NEW PATIENT INTAKE FORM

PLEASE PRINT AND COMPLETE ALL ENTRIES		
FIRST NAME	LAST NAME	DATE OF BIRTH __________/__________/___________

SEX	SOCIAL SECURITY	PHONE NUMBER	EMAIL ADDRESS
❑ Male ❑ Female			

ADDRESS

CITY	STATE	ZIP CODE

MARITAL STATUS ❑SINGLE ❑MARRIED	SPOUSES NAME	SPOUSE PHONE NUMBER
EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

INSURANCE INFORMATION		
DO YOU HAVE INSURANCE? ❑YES ❑NO	PRIMARY CARD HOLDER ❑SELF ❑SPOUSE. ❑PARENT. ❑OTHER______________	PRIMARY POLICY HOLDER NAME
PRIMARY INSURANCE COMPANY	PRIMARY ID NUMBER	PRIMARY GROUP NUMBER
DO YOU HAVE SECONDARY INSURANCE? ❑YES ❑NO	SECONDARY CARD HOLDER ❑SELF ❑SPOUSE. ❑PARENT. ❑OTHER______________	SECONDARY POLICY HOLDER NAME
SECONDARY INSURANCE COMPANY	SECONDARY ID NUMBER	SECONDARY GROUP NUMBER

PAYMENT POLICIES

- You are financially responsible for anything insurance does not cover. All copays are due and payable at each visit. The amount your insurance will allow and pay for and your financial responsibility is determined by your insurance company and the policy you have chosen. Your claim will be processed according to the benefits of your insurance plan. The deductible, co-insurance and co-pay are your financial responsibility. It is your responsibility to understand your insurance plan.
- $5 Fee for Co-pays not paid at the time of service.
- $50 No Show Fee for any Missed Appointment that was not cancelled or rescheduled 24 hours prior to the appointment. Please be considerate and call at least 24 hours before your appointment if you cannot come in.
- $35 NSF charge for any returned check from the bank.
- If you are a private patient without insurance, all charges are due at the time of the visit. We do not send a statement to private pay patients.

PRESCRIPTION POLICY

PHARMACY NAME	PHARMACY PHONE NUMBER

Please do not wait until your last pill to call for a refill. If you have not seen the provider in six months, the prescription will be Denied.

PATIENT SIGNATURE	**DATE**

PATIENT MEDICAL HISTORY

Allergies

- ❑ NONE/Known Allergies
- ❑ Adhesive Tape
- ❑ Anesthesia
- ❑ Aspirin
- ❑ Codeine
- ❑ Dairy Products
- ❑ Iodine/Shellfish/Contrast
- ❑ Latex
- ❑ Morphine
- ❑ Penicillin

OTHER:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER
Anesthesia Problems		
Arthritis		
Cancer		
Diabetes		
Heart Problems		
Hypertension		
Stroke		
Thyroid Disorder		

SOCIAL HISTORY

- **Yes** **No -** Do you drink alcohol? Daily Weekly Infrequently Recovering Alcoholic
- **Yes** **No -** Do you smoke? Smoke (___packs per day) Chew
- **Yes** **No -** Do you drink caffeine? Daily Weekly Infrequently
- **Yes** **No –** Are you sexually active?
- **Yes** **No –** Do you wish to be checked for STDs?

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

- ❑ NONE of the problems listed
- ❑ Allergies
- ❑ Anemia
- ❑ Arthritis conditions
- ❑ Asthma
- ❑ Arterial fibrillation
- ❑ Bleeding problems
- ❑ BPH
- ❑ CAD coronary artery disease
- ❑ Cancer
- ❑ Cardiac arrest
- ❑ Celiac disease
- ❑ Chest pain
- ❑ Congestive heart failure
- ❑ Chronic fatigue syndrome
- ❑ Depression
- ❑ Diabetes
- ❑ Drug/alcohol abuse
- ❑ Erectile dysfunction
- ❑ Fibromyalgia
- ❑ Gerd
- ❑ Heart disease
- ❑ Hyperinsulinemia
- ❑ Hyperlipidemia
- ❑ Hypertension
- ❑ Hypogonadism male
- ❑ Hypothyroidism
- ❑ Infection problems
- ❑ Insomnia
- ❑ Irritable bowel syndrome
- ❑ Kidney problems
- ❑ Menopause
- ❑ Migraines/headaches
- ❑ Neuropathy
- ❑ Onychomycosis
- ❑ Organ injury
- ❑ Osteoporosis
- ❑ Pulmonary embolism
- ❑ Seizure disorders
- ❑ Shortness of breath
- ❑ Sinus conditions
- ❑ Stroke
- ❑ Syndrome X
- ❑ Tremors
- ❑ Wheat allergy

Medications: List any medications you are currently taking (please include over the counter medications):

PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PRESCRIBING DOCTOR

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- · The practice reserves the right to change the privacy policy as allowed by law.
- · The practice has the right to restrict the use of the information but the practice does not have to agree to those

  restrictions.

- · The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- · The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: ___________________________________(PRINTNAME)

Signature: ____Date: __________

MEDICAL SERVICES AGREEMENT

Medical Consent: I consent to any treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include but are not limited to medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of Acute Care OnCall assisting my care.

Financial Agreement: I understand that all charges are due at the time of service. I agree to pay Acute Care OnCall for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. Acceptable forms of payment include Cash, Visa, MasterCard, Discover, and American Express. If I am a non-insured patient, I agree to pay for my visit in full at the time of service. If Acute Care OnCall is a participating provider with my insurance company, I understand that my co-pay, coinsurance, deductible, and/or any outstanding balances are due at the time of service. I understand that my insurance policy is a contract between myself and my insurance company, Acute Care OnCall is not involved. In order for Acute Care OnCall to file claims and accept payments from my insurance carrier, I understand that I must present current insurance information at each visit and that Acute Care OnCall will need to verify my health insurance coverage. In the event that Acute Care OnCall is not able to verify my insurance eligibility and benefits before my visit, I agree to pay for my visit in full at the time of service. A refund will be issued if my insurance pays for the visit. I also understand that I am financially responsible for any services not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individual liable with me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney's fees (including costs) and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral.

Insurance Authorization and Release: I request the payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans to be made to Acute Care OnCall for any services furnished by that provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize Acute Care OnCall to disclose portions of or all of my records, including my medical records to any person or corporation which is or may be liable for all or any portion of Acute Care OnCall charges, including but not limited to insurance companies, health care service plans, governmental agencies, or worker's compensation carriers. I authorize Acute Care OnCall to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give Acute Care OnCall any information required to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Release of Medical Information: I hereby authorize Acute Care OnCall to release any information in my chart to any practitioner, doctor, hospital, or medical institution to which I may be referred to assist in my care. Additionally, I authorize Acute Care OnCall to provide a copy of my medical records to my Primary Care Physician (PCP) to allow for continuity of care.

Notice of Privacy Practices: By signing this form, you acknowledge receipt of the "Notice Of Privacy Practices" of Acute Care OnCall. Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting Acute Care OnCall at (629)910-7500.

Membership Agreement: I acknowledge I have read and understand the Membership Agreement in it's entirety and elect the following option:

- **O Monthly Membership billing ($50.00 per month x12 months)**
- **O Annual Membership billing ($500.00 one time, with 2 month discount)**
- **O No Membership election – subject to cash pay or insurance rules**

The undersigned certifies that he/she has read and agree to the foregoing, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Signature:

Date: