions or concerns before treatment is provided.
- In the event that a healthcare worker is exposed to my blood or body fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus, or hepatitis C virus, I consent to the testing of my blood and/or body fluids for these infections and the reporting of my test results to the health care worker who has been exposed, as required by Virginia law.
- I understand that Bon Secours Health System utilizes an electronic medical record system.
- I understand that Bon Secours Health System utilizes an electronic prescribing mechanism for electronic transmission of prescriptions and that any medications my physician prescribes for me may be communicated electronically through any local or mail order pharmacy I have designated.
- I authorize the release of my prescription history to my Bon Secours Health System physician from any pharmacy or drug monitoring agency.

Payment Arrangements

- I agree to accept financial responsibility for the payment of the costs of health care services provided to me and my dependent(s) by or on behalf of Bon Secours Health System.
- By signing this document, I authorize the assignment to the Medical Practice of all payments under any insurance benefits otherwise payable to me for services provided under any insurance policy (hospitalization, major medical, workers' compensation, or any other insurance or benefit plan).
- I agree to pay, at the time of service, any required co-payments, co-insurance and deductibles, as well as charges for services provided by Bon Secours Health System which are not covered by my insurance.
- I understand that all unpaid balances will be billed to my address on file with this office and that I am responsible for updating my registration information as necessary.
- I understand that I am responsible for paying the balance of my bill in full unless other arrangements have been approved in advance.
- I understand that there is a $20 charge for any check returned by my bank.
- I understand that any past due amount owed on my account may be referred to a collection agency, and that I will be responsible for all collection charges and associated legal fees, in addition to the full balance on my account.
- By signing this document, I agree that photocopies of this document are as legally binding as the original.

This Authorization for Treatment is a legal document and no modifications may be made to it without the written approval of an authorized Bon Secours Health System employee. By signing below, I acknowledge that I have read, understand and agree to the above terms.

Patient or Guarantor Signature	Printed Name	Relationship to Patient	Date	Time

Bon Secours

BSRMR50

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

(Patient's Full Legal Name) _____ (DOB) _____ (Day Phone #) _____

Address: _____ City: _____ State: _____ Zip: _____

I, AUTHORIZE: _____
(Name of Organization to Disclose Information)

TO DISCLOSE THE FOLLOWING INFORMATION: **Date(s) of Service:** _____

☐ Abstract of Record	☐ Anesthesia Record	☐ Operative Report	☐ Other: _____
☐ Entire Record	☐ X-rays or Imaging Report	☐ Discharge Summary	☐ Other: _____
☐ ED Record	☐ Laboratory Results	☐ Immunization Record	☐ Other: _____

Person/Facility to Receive Information: _____

Disclosure Format (Paper is default if not marked):

☐ **US Mail** ☐ **Electronic format: CD/DVD** ☐ **Radiology Film/CD** ☐ **MyChart**

☐ **eDelivery by Ciox (for patient's only) - email address:** _____

Purpose of Disclosure:

☐ Physician	☐ Insurance	☐ Legal	☐ Other (Please specify): _____
☐ Disability Determination	☐ Personal	☐ Worker's Compensation	_____

Authorization to Release Information:

1. **I understand that I am giving my permission to disclose confidential health care records, unless indicated below, relating to, if applicable, sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.**

   Special Instructions: _____

2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the organization above disclosing the information.
3. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the facility. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 6 months from the date of signature.
4. I understand that copying charges will be applied, according to the hospital policy.

Signature of Patient or Legal Representative _____
DATE/TIME

If signed by legal representative, relationship to patient: _____

DEPARTMENT USE ONLY

PROCESSED BY: _____ ☐ IDENTITY VERIFIED ☐ SIGNATURE VERIFIED

Virginia Breast Center - Clinical History Form

Date: _____

Patient Name: _____ DOB: _____

Reason for Visit: _____ L R B

Referred by: _____

Date & Location of Mammogram: _____

Family History of Cancer: _____

Personal Breast History: _____

Age of first period: _____ Did you breastfeed? YES NO

Date of last menstrual period: _____ Are you breastfeeding at this time? YES NO

Date of most recent menstrual period: _____ Could you be pregnant? YES NO

Age when first child was born: _____ Have you taken birth control pills? YES NO

Number of children: _____ Ovaries removed? YES NO

Have you taken estrogen/hormone replacement therapy? YES NO Have you had a hysterectomy? YES NO

Have you had any prior breast biopsies? YES NO RIGHT/LEFT When? _____

Allergies: _____

Tobacco Use: _____ Alcohol Use: _____

Check all that applies:

CONSITUTION

Fever _____

Chills _____

Weight loss _____

Malaise/Fatigue

SKIN

Skin rash _____

Itching _____

HEENT

Hearing loss _____

Tinnitus _____

Ear pain _____

Ear discharge _____

Nosebleeds _____

Congestion _____

Sinus pain _____

Stridor _____

Sore throat _____

Blurred vision _____

Double vision _____

Photophobia _____

Eye pain _____

Eye discharge _____

Eye redness _____

CARDIOVASCULAR

Chest pain _____

Palpitations _____

Orthopnea _____

Claudication _____

Leg swelling _____

PND _____

RESPIRATORY

Cough _____

Hemoptysis _____

Sputum production

Shortness of breath _____

Wheezing _____

Heartburn _____

Nausea _____

Vomiting _____

Abdominal pain _____

Diarrhea _____

Constipation _____

Blood in stool _____

Melena _____

GU

Dysuria _____

Urgency _____

Frequency _____

Hematuria _____

Flank pain _____

MUSCULO

Myalgias _____

Neck pain _____

Back pain _____

Joint pain _____

Falls _____

Easy bruises/bleed _____

Enc allergies _____

NEURLOGICAL

Dizziness _____

Headaches _____

Tingling _____

Tremor _____

Sensory change _____

Speech change _____

Focal weakness _____

Seizures _____

LOC _____

PSYCHIATRIC

Depression _____

Suicidal ideas _____

Substance abuse _____

Hallucinations _____

Nervous/anxious _____

Insomnia _____

Memory loss _____

VA Breast Center

Patient Name: _____ DOB: _____ Date: _____

Medication List ~ do not bring bottles

Medication	Dose	Frequency	Why Taking?

Revised 3/2019