Patient Name _____Date: _____
Email: _____ SS: _____ DOB: _____
Home Phone: _____ Cell Phone: _____ ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
Employer Name: _____ Phone: _____
Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Spouse or Patient's Guardian Name: _____ Phone: _____
Person to contact in case of an emergency: _____ Phone: _____
Do you have any Medical Insurance? If yes, complete the following:
Name of the guarantor: _____Relationship to Patient: _____
Insurance Company: _____ID#: _____ Group #: _____
Ins. Co. Address: _____ City: _____ State: _____ Zip: _____
Financially Responsible Party
Name of the primary insured: _____ Relationship to Patient: _____
Birthdate: _____
Whom may we thank for referring you? _____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY:

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay The Center for Integrative and Functional Health and Wellness, as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my right to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that have been or will be rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policies. I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitles, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Provider. *A photocopy or scan of this document is considered valid and enforceable as the original.*

Patient Name: _____ Patient Signature: _____ Date: ___/___/____
If the patient is of school age, 16+, it is ok to treat in case of a medical emergency in my absence. If yes, please sign:

Minor Patient's Name: _____ Guardian Signature: _____ Date: ___/___/____
Patient Name: _____ DOB: _____ Date: ___/___/____

If this visit is related to an Auto Accident, please fill out the following' if not, disregard.
YOUR Auto Insurance Company: _____ Phone: _____
Policy: _____ Claim Number: _____
Adjuster Name: _____ Phone: _____
Date of Accident: _____ State of Accident: _____ Did you go to hospital? ☐ Yes ☐ No
Name of Hospital: _____
Attorney: _____

Health History

Chief Complaint:

_____

History of Present Illness:

Location: _____ **Quality:** _____
(Where is the pain/problem?) (Example: normal vs abnormal color, activity, etc…)

Severity: _____ **Duration:** _____
(On a scale of 1-10 with 10 being the most severe) (How long have you had this pain/problem? When did it start?)

Timing: _____ **Context:** _____
(Does the pain/problem occur at a specific time?) (Where were you at the onset of this pain/problem?

Associated Signs/Symptoms: _____
(What other associated problems have you been having?)

Modifying Factors: _____
(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

Have you ever had any of the following conditions? Please <u>circle</u> "yes" for any that may apply.

Measles …… YES
Mumps …… YES
Chicken Pox …… YES
Whooping Cough …… YES
Scarlet Fever …… YES
Diphtheria …… YES
Small Pox …… YES
Pneumonia …… YES
Rheumatic Fever …… YES
Arthritis …… YES
Mitral Valve Prolapse …… YES
Anemia …… YES
Bladder Infection …… YES
Epilepsy …… YES
Migraine Headaches …… YES
Tuberculosis …… YES
Diabetes …… YES
Cancer …… YES
Polio …… YES
Glaucoma …… YES
Hernia …… YES
Transfusion …… YES
Back Trouble …… YES

High Blood Pressure …… YES
Low Blood Pressure …… YES
Hemorrhoids …… YES
Date of Last Chest X-Ray _____
Asthma …… YES
Hives of Eczema …… YES
AIDS & HIV …… YES
Infectious Mono …… YES
Bronchitis …… YES
Stroke …… YES
Hepatitis …… YES
Ulcer …… YES
Kidney Disease …… YES
Thyroid Disease …… YES
Bleeding Tendency …… YES
Any Other Disease …… YES
Please List:
_____
_____
_____
_____
_____
_____

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____.	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (Include nonprescription)

_____
_____
_____

Allergies: (Please include all known allergies and the type of reactions you have)

_____
_____
_____

Patient Social History

Use of alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Drugs Never: _____ Type/Frequency: _____
Excessive Exposure
At home or work to: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

Family Medical History

	Age	Disease	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings.	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Do you now or have you had any problems related to the following systems? Check all that apply.

Eyes/Ears/Nose/Throat/Respiratory
- o Asthma
- o Stuffy Nose
- o Hay Fever
- o Sore Throat
- o Chronic Cough
- o Chest Congestion
- o Frequent Sneezing
- o Itchy/Watery Eyes
- o Drainage
- o Earache or Ear Infection
- o Itching
- o Hoarseness
- o Shortness of Breath
- o Wheezing

Neurological
- o Headaches
- o Migraines
- o Dizziness
- o Numbness
- o Tingling
- o Pins/needles in hands or feet
- o Diarrhea

Muscular/Skeletal
- o Muscle Aches
- o Fibromyalgia
- o Arthritis
- o Joint Pain
- o Low Back Pain
- o Neck Pain
- o Wrist/Hand Pain
- o Elbow Pain
- o Hip Pain
- o Knee Pain
- o Ankle/Foot Pain
- o Pain b/t shoulder blades

General
- o Fatigue
- o Malaise
- o Weakness, tiredness
- o Lightheadedness
- o Irritability
- o Constipation

Cardiac
- o Chest Pain
- o Palpitation
- o Irregular Heartbeat
- o Leg Swelling

Constitutional/Endocrine
- o Fever
- o Chills
- o Weight Loss
- o Weight Gain
- o Insomnia
- o Excessive Thirst
- o Excessive Urination

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 doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____
Signature of the Patient, Parent or Guardian **Date**

Clinician's Review

_____ _____
Signature of Clinician **Date**

Financial Policy

Thank you for choosing The Center for Integrative and Functional Health & Wellness, LLC, to be of service to you. Please understand that our billing is done according to the contractual obligations we have with your insurance company and we must be in compliance with Federal and State laws regarding financial transactions related to providing medical care.

PAYMENT FOR SERVICES IS EXPECTED AT THE TIME OF SERVICE

- We do NOT accept Worker's Compensation or Motor Vehicle Insurance Claims.
- Please do not discuss or negotiate your co-pays or deductibles with your provider.
- Please ask to speak with our financial advisors who better understand the insurance requirements, the rules and regulations that we must comply with, and how we can best help you with your financial considerations.
- Patient Obligations:
    - Co-pays must be paid at time of service.
    - Patients are responsible for their deductibles, co-insurance, out-of-pocket expenses, and any other agreed services not covered by their insurance.
- Collection Policy: Any unpaid balance over 90 days will be forwarded to a Collection Agency, unless other arrangements have been made with our financial counselor.

We are committed to serving those in need, but we must do so in a legal manner that will also not jeopardize our business and/or deny others access to the health care they deserve.

Acknowledgement:

- I acknowledge full financial responsibility for services provided to me by The Center for Integrative and Functional Health and Wellness, LLC.
- I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including copayments, co-insurance, out-of-pocket expenses, and deductibles.
- I understand co-payments are due at the time of service, as well as any prior balance I may owe.
- I understand that under provisions of HIPAA (Health Insurance Portability and Accountability Act), my insurance company and/or employer group plan administrator may be notified if I fail to fulfill my financial obligations for payment.
- I agree to all reasonable attorney fees and collection costs in the event I default on payment of my charges.
- I also give my consent for the release of billing information and for the direct payment of authorized insurance benefits paid on my behalf to The Center for Integrative and Functional Health and Wellness, LLC.

Patient's Name: (Please Print) _____ **DOB:** _____
Patient's Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly or indirectly.
- Obtain payment from third-party payers/collectors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

The Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information has been made available to me. I understand that this organization has the right to change its notice of Privacy Practices from time to time and that I may contact this organization at any time to address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my confidential information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

It is the policy for The Center for Integrative and Functional Health and Wellness, LLC, to inform patients of pertinent test results. We may also be asked to discuss your health information with other family members, or a close friend. Laws prevent us from leaving any messages regarding these results without your permission.

Notification/Permission to Call and/or Leave Messages:

Please check all acceptable options regarding notification of test results or health information and provide current phone numbers:

- I will call the office, please do not call with results.
- Patient Only: Phone: (____) _____ - _____
- Spouse Name: _____ Phone: (____) _____ - _____
- Child Name: _____ Phone: (____) _____ - _____
- Other Name: _____ Phone: (____) _____ - _____
- And/Or Name: _____ Phone: (____) _____ - _____

By signing below, I acknowledge the following:

- I have been provided with a copy of the Notice of Privacy Practices.
- I give The Center for Integrative and Functional Health and Wellness, LLC, the authority to access my medication history automatically from Pharmacy Benefit Managers (PBMs).
- I give consent to call me using automated phone calls or to send text messages on my cell phone.

Patient's Name: (Please Print) _____ DOB: _____
Patient's Signature: _____ Date: _____

OFFICE USE ONLY: I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Name: _____
Initials: _____ Reason: _____

Billing Policies

Please carefully review all the billing policies below and initial where indicated. Complete all fields in the "Credit Card Information" section of this form. This form must be completed and signed at the time of your initial session.

Overview

Why does The Center for Integrative and Functional Health and Wellness have a credit card policy? By utilizing your credit card information for balances due, we will be able to process payment more efficiently.

We are currently sending statements for your unpaid balances. By reducing the number of statements printed and mailed each month, we will be lowering billing costs by saving on paper, time, and postage. These savings allow us to keep services affordable and to keep your fees to a minimum.

We require that a valid credit card be kept on file for all clients. If you do not wish to have your credit card charged, you must provide an alternate form of payment at the time of service or contact our billing department with an alternate form of payment upon receipt of the Explanation of Benefits (EOB) from your insurance company.

Please contact our billing department with any questions at: (630) 980-1400.

Policies

Initial Here: _____ Co-Pay:

- All payment for co-pays are due at the time of each appointment.
- If an alternative form of payment (i.e., cash or check) is not received at time of service, your credit card will be manually charged for any fees.

Initial Here: _____ Cancellation Policy:

- We require a 24-hour notice for all cancellations.
- Your credit card will be charged $100.00 for all cancellations/no-shows with less than a 24-hour notice.

Initial Here: _____ Insurance (Payments, Deductibles, Etc.):

- It is the Client's responsibility to cover any deductible and all co-payments.
- Upon receipt of the EOB from your Insurance Company, we will apply the insurance payment to your account and charge your credit card for the client balance due for each applicable date of service. A copy of the billing statement and credit card receipt will be mailed promptly.
- We will submit medical claims to the primary and secondary (if applicable) Insurance Company. There is no guarantee that the services provided by us will be covered and paid for by your insurance.
- Insurance companies typically take 30-90 days to process claims. When the claim is processed, the insurance company will mail an EOB to both the member (you) and to the provider (us).
- Not all services are covered by insurance plans; it is the client's responsibility to know their health benefits. Please contact your insurance provider to obtain the benefit details of your policy.

Credit Card Information

Type of Credit Card: ☐ Visa ☐ MasterCard ☐ Discover ☐ Amex

Credit Card #: _____ Exp. _____
Date: _____ 3 or 4-Digit Security Code (found on back of card):_____
Billing Street Address: _____ Zip Code: _____

I hereby authorize The Center for Integrative and Functional Health and Wellness, LLC, to charge my credit card for any unpaid balance, including missed or cancelled appointment fees. The signature below will serve as the authorization for said charges. By signing this form, I understand that my credit card will continue to be charged until my account balance for services rendered is $0.00.

_____	_____	_____
Signature of Card Holder	**Printed Name of Card Holder (as Shown on Card)**	**Today's Date**