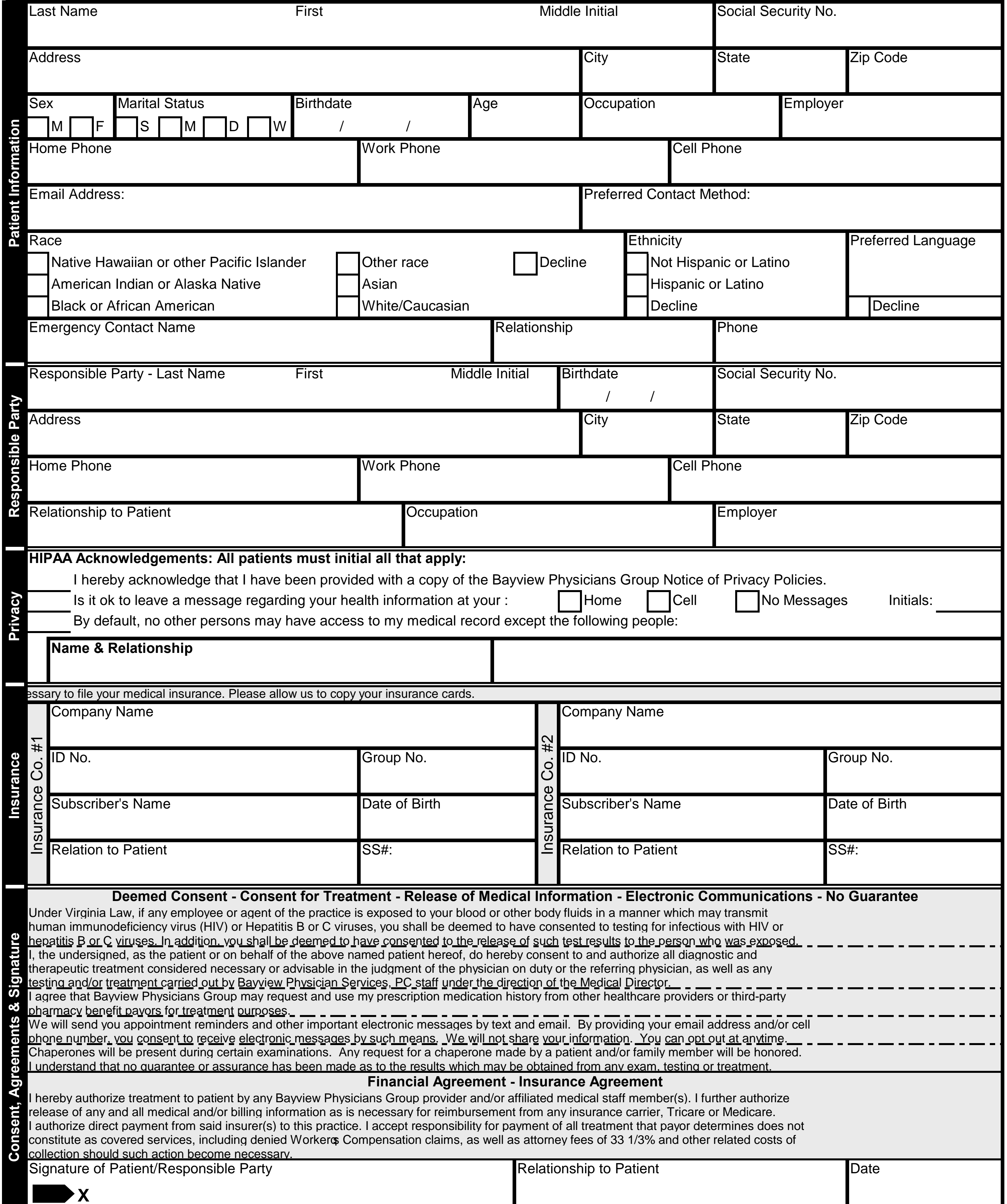
BAYVIEW

Medical Record #: ______________

Patient Information



Patient Information

Last Name	First	Middle Initial	Social Security No.

Address	City	State	Zip Code

Sex	Marital Status	Birthdate	Age	Occupation	Employer
☐ M ☐ F	☐ S ☐ M ☐ D ☐ W	/ /			

Home Phone	Work Phone	Cell Phone

Email Address:	Preferred Contact Method:

Race			Ethnicity	Preferred Language
☐ Native Hawaiian or other Pacific Islander	☐ Other race	☐ Decline	☐ Not Hispanic or Latino	
☐ American Indian or Alaska Native	☐ Asian		☐ Hispanic or Latino	
☐ Black or African American	☐ White/Caucasian		☐ Decline	☐ Decline

Emergency Contact Name	Relationship	Phone

Responsible Party

Responsible Party - Last Name	First	Middle Initial	Birthdate	Social Security No.
			/ /	

Address	City	State	Zip Code

Home Phone	Work Phone	Cell Phone

Relationship to Patient	Occupation	Employer

Privacy

HIPAA Acknowledgements: All patients must initial all that apply:

_____ I hereby acknowledge that I have been provided with a copy of the Bayview Physicians Group Notice of Privacy Policies.

_____ Is it ok to leave a message regarding your health information at your : ☐ Home ☐ Cell ☐ No Messages Initials: _____

_____ By default, no other persons may have access to my medical record except the following people:

Name & Relationship	

Insurance

essary to file your medical insurance. Please allow us to copy your insurance cards.

Insurance Co. #1		Insurance Co. #2	
Company Name		Company Name	
ID No.	Group No.	ID No.	Group No.
Subscriber's Name	Date of Birth	Subscriber's Name	Date of Birth
Relation to Patient	SS#:	Relation to Patient	SS#:

Consent, Agreements & Signature

Deemed Consent - Consent for Treatment - Release of Medical Information - Electronic Communications - No Guarantee

Under Virginia Law, if any employee or agent of the practice is exposed to your blood or other body fluids in a manner which may transmit human immunodeficiency virus (HIV) or Hepatitis B or C viruses, you shall be deemed to have consented to testing for infectious with HIV or hepatitis B or C viruses. In addition, you shall be deemed to have consented to the release of such test results to the person who was exposed.

I, the undersigned, as the patient or on behalf of the above named patient hereof, do hereby consent to and authorize all diagnostic and therapeutic treatment considered necessary or advisable in the judgment of the physician on duty or the referring physician, as well as any testing and/or treatment carried out by Bayview Physician Services, PC staff under the direction of the Medical Director.

I agree that Bayview Physicians Group may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

We will send you appointment reminders and other important electronic messages by text and email. By providing your email address and/or cell phone number, you consent to receive electronic messages by such means. We will not share your information. You can opt out at anytime.

Chaperones will be present during certain examinations. Any request for a chaperone made by a patient and/or family member will be honored.

I understand that no guarantee or assurance has been made as to the results which may be obtained from any exam, testing or treatment.

Financial Agreement - Insurance Agreement

I hereby authorize treatment to patient by any Bayview Physicians Group provider and/or affiliated medical staff member(s). I further authorize release of any and all medical and/or billing information as is necessary for reimbursement from any insurance carrier, Tricare or Medicare. I authorize direct payment from said insurer(s) to this practice. I accept responsibility for payment of all treatment that payor determines does not constitute as covered services, including denied Workers Compensation claims, as well as attorney fees of 33 1/3% and other related costs of collection should such action become necessary.

Signature of Patient/Responsible Party	Relationship to Patient	Date
X		