Heal 360

PATIENT INFORMATION

Name ____________________
Address ____________________
City ____________ State ________ Zip ____________
Date of Birth ____________
Age ________
SSN ______/______/________
Sex O Male O Female
Marital Status O Married O Single O Divorced O Widowed
Home Phone ____________ Cell/Pager ____________ Email ____________
Employer ____________ Work Phone ____________
Employer Address ____________________
City ____________ State ________ Zip ____________
Primary Care Physician ____________ Office Phone ____________
Referring Physician ____________ Office Phone ____________
Name of Closest Relative Not Living With You ____________
Relative's Address ____________________
City ____________ State ________ Zip ____________ Phone ____________
How Did You Hear About Us? O Doctor O Relative/Friend O Online O Other ________

SPOUSE INFORMATION

Name ____________________
Address ____________________
City ____________ State ________ Zip ____________
Date of Birth ____________
Age ________
SSN ______/______/________
Home Phone ____________ Cell/Pager ____________ Email ____________
Employer ____________ Work Phone ____________
Employer Address ____________________
City ____________ State ________ Zip ____________

INSURANCE INFORMATION

Primary Insurance Company ____________________
Relationship to Insured O Self O Spouse O Child O Other
Name of Insured ____________________
Date of Birth ____________
SSN ______/______/________
Sex O Male O Female
ID ____________ Group ____________ Phone ____________
Address to Mail Claims ____________________
City ____________ State ________ Zip ____________
Referral Obtained from PCP O Yes O No
Copay $ ____________ Deductible $ ____________

Secondary Insurance Company ____________________
Relationship to Insured O Self O Spouse O Child O Other
Name of Insured ____________________
Date of Birth ____________
SSN ______/______/________
Sex Male Female
ID ____________ Group ____________ Phone ____________
Address to Mail Claims ____________________
City ____________ State ________ Zip ____________
Referral Obtained from PCP O Yes O No
Copay $ ____________ Deductible $ ____________

I hereby assign my insurance benefits to be paid to Heal 360. I understand that I am financially responsible for this bill, regardless of insurance coverage. I also authorize the release of any information required in the processing of insurance claims. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).

Patient Signature ____________________ Date ____________

Heal 360

MEDICAL HISTORY

Patient ______________________ Date ______________

Reason for today's visit ______________________

Are you allergic to any MEDICATIONS? O Yes O No

If Yes, list ______________________

List any medications you are currently taking ______________________

PAST MEDICAL HISTORY

Do you have now, or have you ever had, diseases or conditions of the following

- O Bronchitis/Asthma
- O Emphysema
- O Kidney
- O Chronic Cough
- O Morning Cough
- O Hepatitis or Yellow Skin
- O High Blood Pressure
- O Chest Pain
- O Heart Attack
- O Heart Murmur
- O Irregular Heartbeat
- O Diabetes
- O Thyroid Disease
- O Bleed Easily
- O Bladder
- O Stomach
- O Glaucoma
- O Arthritis/Joint Deformity
- O Convulsions/Epilepsy
- O Seizures
- O Fainting
- O Pacemaker
- O Exposure to HIV/AIDS
- O Artificial Joint ______________________
- O Other ______________________

FAMILY HISTORY

Does anyone in your IMMEDIATE family have any chronic medical condition, such as Bleeding Disorders, Cancer, High Blood Pressure or other conditions? O Yes O No

If Yes, Who? ______________________

SURGICAL HISTORY

Please list any previous surgeries ______________________

SOCIAL HISTORY

Do you drink alcohol? O Yes O No

If Yes, _______ drinks per day

Do you use IV drugs? O Yes O No

If Yes, what type/how often? ______________________

Do you smoke? O Yes O No

If Yes, how much? ______________________

What is your occupation? ______________________

Are you pregnant? O Yes O No

If Yes, what is your Due Date? ________________

Heal 360

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name ______________________________

Date of Birth ______________

Date of Visit ______________

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any Medical service or visit, Preventive exam or Physical, Lab testing, X-ray, EKG and any screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the physician or clinic to know if my insurance will pay for my Medical service or visit, Preventive exam or Physical, X-ray, EKG and any other screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if my insurance has any Deductible, Copayment, Coinsurance, Out-of-network amount, Usual and Customary limit or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provoder recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out-of-pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP chaoice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company or plan, it may result in claims being denied. I understand this and agree to be be financially responsible and make full payment.

Signature ______________________________

(Please sign here- patient or Responsible Party)

Date ______________

Responsible Party Name ______________________________

(Please print name of Responsible Party if different from patient)

CREDIT CARD/DEBIT CARD AUTHORIZATION

Heal 360 submits claims to insurance carriers as a convenience to all our patients. At this time we request authorization to balance bill to a major credit card or debit card to cover amounts determined by your insurance to be your responsibility.

Upon receipt of an explanation of benefits from your insurance carrier, any unpaid portion of your claim will be billed to your credit card or debit card. Should insurance pay in full, your account will not be charged.

All credit card and debit card information will remain absolutely confidential and securely by First Data. Heal 360 will not store any banking account data.

I hereby authorize Heal 360 to charge any and all outstanding balances, after insurance company reimbursement or denial, to my credit/debit card. I understand that i will not recieve a statement if there is no balance due after processing my credit/debit card for payment.

Cardholder's Signature ______________________________

Date ______________

Heal 360

CONSENT TO RELEASE INFORMATION

Patient Name ____________________
Date of Birth ____________________
Address ____________________
City ____________________ State ____________ Zip ____________
Phone ____________________

I hereby authorize and request medical records be released from

____
____
____
____

Please release a copy of medical records, including progress notes, immunizations, labs/x-ray results, hospitalization reports and previous physical notes. I understand I may revoke this consent at any time and that upon fulfillment of the above stated purpose, this consent will automatically expire. Do not forward requested information to another person or agency without my consent.

Date ____________________
Patient or Responsible Party ____________________
Date ____________________
Witnessed By ____________________

ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES

Heal 360 reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the NOTICE OF PRIVACY PRACTICES.

Printed name ____________________
Signature ____________________
Date ____________________
Signature of Patient Representative ____________________
(Required if patient is a minor or adult unable to sign this form)
Relationship to Patient ____________________

REQUEST FOR CONFIDENTIAL COMMUNICATION OF YOUR PROTECTED HEALTH INFO

May we leave messages concernin g your appointments with a co-worker, receptionist or secretary who regularly answers your calls?
○Yes ○No ○N/A

May we leave messages on a voicemail at your work?
○Yes ○No ○N/A

May we discuss your appointments and/or treatment with your spouse?
○Yes ○No ○N/A

If you are over 18, may we discuss your appointments and/or treatment with your children?
○Yes ○No ○N/A

You must inform us in writing if you wish to change the manner in which Heal 360 communicates with you. Thank you.