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First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Middle Initial\_\_\_\_ SSN\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_

DOB\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Gender\_\_\_\_\_\_\_\_\_\_

**Race** (Circle one) American Indian Asian African American Native Hawaiian Other

**Ethnicity** (Circle one) Hispanic or Latino OR Not Hispanic or Latino

Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Information:**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy** Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pharmacy Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY INSURANCE INFORMATION

Insurance company name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please select one: Medicare\_\_\_\_ Medicaid\_\_\_\_ CHP\_\_\_\_\_ Other\_\_\_\_\_ Initials:\_\_\_\_\_\_

SECONDARY INSURANCE INFORMATION

Insurance company name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of insurance plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicare\_\_\_\_ Medicaid\_\_\_\_ CHP\_\_\_\_\_ Other\_\_\_\_\_ Initials:\_\_\_\_\_\_

Guarantor Information for minor:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Questionnaire

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Any special concerns today?***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***List your Past Medical History?***

|  |  |  |  |
| --- | --- | --- | --- |
| **Diagnosis** | **Year Diagnosed** | **Current Treatment** | **Is there a health care provider currently managing the care?** |
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***List your Past Surgical History (please specify)?***

**Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***List your Allergies (medications, food, supplements, environmental and etc…)?***

**Allergen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***List your Family Medical History:***

**Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Siblings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Please mark a X for tests/screening completed and when last done (****if never done or do not know, leave blank)****:***

**Last Dental Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Last Eye Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any ocular diseases?** Yes or No

**Last Yearly Physical:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Digital Rectal Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Echocardiogram:**\_\_\_\_\_\_\_\_\_ **Findings:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CIMT:\_\_\_\_\_\_\_\_\_\_ Findings:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mammogram:\_\_\_\_\_\_\_\_\_ Abnormal Findings:** Yes or No

**DEXA (bone scan):\_\_\_\_\_\_\_\_\_\_\_ Findings:** Yes or No

**Colonoscopy:\_\_\_\_\_\_\_\_\_\_\_ Findings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AAA Screening: \_\_\_\_\_\_\_\_\_\_ Findings:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***GYN History:***

**Last Menstrual Period:\_\_\_\_\_\_\_\_\_\_\_**

**Are your periods usually regular?** Yes or No

**Total amount of days in cycle?\_\_\_\_\_\_\_\_\_\_\_**

**Usual Flow (circle one)?**  Heavy Medium Light

**Last pelvic exam?\_\_\_\_\_\_\_\_\_\_\_\_ Normal?** Yes or No

**History of abnormal pap?** Yes or No

**# Pregnancy:\_\_\_\_ # Births:\_\_\_\_ # Abortions:\_\_\_\_ # Miscarriages:\_\_\_\_**

**Current Family Planning Method?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Social History(please mark and indicate amount):***

**Tobacco use?** Yes or No **Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Circle one:** Current or Former **How many years:\_\_\_\_\_\_\_ How many packs per day:\_\_\_\_\_\_**

**Illicit drugs?** Yes or No **Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Circle one:** Current or Former **How many years:\_\_\_\_\_\_\_ How many times per day:\_\_\_\_\_\_\_\_**

**Alcohol?** Yes or No **How many drinks per (circle one) day, week or month:\_\_\_\_\_\_\_\_\_**

**Are you on any special diet?** Yes or No **Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Describe your current diet:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Caffeine?** Yes or No **Servings per day:\_\_\_\_\_\_\_\_\_\_\_\_ Type of exercise:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often:\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health hazards associated with occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you get vaccinations?** Yes or No **Please list year: Tetanus:\_\_\_\_\_\_\_\_\_\_ Influenza:\_\_\_\_\_\_\_\_ Pneumovax:\_\_\_\_\_\_\_\_\_\_ Zostavax:\_\_\_\_\_\_\_\_\_**

***List all medications and supplements taken on a regular basis:***

|  |  |  |
| --- | --- | --- |
| **Medication/Supplement** | **Dosage** | **How Often** |
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***Review of Systems (please circle all that apply:***

***General* -** weight loss, weight gain, fatigue, loss of appetite, faintness, crave certain foods, binge eating,

***Skin*-** rash, new mole, change in mole, acne, hives, dry skin, hair loss

***Eyes* –** blurred vision, double vision, redness, tunnel vision (does not include near/far-sightedness)

***ENT* –** hearing loss, difficulty swallowing, hoarseness, ear aches, ear infections, drainage from ear, ringing in ears, sore throat,

canker sores, discolored gums/lips or tongue

***Allergy* –** sneezing, itching, watery eyes, bags or dark circles under eyes, itchy ears, sinus problems, stuffy nose, hay fever, sinus pain

***Respiratory* –** cough, wheeze, sputum, shortness of breath, tuberculosis exposure, gagging, frequent need to clear throat, chest congestion

***Cardiovascular* –** chest pain, swelling in feet, heart palpitations, skipped heartbeat, rapid/pounding heartbeat

***Breast* –** lump, pain, nipple discharge

***GI* –** nausea, vomiting, diarrhea, constipation, blood in stool, abdominal pain, bloated feeling, belching, passing gas, heartburn

***GU* –** pain with urination, frequent urination, blood in urine, problems with erection,

***GYN*** – vaginal discharge, vaginal itching, anal itching

**Do you want screening for sexually transmitted diseases?** Yes or No

***Endocrine* –** excess thirst, heat/cold intolerance, nervousness, flushing/hot flashes, excessive sweating, water retention

***Blood/Immune System*** – bruise easily, bleed easily, anemia, recurrent infections/illness, fever

***Musculoskeletal*** – joint pain, joint or limb swelling, loss of motion, stiffness/limitation of movement, muscle aches/pain, muscle weakness; **which joints?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Neurologic*** – headache, numbness, weakness, dizziness,

***Mind* –** stress, sleep disturbance, poor memory, poor comprehension, poor concentration, poor physical coordination, difficulty making decisions, stuttering/stammering, slurred speech, learning disabilities

***Energy/Activity*** – fatigue, lethargy, hyperactivity, restlessness

***Emotions*** – mood swings, anxiety, fear, nervousness, anger, irritability, aggressiveness, depression

***Are you interested in a free Anti-Aging Aesthetic consultation?***

*Yes or No*

***Please tell us who referred you to our office:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***I have read this questionnaire, understand the questions that were asked and filled out to the best of my ability:***

***Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_/\_\_\_/\_\_\_***

***Clear Sky Medical Patient Policy***

***Please read each policy and initial in box for each***

Our practice philosophy, as a comprehensive, preventive, healthy aging practice, is to provide our patients with cutting edge progressive medical care. Treatment options may include natural and conventional options, which combine ‘the best of 2 worlds’, in order to give you all benefits possible for optimal wellness.

In order to maintain your high level of care with us, we ask that you acknowledge your understanding of the following policies by initialing each square, and by signing this policy document at the bottom.

Labs are ordered by the provider when necessary to detect the cause of a medical complaint or for in-depth screening. Naturally, labs **require** follow up appointments to discuss results and treatment options.

Labs ordered may or may not be covered by Insurance. Insurance verification is the patient’s responsibility.

In order to thoroughly evaluate and treat each complaint in depth, we will focus on one major medical issue or one major portion of a lab at a time.

To reduce confusion and possible interactions from multiple medications, modifications in your treatment, including prescriptions and refills, needs to be based on documented evidence at an appointment. As a courtesy to you we will fax your prescription to your pharmacy **once** and give you the hardcopy.

Due to poor, or no, insurance reimbursement for phone consultations, we no longer process insurance claims for phone consultations. Should you request this service, we will provide you with an invoice.

In fairness to other patients, please arrive on time for your appointments. At the practice’s discretion, late arrivals may need to be rescheduled.

A $75.00 fee is charged for any appointment not cancelled within 24 business-day hours.

In consideration of our patients with chemical sensitivity we ask you to refrain from wearing any products with fragrance

Thank you for understanding our endeavor to provide you with exceptional proactive medical care.

Signature of patient or guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Confirmation of Receipt of Privacy Notice and Financial Policy Agreement**

I acknowledge that I have received a Notice of Privacy practices on the date below on behalf of Clear Sky Medical, PC and I am aware I may receive a copy at the clinic, or request a copy by written request. I also understand the notice describes the uses and disclosures of my protected health information and informs me of my rights with respect to my protected health information. I also understand my rights as a patient, and the right of my medical records.

I have also reviewed the Financial Policy Agreement, and understand additional charges may be billing to me as provided by this agreement. I also understand my rights as a patient and the right of my medical records.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the patient is a minor (under the age of 18), or someone unable to physically sign, the patient’s legal guardian/representative will sign the document and state the relationship after their printed name.

**Consent for Treatment**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE LIST ALL PERSONS WHO MAY HAVE ACCESS TO YOUR MEDICAL RECORDS

Name: Relationship to Patient:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient, parent or legal guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

CLEAR SKY MEDICAL, PC

**I hereby authorize my insurance benefits be paid directly to the physician. I am financially responsible for non-covered services, co-payments, coinsurance, labs and deductibles. I also authorize Clear Sky Medical, PC, to release any information required for prompt and efficient processing of my insurance claims.**

**I have read and understand *Clear Sky Medical, PC, Financial Policy Agreement*, and I agree to comply. I accept responsibility for any payment due as outlined within this agreement.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(PLEASE PRINT) Patient’s Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Guarantor Date

**FINANCIAL POLICY AGREEMENT**

Thank you for choosing Clear Sky Medical, PC, for your medical care. We are committed to providing you quality health care, and appreciate your commitment to adhere to this **Financial Policy Agreement**. The following is our statement of financial policy, which we require all patients read, understand, and sign prior to any non-emergent treatment or care.

***Insurance Verification and Past Due Balances***

In order for you to receive maximum benefits from your insurance company, we need complete information and require

a copy of your insurance card at **each** visit. You are responsible for ensuring your information is correct and effective at

the time of each service. ***All past due balances are due and payable at time of service.***

***Insurance Coverage***

* *Commercial/Indemnity Insurance:* Your policy is a contract between you and your insurance company. Because we are not a party to that contract, your account balance is your responsibility regardless of whether your insurance pays. Take time to read your insurance policy and be sure you understand what your co-pays and deductibles are. As a courtesy, we will file claims on your behalf. **However, if your insurance does not pay within 60 days, you will be responsible for the balance of unpaid charges and for following up directly with your insurance company.**
* *Medicare:* We will file all Medicare claims for you. You are responsible for all Medicare deductibles and coinsurance amounts, and for services not covered by Medicare.
* *Self-Pay:* If you do not have insurance coverage, or are unable to provide valid insurance information, you are responsible for payment in full at the time of service***.***

***Non-Covered Services***

Clear Sky Medical does not perform insurance verifications. It is **your** responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, for a procedure, and what services are covered PRIOR TO THE SERVICE. Any service determined to not be covered by your insurance plan will be **your** responsibility.

***Same-Day Wellness and Illness Care***

Often insurer’s payment policies dictate we may have to complete your wellness care annual physical and your illness care, concerning a medical issue, in two separate visits. If you have a health problem you want to discuss with the doctor during your wellness visit, the doctor may need you to schedule another appointment for your wellness visit, in order to treat a more pressing medical problem right away. If the health problem is addressed at the time of your preventative examination, a separate office visit will have to be charged.

***Appointments***

Clear Sky Medical, PC, reserves time especially for you. All appointments require **a 24-hour business day notice to cancel**. You will be charged a **$75 cancellation fee** if you fail to cancel within 24 hours or do not appear for your appointment.

***Payments***

All co-payments as determined by your insurance company are due at the time service is rendered**.** Any balance billed to you must be paid within thirty (30) days unless an alternative payment arrangement is made directly with our billing department.

In the event you disagree with a balance due, it is your responsibility to contact our billing department within thirty (30) days of receiving your statement. If you have a past due balance upon arrival at your next visit, we will ask that you pay the balance in full. We accept cash, check, Visa, Discover, American Express and MasterCard. There is a twenty-five (25) dollar fee for all checks returned for insufficient funds, which will be automatically charged to your account.

***Past Due Account***

In the event you have an unpaid balance sixty (60) days overdue, and no alternative payment arrangement has been approved, appropriate action will be taken to collect the amount owed. You will be responsible for additional fees:

* Ten (10) dollar monthly re-billing fee
* Forty (40) percent surcharge added to the unpaid balance to cover any collection agency costs

***Doctor Referrals***

If your insurance company requires a referral from your primary care physician, you are responsible for obtaining the referral. You understand you will be financially responsible for the cost of services provided if the required referral is not secured.

***Release of Medical Records***

To ensure your privacy, we require a written request to release medical records. A twenty-five (25) dollar administrative fee will be charged to cover the cost of retrieving and copying medical records in a timely manner, unless the request comes from another provider’s office.

Thank you for your understanding and cooperation. It is our pleasure to provide you quality health care.