Authorization to Disclose Health Information

As a patient of Bozeman Creek Family Health, you are protected under The Health Insurance Portability and Accountability Act of 1996 (HIPAA). We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

I authorize _____ to inquire about:

(Print name of: parent, significant other, spouse, family member, etc.)

Please check all that apply:

☐ Payments/Charges

☐ Health Information (prescriptions, test results)

☐ Consult with my Doctor regarding my healthcare

Patient Signature: _____ **Date:** _____

No Show and Cancellation Policy for Medical Appointments

Cancellation:

As a patient in our clinic, it is your responsibility to keep scheduled appointments. Bozeman Creek Family Health requires notification of cancellation at least 24 hours prior to the scheduled appointment time. BCFH will consider it a "failed appointment" any time a patient has not given the advanced notice required above or fails to arrive within 10 minutes of their scheduled appointment time. If a patient has 3 failed appointments in a one year period, BCFH will no longer schedule appointments for that patient.

No Show:

If a patient fails to arrive at the scheduled appointment time and does not call to cancel the appointment, the patient will receive a letter in regards to the missed appointment. If a patient has 2 "no show" appointments in a one year period, BCFH will no longer schedule appointments for that patient.

All patients will be charged a $75.00 fee for every failed appointment or no show.

If you feel there has been an error in scheduling or believe you deserve special consideration, please let us know and you may speak with our Patient Accounts Manager.

Print Patient Name: _____

Patient/Guardian Signature: _____ **Date:** _____

BOZEMAN CREEK family health

Patient Signature Renewal Form:

In compliance with HIPAA regulations, BCFH is required to have patient signatures on file once a year.

I, _____ attest that all demographic information is correct and current
(Patient name)
to my knowledge. I have read the credit policy and agree with the terms. I have read the privacy policy

and agree with the terms. I have provided BCFH with my current insurance information.

Signature of patient: _____ **Date:** _____

Relationship to Patient (if not patient): _____

Current Insurance Company: _____

How would you like to be contacted for your Appointment Reminders? (Choose One)

[ ] Voicemail [ ] Email [ ] Text Message

May we leave clinical messages on your phone? [ ] Yes [ ] No #:_____

Current E-mail Address: _____

Current Demographic Information:

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Primary #: _____ Work #:_____

*** You will receive appointment reminder calls, text messages, or emails on the primary number or email address listed above.**

Secondary # (optional): _____
If the secondary # that is listed **DOES NOT BELONG TO PATIENT**, Please clarify who the number belongs to.

Secondary # belongs to (Name): _____ *[ ] Spouse [ ] Mother [ ] Father [ ] Other*