Patient Information

Name: ____
Last First MI

Date of Birth:___/___/____ Sex: Male Female SS#:_______________________________

Mailing Address:___________________________________City:________________State:______Zip:_______

Phone Number (H)______________________(W)______________________(C)_______________________

Email Address: ____

Marital Status: Single Married Divorced Widowed Separated Minor

Race: Caucasian African American Asian Native American Latin American Other____

Occupation: ________________________________ Employer: ________________________________

Employer Address: ____Phone:___________________

How did you hear about our practice?____

Emergency Contact

Name:____________________________________ Relation:__________________________________

Emergency contact Phone: (H) ____________________ (W) ___________________ (C)________________

Accident Information

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? ____

Insurance Information

Do you have Insurance? Yes No Name of carrier:_________________________________

Do you have secondary Insurance? Yes No Name of carrier:_________________________________

Policyholder Name:____ D.O.B:______________________

Relationship to patient (if other than self):__________________________ Phone:______________________

PLEASE PROVIDE THE OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Signature________________________________ **Date:**____________________

Review of Systems

Name:___________________________________ Date:____________________

Y N Neurological

___ ___ Migraines
___ ___ Headaches
___ ___ Slurring of speech
___ ___ Ringing in ear

Y N Ear/Nose/Throat

___ ___ Altered taste/smell
___ ___ Night Blindness
___ ___ Sore Throat
___ ___ Gingivitis
___ ___ Nose Bleeds

Y N Cardiovascular

___ ___ Chest Pain
___ ___ Palpitations- racing heart beat
___ ___ Swelling in hands/feet
___ ___ Anemia

Y N Respiratory

___ ___ Recurrent Respiratory Infections
___ ___ Asthma
___ ___ Chest Congestion
___ ___ Wheezing
___ ___ Frequent Sneezing

Y N GI

___ ___ Stomach pains or Cramping
___ ___ Constipation
___ ___ Reflux or Heartburn
___ ___ Bloating
___ ___ Gas
___ ___ Nausea or Vomiting

Y N Musculoskeletal

___ ___ Joint Pain
___ ___ Arthritis
___ ___ Chronic Pain
___ ___ Muscle Aches

Y N Skin

___ ___ Eczema
___ ___ Dermatitis
___ ___ Excessive Sweating
___ ___ Rashes
___ ___ Brittle Nails
___ ___ Easy Bruising
___ ___ Increased Bleeding
___ ___ Numbness/tingling

Y N Genitourinary

___ ___ Uterine Fibroids
___ ___ Ovarian cysts
___ ___ Cancer (breast, ovarian, prostate, uterine)
___ ___ Prostate Problems

Y N Emotional/Mental

___ ___ Depression
___ ___ Anxiety
___ ___ Mood Swings
___ ___ Irritability
___ ___ Memory Loss
___ ___ Confusion

Y N Energy

___ ___ Fatigue
___ ___ |Hyperactivity
___ ___ Restlessness
___ ___ Insomnia
___ ___ Decreased Libido
___ ___ Stress

Y N Weight

___ ___ Decreased Appetite
___ ___ Weight Gain
___ ___ Inability to lose weight
___ ___ Food Cravings
___ ___ Binge Eating
___ ___ Water Retention

Please check ALL options you have previously tried to assist in the above symptoms:

___ Over the counter medications
___ Prescriptions
___ Dietary changes
___ Exercise
___ Consult with specialist
___ Supplements
___ Alternative medication/treatment therapies

Have you ever had any type of food sensitivity or vitamin/mineral testing done? Yes No
If Yes, What?__________________________________ **When?**________________________________

X-Ray Questionnaire: For Women Only

Our consultation and examination may indicate the 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.

Name:____________________________

- ☐ 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:__________________________________

____

Date of last menstrual period: _______________

__________________________________ **_Patient Signature_**

_________________ **_Date_**

Informed Consent to Care

A Patient coming on 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 health care, 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 in attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examination 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 form any mast medical history, illnesses, medicines, or allergies.

I agree to settle andy 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.

I have read and understand the above consent form

____ ______________________

Signature **Date**

Acknowledgment of receipt of notice of privacy practices

I acknowledge that I have reviewed the Notice of Privacy Practices of ***Apex Integrated Medical***

(please initial one of the following option and sign below)

______________ I wish to receive a paper copy of Privacy Notice

______________ I DO NOT wish to receive a copy of Privacy Notice at this time. I acknowledge that I can request a copy at this 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 prescriptin history through your insurance carrier. .

I acknowledge that it is the policy of this office to leave reminder messages on 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 **Date**

____ ______________________

Witness Signature (Office Staff) **Date**

ASSIGNMENT OF HEALTH 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 **Apex Integrated Medical** 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, test, 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, test, 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 sas 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 the 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. 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 have remain in effect unless revoked in writing. A photocopy or scan or this document is to be considered as valid and enforceable as the original.

Signed this _____________ day of ___________________ 20_________.

________________________________ ____________________________ ___________

Printed Name **Signature** **Date**

____

(Signature of Guardian if applicable)

PAYMENT & REFUND POLICY ACKNOWLEDGEMENT STATEMENT

I hereby acknowledge by initialing and checking the boxes below that I have been made aware of the Apex Integrated Medical Payment Policy and Refund Policy.

PAYMENT POLICY

A **$35 Fee** will be assessed for all insufficient funds payments processed.

A **$25 Fee** will be assessed for all payments more than 3 days late.

☐__________ (initials)

REFUND POLICY

1. No refunds will be given on any needles.
2. No refunds will be given on any Durable Medical Equipment such as back braces, Denerolls, etc.
3. No refunds will be given on any medicine, supplements or weight loss products such as HCG or B12 etc.
4. No refunds will be given on any unused testing kits which the patient has taken home.
5. No refunds will be given on any services rendered for chiropractic, weight loss and medical care.
6. No refunds will be given due to cancellation of treatment for Stem cells with less than 48 hour notice. Cancellations must be made 48 hour in advance during our normal business hours Mon-Thurs 9-6 and no later than 12pm on Friday. Contact the office if your Stem cell treatment needs to be rescheduled or cancelled.

In order to receive a refund, an appointment must be scheduled with the Office Manager. No refunds will be issued over the phone.

Refunds that are given will be calculated on normal rates for services rendered. No discount applies to refunds.

☐______ (initials)

I have read and understood the Apex Integrated Medical Policy. By signing this acknowledgment I agree to the policy as stated above.

______________________________	___________________________________	_______________
Printed Name	Patient Signature	Date

<u>Financial Office Policies</u>

1. All patients are on a cash basis until our staff can verify all insurance coverage(s).
2. Your insurance will be verified promptly and will be reviewed with you if applicable.
3. After coverage and deductible are verified, this office may accept assignment on most policies provided the insured/patient signs an appropriate statement of benefits and/or lien authorizing payment to be sent to the doctor
4. Waiting for the insurance payment is a courtesy and it may be withdrawn under certain circumstances.
5. As a patient, it is your responsibility to take care of the co-payment (usually a percent or fixed dollar amount) and any non-covered services on a monthly basis. This office jay make payment arrangements on an individual basis. Any such plan or arrangements will be discussed during your report of findings.
6. This office does not warrant or guarantee that your insurance company will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured.
7. Any service not covered or coverage reductions by your insurance carrier will be the patient's responsibility.
8. This office will submit an insurance claim for you. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated and uncovered.
9. Should your account balance become delinquent (30 days past due), we reserve the right to pursue further action in an attempt to collect any unpaid balance, such as liens, garnishments, court proceedings and/or your account being sent to collections/court.
10. If your account should go to collections/court for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and/or collection costs incurred in collecting the account balance. A 20% interest will be added to any remaining balance being sent to collections/court.
11. I authorize the release of any medical or other records or information from my health record. I authorize release of records or information necessary to process any claims.
12. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means refunds are made only after your balance is completed and cleared with this office.
13. If you receive correspondence checks from your insurance company, you agree to bring these into our department so that we may determine if any action needs to be taken or if the check is on assignment to this office.
14. If you change insurance companies or employers, you agree to provide this office with the current information immediately .
15. If this office gives you any professional or accounting discount for treatment and you decide to drop out of care then our standard fees will apply.
16. This office accepts MasterCard, Visa, American Express, Discover Card, personal checks and cash.
17. If you stop care and have a financial agreement signed with our office, you will be responsible for any/all charges that you have incurred at our office.

***Patient Signature:*____________________________________ *Date :*______/______/_______** *I Have read and fully understand the financial office policy and agree to abide by these terms. If you have any questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the doctor. Thank you for your cooperation in this matter.*

SIGN UP FOR TEXT MESSAGE ALERTS!

OPT IN:

I authorize Apex Integrated Medical to send text message appointment reminders and updates to me on my provided cell phone number. Text message charges from my cell phone provider may apply.

Patient's Cell Phone: (_____) ________---_________

My signature below indicates that I represent and warrant that I am the person legally responsible for all use of the account, and that I agree to all terms and conditions of use for the text messaging services.

_____________________________	_________________________________	______________
Print Name	Signature	Date

OPT OUT:

I refuse consent for Apex Integrated Medical to send text message appointment reminders and updates to me on my phone number

_____________________________	_________________________________	______________
Print Name	Signature	Date