Welcome

ABOUT YOU

Today's Date: ____________/____________/_________

Patient Name: ____
Last First MI

What You Like To Be Called _______________ ☐Male ☐ Female

Email Address: ____

B-Day: _____/_____/_____ Age:______ SS# ________________

Mailing Address ____

____
City State Zip

Home Phone #: (__________)____________________________

Work Phone #: (_________) ____________________ Ext: _____

Cell Phone #: (__________) ____________________________

May we call you at: ☐Home ☐Work ☐Cell

How did you hear about our practice?______________________

Marital Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed

Spouse's Name: ____

Race: ☐Caucasian ☐African American ☐Asian ☐Latin American ☐Native American ☐Other ☐ I decline

Ethnicity: ☐Hispanic ☐Non-Hispanic /Non-Latino ☐ I decline

Occupation: ________________ Employer: ________________

Employer's Address: ____________________________________

____
City State Zip

X-RAY QUESTIONNAIRE (WOMEN ONLY)

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

☐ There is a possibility that I may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because:

____

INSURANCE INFORMATION

Primary Insurance (Please provide card)

Co. Name: ____________________________

Insured's ID #: ________________________

Insured's Name: _______________________

Relation: ____________ DOB ___/___/___

Insured's Employer: ____________________

Secondary Insurance (Please provide card)

Co. Name: ____________________________

Insured's Name: _______________________

Relation: ____________ DOB ___/___/___

Insured's Employer: ____________________

____

Is this visit due to an accident? ☐Yes ☐No

If yes, what type? ☐Auto ☐Work ☐Other

Has it been reported? ☐ Yes ☐ No

If yes, to whom? ____________________

EMERGENCY CONTACT

In the event of an emergency, who should we contact?

Name: ______________________________

Relation: ____________________________

Home Phone #: (_____) ________________

Work Phone #: (_____) ________________

Cell Phone #: (_____) ________________

Who is your medical doctor?

____

Medical Doctor's Office #:

(_____) ____________________________

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

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Real Health Clinic, LLC 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 rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, 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 plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies).

I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or 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 to obtain benefits and/or payments that are due 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 entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this ______ day of _________________ 20 ____.

X____
Signature of Patient

____
Name (printed)

X____
Signature of Guardian (if applicable)

INFORMED CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here: X_______________________________I have read and understand the above consent form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Real Health Clinic.
(Please initial one of the following options and sign below.)

__________ I wish to receive a paper copy of Privacy Notice.

__________ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

This serves a notice that as part of our efforts to deliver the most consistent healthcare we can to every patient, we use an electronic healthcare system that enables us to retrieve up to 13 months of prescription history through your insurance carrier.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

____ ________________________
Signature of Patient/Guardian Date

____ ________________________
Witness (Office Staff) Date