NEW PATIENT INTAKE & POLICIES FORM

☐ PRIMARY CARE ☐ PHYSICAL THERAPY ☐ MASSAGE THERAPY

NAME: _____

DATE OF BIRTH: _____ MALE: ☐ FEMALE: ☐

STREET ADDRESS: _____ APT/SUITE: _____

CITY: _____ STATE: _____ ZIP: _____

THIS PRACTICE PERFORMS CLINICAL NOTIFICATION VIA EMAILS AND TEXT MESSAGES. BY CHECKING THE BOXES BELOW AND PROVIDING CONTACT INFORMATION, YOU ARE GIVING CONSENT FOR OUR CLINIC TO DO SO.

IS IT OKAY TO LEAVE A DETAILED MESSAGE? ☐PHONE ☐PORTAL

☐ PRIMARY PHONE: (_____) _____

☐ EMAIL: _____

EMERGENCY CONTACT

NAME & RELATION: _____ PHONE: (_____) _____

PARENT OR GUARDIAN (IF UNDER 18)

NAME: _____ PHONE: (_____) _____

REFERRING PROVIDER / CLINIC

NAME: _____ PHONE: (_____) _____

PREFERRED PHARMACY

NAME: _____ PHONE: (_____) _____

INSURANCE

EMPLOYER: _____ OCCUPATION: _____

☐ AUTOMOBILE ☐ COMMERCIAL ☐ SELF-PAY ☐ WORKMEN'S COMPENSATION

PRIMARY: _____

ID/POLICY #: _____ GROUP #: _____

SECONDARY: _____

ID/POLICY #: _____ GROUP #: _____

DATE OF INJURY/ACCIDENT: _____

CLAIM MANAGER: _____ PHONE: (_____) _____

HOW DID YOU HEAR ABOUT US?

☐ FAMILY OR FRIEND ☐ PC MEMBER ☐ ONLINE ☐ PHYSICIAN ☐ OTHER: _____

NO SHOW & CANCELLATION POLICY

We make every effort to provide you with an appointment that accommodates your schedule. Once the appointment is made, that time is reserved specifically for you. If an appointment is canceled without advanced notice, it not only means that you do not get the service you need, it also prevents other patients the opportunity to schedule that appointment time.

- ❖ LATE CANCELS - CANCELS GIVEN WITH LESS THAN 24 HOURS NOTICE, MAY RESULT IN A $50.00 FEE.
- ❖ NO-SHOWS - PRIMARY CARE: $175.00 |MASSAGE/PHYSICAL THERAPY $75.00

It is important that you arrive and are ready to start at the time of your scheduled appointment.

- ❖ LATE ARRIVAL OF 10 MINUTES OR MORE MAY BE CONSIDERED A LATE CANCEL, REQUIRING TO RESCHEDULING YOUR APPOINTMENT AND SUBJECT TO THE $50.00 LATE CANCEL FEE.

Cancel and No Show Fees may require payment prior to scheduling future appointments. Please note that your insurance carrier is NOT responsible for these charges. We appreciate your understanding and cooperation.

Patient Initials: _____

CONSENT FOR SURESCRIPTS

I hereby give consent to the Center for Functional Health/The Pacific Clinic and its employees and/or contract personnel to obtain medical information using Surescripts. *Surescripts is an information technology company that supports e-prescription, the electronic transmission of prescriptions between health care organizations and pharmacies, as well as general health information exchange of medical records.

Patient Initials: _____

NOTICE OF PRIVACY PRACTICES

I understand Center for Functional Health will use and disclose health information about me in compliance with the HIPAA Act. I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices. I understand I may request a copy of the full Notice of Privacy Practices for Center for Functional Health, as outlined by Federal Regulations at any time.

I authorize the Center for Functional Health to share my protected health information with The Pacific Clinic team members on an as needed basis as it pertains to my health treatment, Regenerative Therapy and/or Medical Weight Loss Program.

Patient Initials: _____

NOTICE OF NON_PARTICIPATION

Center for Functional Health is not a participating provider for Medicaid State Insurance(s). I understand I am fully responsible for all charges and balances that can not/will not be billed to my Medicaid State Insurance Plan.

I understand I am responsible for all unpaid balances on my account for any copay, deductibles, or coinsurance regardless if it is primary or secondary.

Patient Initials: _____

FINANCIAL POLICY & PATIENT AUTHORIZATION

I assign medical and/or major medical benefits to Center for Functional Health and authorize Center for Functional Health to provide and receive any medical information necessary to bill an insurance/third party and receive a direct payment from listed insurance/third party.

I understand that it is my responsibility to know information pertaining to my insurance plan/third party billing company and their benefits, limitations etc. All co-payments and patient statement balances are due at the time that services are provided. Any amounts not covered by my insurance company are my responsibility. This includes, but is not limited to, charges for office visits, supplies, dme, supplements, prescriptions and/or labs. Should my account not be paid within one hundred and twenty days (120) of first statement billing, my full account may be sent to collections. In the event that legal action becomes necessary related to your collections, you will be responsible for all attorney's fees and court costs.

I hereby give consent to Center for Functional Health/The Pacific Clinic and its employees and/or contract personnel to render treatment to myself and/or my child (or child under my guardianship). Although rare, complications from treatment are a possibility and I will discuss any concerns I may have with the provider prior to the initiation of treatment. I authorize payments of all medical benefits directly to Center for Functional Health for services provided.

Patient/Guarantor Name: _____

Patient/Guarantor Signature: _____ Date: _____

(signature indicates patient has read, understood & initialed all the afore-stated policies)