Clear Sky Medical™
Wellgevity & Aesthetics
www.ClearSkyMedical.com

9085 E. Mineral Circle, Suite 260
Centennial, CO 80112
Fax: (303) 242-8216
Tel: (303) 790-7860

First Name_____

Last Name_____

Middle Initial____ SSN_____-_____-_____

DOB_____/_____/_____ Gender_____

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

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 #_____ Mobile #_____

Pharmacy Name _____ Pharmacy Phone # _____

Primary Care Physician: _____

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PRIMARY INSURANCE INFORMATION

Insurance company name: _____

Policy holder's name: _____

Subscriber's date of birth: _____

ID number: _____

Group number: _____

Please select Insurance 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 #_____ SSN_____

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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?

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: _____

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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
 # Pregnancy:___ # Births:___ # Abortions:___ # Miscarriages:___
Current Family Planning Method?_____
Last pelvic exam?_____ Normal? Yes or No
History of abnormal pap? Yes or No

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:***__/__/__

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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 $50.00 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: _____

Printed name:

_____

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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

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 $50 cancellation fee if you fail to cancel within 24 hours or do not appear for your appointment.

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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.

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

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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.

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Consent for Treatment

Patient Name: _____

Date of Birth: _____

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

Name:	Relationship to Patient:
_____	_____
_____	_____
_____	_____

_____

Signature of patient, parent or legal guardian

_____

Date