Complete this form online by typing on each line to enter text Click on a box to place a check in that selection. ✔

Then print the form and complete signature lines.

Please bring this completed form with you to your appointment.

Yu & I Wellness Center

6268 S. Rainbow Blvd Ste 100, Las Vegas, NV 89118

Phone 702-292-9729 Fax 702-505-9235

PATIENT INFORMATION

Today's Date: _____

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Age: _____ Sex: Male____ Female ____ SSN#:_____

Street Address: _____ Mailing Address (If Different):_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

Work Phone:_____ Employer/Occupation:_____

Marital Status: Single____ Married____ Divorced____ Widowed____ Email Address:_____

Race: _____ Ethnicity ___Hispanic ___ Non-Hispanic Primary Language: _____

Emergency Contact Name: _____ Phone # _____

Relationship:_____ May we leave you message: Yes_____ No _____

Pharmacy Name and address _____ Ph#_____

ACCOUNT RESPONSIBILITY (If different than above)

Who is responsible for this account? _____ Relationship to patient: _____

Mailing Address: _____ City: _____ State: _____

Cell Phone: _____ Home Phone: _____ Date of Birth: _____SSN#: _____

MEDICAL INSURANCE

Name of Primary Insurance Company: _____

Subscriber Name: _____ Group # _____

Member ID: _____ Subscriber Date of Birth: _____

Name of Secondary Insurance Company: _____

Subscriber Name: _____ Group # _____ Member ID: _____

Subscriber Date of Birth: _____ Medicare ID (If on Medicare): _____

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to Yu & I Wellness Center. I understand that I am responsible for all charges whether or not paid by insurance and also responsible for paying any copayment and deductibles that my insurance does not cover.

Patient/Guardian Signature: _____ Date _____

CLINIC BILLING AND EXPECTATIONS

Please sign below to indicate you have read and understand the following:

1. **Responsibility for payment of your account remains with you at all times**; and although you may have a pending insurance claim, we will require you to pay regardless of the circumstances involved. Please contact us immediately if there is a problem with your claim or if your claim is related to NEVADA WORKERS COMP, AUTO RELATED, OR THE RESPONSIBILITY OF A THIRD PARTY PAYOR.

2. Copays and other estimated out of pocket amounts due are to be collected at the time of service.

3. You will receive a statement if you have a balance. Payment in full is required within 30 days of the statement date, unless arrangements are made with our billing office.

4. If you need to set up a payment plan, please contact us for the details.

5. Yu & I Wellness Center and/or contracted business associates may need to contact you for additional information or to collect any amounts you may owe. You give your express agreement and consent to allow Yu & I Wellness Center and/or contracted business associates to call you at any telephone number provided or obtained, without limitation of wireless. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. A $35.00 fee will be charged to your account if you do not cancel your appointment 24 hours in advance. After three no show appointments, you will be subject to discharge from Yu & I Wellness Center.

7. There is a $25.00 fee for all returned checks and for stop payments.

8. No credit will be extended to patients having a past due account, or to patients who have been referred to a collections agency. If your account has been referred to a collections agency two times, you will be discharged from Yu & I Wellness Center.

9. If you arrive more than ten minutes late to an appointment, you may be asked to reschedule. Each provider may have a separate no-show policy.

10. Yu & I Wellness Center requires 4 business days to respond to all medication refill requests. Medications will not be refilled after clinic hours. Please contact your pharmacy to initiate refill requests.

CONSENT FOR TREATMENT

By signing below, you state that you have read and understand the above **CLINIC BILLING AND EXPECTATIONS.**
I am requesting Yu & I Wellness Center to provide health care related treatment and consultation to the below named patient, and that I may refuse treatment or services at any time. I understand Yu & I Wellness Center does not guarantee any outcome for any services or treatments, either stated or implied.

Patient Name (Please Print):_____Date of Birth: _____

Signature (Patient/Guardian): _____Date:_____

Acknowledgment Privacy Policy Offered

My health information may be created or reviewed by Yu & I Wellness Center and may be in the form of written or electronic records, or spoken words. My health records may include information on my health history, health status, test results, diagnoses, treatments, procedure, prescriptions and similar types of related health information.

I understand that I have the right to receive and review a written description of how Yu & I Wellness Center will handle my health information. This written description is known as a **Notice of Privacy Practices**. This notice describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Yu & I Wellness Center and my right regarding my health information. I may obtain a copy of the **Notice of Privacy Practices** at the reception desk.

I understand that the **Notice of Privacy Practices** may be revised from time to time, and that I am entitled to receive a copy of any revised **Notice of Privacy Practices**. I also understand that a copy or summary of the most current version of the Yu & I Wellness Center's **Notice of Privacy Practices** in effect will be posted in the waiting/reception area and on the clinic website.

By signing, I agree that I have reviewed and understand the above information and that I am entitled to receive a copy of Yu & I Wellness Center's Notice of Privacy Practices.
Notice of Privacy Practices copies are available at the reception desk.

Patient Confidential Communication

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method or certain locations. In order to protect the privacy and confidentiality of your information, please complete the following.

I give permission to Yu & I Wellness Center to leave messages regarding:

☐ Appointments ☐ Billing information

☐ Limited medical information, such as: normal results (Abnormal results and sensitive information will never be left on voice message), generic recommendations, medication information or referral status or updates on any of the following phone numbers listed on patient information form:

☐ **Home** ☐ **Mobile** ☐ **Work**

And/Or with the following person(s):

Name:_____ Relationship: _____ Phone number:_____
Name:_____ Relationship: _____ Phone number:_____
Name:_____ Relationship: _____ Phone number:_____

This release will be revoked by written permission only. I understand that I must send a written request to Yu & I Wellness Center in order to revoke this request. When translation services are utilized, you give express consent that it may be done using a wireless mobile device.

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications: Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

Patient Name (Please Print):_____Date of Birth: _____

Signature (Patient/Guardian): _____Date:_____

Formulary Benefits Management (PBM) Consent Form

Formulary Benefit data are maintained for health insurance providers by organizations known as Pharmacy Benefit Managers (PBM). PBM's are third-party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

We may need access to your data as maintained by the PBM's to know what medications have been prescribed to you in the past, and to know which drugs are covered by your insurance plan.

By signing below I give permission for Yu & I Wellness Center to access my pharmacy benefits data electronically.
This consent will enable Yu & I Wellness Center to:

- Determine the pharmacy benefits and drug copays for a patient's health plan
- Check whether a prescribed medication is covered (in formulary) under a patient's plan
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies
- Download a histories list of all medications prescribed for a patient by any provider

In summary, we ask your permission to obtain formulary information and information about other prescriptions by other providers. This consent will be in place until revoked in writing.

I give permission for Rx History consent: Yes _____ No _____

Care Management Services Financial Agreement

With the transformation of health care across the country, there were new government billing guidelines established in 2015 for services identified as "Care Management". These services are non-face to face and include but are not limited to: follow ups for emergency room visits, inpatient hospitalizations, as well as coordination of care for ongoing chronic conditions. Examples: Diabetes, Hypertension.

These services are rendered by multiple means, to include but are not limited to: telephone and/or email contact, directly with client or their designated health contact, other health care professionals, as well as verbal and written reports.

These services may be billable to your insurance plan; any insurance payment processing will depend on your individual plan coverage. By signing below you agree to allow us to provide these services for you.

I give permission for care management services: Yes _____ No _____
By signing below you state that you have read and understand the above statements regarding PBM consent and Care Management Services financial agreement.

Patient Name (Please Print):_____Date of Birth: _____

Signature (Patient/Guardian): _____Date:_____

History Form

✔ Click a box to place a check mark in that box

What name do you like to be called? _____

Medical History: Have you ever been treated for any of the following medical conditions?

☐ No Known Medical Problems
☐ Seasonal Allergies ☐ Gastric Reflux ☐ Liver Disease
☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes
☐ Thyroid Disorder ☐ Heart disease ☐ Asthma/COPD
☐ Depression ☐ Anxiety ☐ Cancer ☐ Arthritis
☐ Dizziness/Vertigo ☐ Migraines ☐ Stroke/TIA
☐ Osteoporosis ☐ Back/Joint pain ☐ Kidney Disease

Please list any additional medical conditions:

_____

Have you ever been hospitalized overnight ☐ Yes ☐ No

List reason _____

Have you ever had surgery? ☐ Yes ☐ No

_____

Allergies or Adverse Reactions to Medications

_____
_____
_____
_____
_____

Medications: (including dosage)

_____
_____
_____
_____
_____
_____
_____

Please bring your bottles with you or a complete list of everything you take on a regular basis.

Do you take any supplements (Muti-Vitamins, Fish oil, Vit D, Calcium, etc)? ☐ Yes ☐ No Please list them

_____
_____

Pharmacy Name and Phone: _____ Ph# _____

Family History: Please list any known medical problems for the relatives listed below: Including history of Diabetes, Heart disease, Hypertension, Breast/Colon/Ovarian/Prostate Cancer, Alcohol abuse, Depression, Osteoporosis, Skin cancer, Autoimmune disease, Dementia

Mother: _____
Father: _____
Brother/Sister: _____
Children: _____
Other: _____

Habits: What do you do for exercise? _____
How often? _____
Tobacco use: Current Smoke _____ per day _____ Yrs
Previously Smoked _____ per day for _____ Yrs
Alcohol use: (Beer/Wine, etc): _____ per day
Drugs use (Marijuana, Cocaine etc): _____
Caffeine use (Coffee/ tea/ Soda): _____ per day
Any trouble sleeping? ☐ Yes ☐ No
Describe your eating habits: (poor, well-balanced, Vegetarian, gluten-free, etc): _____
Do you eat out more than twice a week? ☐ Yes ☐ No

Preventative Screening:

Do you wear seatbelts/helmets? ☐ Yes ☐ No
Do you wear sunscreen? ☐ Yes ☐ No

Who do you live with: _____ How many children do you have? _____
Do you have an eye exam at least every two years? ☐ Yes ☐ No
Any major stresses in your life? _____
Do you feel you ever have been abused (verbally, physically or sexually? ☐ Yes ☐ No
Do you have a dental exam at least yearly? ☐ Yes ☐ No
Do you have an Advanced Directive? ☐ Yes ☐ No
If yes, please provide the office with a copy for your records.
If no, would you like an information packet concerning Advanced Directive ☐ Yes ☐ No

REVIEW OF SYSTEMS

Please circle any current symptoms below :

General Symptoms: Fever, unexplained tiredness, swollen glands, excessive thirst, feeling unusually hot or cold, easy bruising or bleeding, passing out.

Eyes: Vision loss, eye pain, blurred vision.

Ears/Nose Mouth & Throat: awakening sore throat, runny nose, hearing loss, ringing in ears, problems with mouth, gum problems, voice changes

Breasts: Lumps, skin changes, nipple discharge.

Lungs & Heart: Chest pain/pressure, irregular heart beat, cough, wheezing, breathing problems.

Abdomen: Nausea, vomiting, abdominal pain, heartburn, bloating, indigestion, stomach pain, diarrhea, constipation, bloody stools.

Musculoskeletal: Joint pain, muscle pain, muscle weakness, limited range of motion.

Neurological: Unusual or new headaches, weakness or numbness, falling.

Skin: Rashes, changes moles, changes in hair/skin/nails.

Mood: Worry too much, felt down and depressed in the last two weeks, loss of desire to do things you used to enjoy, thoughts of self harm or suicide.

Sleep: Difficulty falling asleep, frequent awakening, Snoring.

Men Only: Difficulty starting or weak stream, difficulty getting/maintaining an erection, feeling like bladder won't empty, getting up at night to urinate, testicular pain/ lumps/swelling, possible sexually transmitted infections.

Women Only: Heavy periods, bleeding after menopause, sexual concerns, unusual vaginal discharge, Possible sexually transmitted infections, severe pain with periods, leaking urine.

Menstrual Cycle question: Still having cycle? ☐Yes ☐ No ☐Regular ☐ Irregular

Date of Last Period:_____ Birth Control Type: _____

Hysterectomy: ☐ Yes ☐No If yes, what age?_____ Due to What? _____

Number of Pregnancies: _____ Vaginal Deliveries:_____ C-Section Deliveries:_____

Other: (Stillbirth, miscarriage/abortion) Diabetes in pregnancy? ☐ Yes ☐ No

Have you ever had an abnormal pap or colposcopy? ☐Yes ☐ No

Prevention:

Women:

Date of Last Pap test:_____

Mammogram: _____

Bone Density test: _____

Men:

Date of Last PSA Screening: _____

Everyone:

Colonoscopy: _____

Lipid Panel: _____

Fasting Glucose: _____ HgA1C:_____

Immunizations:

Pneumovax:_____ Influenza: _____

Zostavax:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that Providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in my medical status.

I hereby give consent for medical treatment to the care providers with **Yu & I Wellness Center** to care for Myself, or I am authorized by the patient as his/her general agent to give consent for such treatment.

X_____ _____ _____

Signature of Patient/Guardian Print Name and relationship if Representative Date