Burnsville Family Physicians
Patient Information Form

First Name_____ MI_____ Last Name_____

Sex: ___F ___M _____Other

MaidenName_____Alias/Nickname:_____

Date of Birth:_____ Primary Language: _____ Need Interpreter? __Y __N

Race: _____ Ethnicity: _____Country of Birth_____

Address: _____ Apt #: _____ County:_____

City/State: _____ Zip:_____

Home Phone: _____ Cell Phone:_____

Email Address:_____

I want to receive appointment and/or HM reminders via: _____text ____email

Employed by: _____Work Phone:_____

Employment Status: FT_____ PT_____

Employee/ Spouse/ Dependent of I-Health ____Y ____N

Marital Status: ____ Married ____ Single ___ Widowed ____ Divorced ____ Separated

Spouse's Name: _____ Spouse's Phone:_____

Spouse's Employer: _____ Work Phone: _____

Emergency Contact (parent, spouse, or nearest relative): _____

Relationship to you: _____ Phone Number:_____

Insurance Policy Holder's Name: _____ SS# _____

Relationship to you: _____Sex: F___ M ___ Date of Birth:_____

Address: _____ Apt #: _____ City/State: _____ Zip:_____

Home Phone: _____ Work Phone: _____

Policy Holder's Employer: _____ FT_____ PT_____

BURNSVILLE
FAMILY PHYSICIANS

Required Signature:

Notice of Privacy Practices: I acknowledge that I have read a copy of Infinite Health Collaborative (i-Health)/Burnsville Family Physicians (BFP) **Notice of Privacy Practices** and understand the content of the notice.
The I-Health Notice of Privacy Practices was updated as of 10/1/19. Please ask the front desk if you would like a copy.

Consent to Disclosures: I agree that i-Health may use and disclose my health information outside of i-Health when necessary for treatment, payment collection, and healthcare operations purposes as allowed by law. *I agree these provisions will remain in effect from the date of my signature below, unless revoked by me in writing.*

Computer Authorization / Shared Information: With the use of our electronic medical record, your protected health information (PHI) may be shared by the service areas affiliated with Fairview Health Services. I understand and authorize the sharing of my protected health information (PHI) by Fairview Health Services and its affiliates, for the purpose of treatment, as well as for continuity and quality of care.

Release of Information by my Insurer: My insurer may share my past, current and future health account records with i-Health about services I've received from i-Health and other care providers unrelated to i-Health. These records may be used by i-Health as needed to manage or coordinate my care and to improve the quality of that care. If I do not agree to this, I will initial below.

☐ My insurer may NOT release any of my identifiable health records from providers unrelated to i-Health for the purposes described above.

Electronic Health Information Exchange (HIE)/Care Everywhere: Your Medical Team and other Medical Teams who treat you may get or share your information from an HIE or similar database service. Also, a health record locator service tells your Medical Team where you've had care and what prescribed medicines you take so they can get facts to help treat you.

☐ If I do NOT wish my Medical Team or other Medical Teams who treat me to get or share my health information through an electronic health information exchange or a record locator service, I will check this box.

By my signature below, I acknowledge that I understand and agree to all the information stipulated above.

Date: _____ Signature: _____

Optional Signature:

Authorization to Release PMI to Someone other than the Patient: I authorize i-Health/BFP to release medical, diagnostic and / or billing information to the following person(s).

Name: _____

Relationship to the person authorizing the release: _____

Name: _____

Relationship to the person authorizing the release: _____

This information may include, but is not limited to test results, scheduling information or claim information that affects the outcome of a bill.

Date: _____ Signature: _____

iHealth
Infinite Health Collaborative

FINANCIAL POLICY

The following information is provided to you in order to provide a clear understanding of Infinite Health Collaborative's ("i-Health") financial policy. If you have any questions about this policy or your financial responsibilities, please call our Business Office at 952-512-5625.

Co-Payments: All co-payments are due at the time of service. We accept cash, check or credit cards. We accept the following credit cards - VISA, MasterCard, Discover, American Express and Care Credit.

Referrals and Pre-Certifications: Referrals to see i-Health providers are the patient's responsibility. If a patient does not obtain the appropriate referrals and his/her claims are denied, payment will become the patient's responsibility. If a prior authorization/pre-certification is needed; i-Health will initiate and complete the necessary information to obtain approval for your procedure and/or service. It is your responsibility to ensure the appropriate authorizations are completed prior to the service and/or procedure being rendered.

Good Faith Estimates: i-Health will provide an estimate of cost for future services. Although we will estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits including co-payments, co-insurance and/or deductible amounts.

Insurance Claims and Benefits: Your insurance policy is a contract between you and your insurance company. It is your responsibility to understand your benefits including information pertaining to co-payments, co-insurance and deductibles. As a courtesy, i-Health will file claims for benefits with all insurance companies with claims offices within the United States or its territories. In order to properly bill your insurance company, it is important that you provide all insurance information including primary, secondary and tertiary insurance, as well as, notify i-Health of any changes to your insurance information. Failure to provide this information may results in larger or inaccurate amounts of patient responsibility.

If your insurance company is not contracted with i-Health, you are considered out-of-network. If you decide to obtain care with an out-of-network provider, you will be responsible to pay any portion of the charges not covered by your insurance, including those charges above the usual and customary allowance.

Uninsured: If you are uninsured, a down-payment may be required prior to your service. Down-payment amounts will vary based on the service. If you cannot afford the down-payment, i-Health offers a Financial Assistance Program. Any remaining amounts will be balanced billed to the patient. If the patient does not bring in required payment at the time of service, the patient may be rescheduled to another day when payment can be made. A prompt pay discount of 20% will be offered for payment in full.

Financial Hardship Program: i-Health offers a financial hardship program. Please contact the i-Health Customer Service Department (952-512-5625) to review this program.

Finance Charges: Finance charges may be imposed on accounts beginning 60 days from the date of the initial billing statement. At present the interest rate is 6% per year.

Outstanding Balances: Any outstanding balances should be paid at the time of service unless prior arrangements have been made. If your insurance does not pay the balance in full, you will receive a statement. Payment is due upon receipt of your statement. Failure to pay your balance may result in your account being transferred to an outside collection agency. If your account is turned over to an outside collection agency, all balances must be paid in full prior to initiating additional treatment for a new problem. If your account is placed with a collection agency, you may be dismissed as a patient from i-Health.

Credit Balances: i-Health will refund any amounts owed to patients within 45 days of discovery, request or notification. All refunds will be processed in the form the payment was made.

Patient/Guarantor Signature:_____ Date:_____

Authorization to Release Medication Information

I allow Burnsville Family Physicians, a partner of I-Health Collaborative to collect details about my medications from my insurers.

Please release my details from: Any insurance company that has paid for my prescribed medicines in the past two years.

Please release details to: Burnsville Family Physicians, a partner of I-Health Collaborative

These are the details I would like to have released: Information about my medications, including:

- Names of medicines
- Dosages
- Dates filled
- Dates refilled

Purpose: These details will be used in my medical care.

I understand the following:

- Once my insurer sends my details, they will become a permanent part of my medical record at Burnsville Family Physicians.
- If I change my mind, I may write to my clinic to stop the release of my medication details. This will not apply to details already received by Burnsville Family Physicians.
- Once the details are released to Burnsville Family Physicians, Burnsville Family Physicians will not re-release it without my permission unless allowed by law.
- To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered. The form will remain valid until I revoke it in writing or until the law states that it has expired.
- If I do not sign this form, I will still be treated.

_____ _____

Patient name (please print) **Birth Date (month, day, year)**

_____ _____ _____

Signature of patient/authorized person *(If authorized person signs, please print)* **Authorized person's authority to sign** *(Parent, Guardian, POA)* **Date**

Reason patient is unable to sign: ___Minor ___Other _____

Below are some statements that people sometimes make when they talk about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally by circling your answer. Your answers should be what is true for you and not just what you think the doctor wants you to say.

If the statement does not apply to you, circle N/A.

1.	When all is said and done, I am the person who is responsible for taking care of my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
2.	Taking an active role in my own health care is the most important thing that affects my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
3.	I know what each of my prescribed medications do	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
4.	I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
5.	I am confident that I can tell a doctor concerns I have even when he or she does not ask.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
6.	I am confident that I can follow through on medical treatments I may need to do at home	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
7.	I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
8.	I know how to prevent problems with my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
9.	I am confident I can figure out solutions when new problems arise with my health.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
10.	I am confident that I can maintain lifestyle changes, like eating right and exercising, even during times of stress.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A