

Heal 360

PATIENT INFORMATION

Name _____
Address _____
City _____ State _____ Zip _____
Date of Birth _____
Age _____
SSN _____ / _____ / _____
Sex Male Female
Marital Status Married Single Divorced 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? Doctor Relative/Friend Online 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 Self Spouse Child 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 Yes No
Copy \$ _____ Deductible \$ _____

Secondary Insurance Company _____
Relationship to Insured Self Spouse Child 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 Yes No
Copy \$ _____ 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? Yes 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

- Bronchitis/Asthma
- Emphysema
- Kidney
- Chronic Cough
- Morning Cough
- Hepatitis or Yellow Skin
- High Blood Pressure
- Chest Pain
- Heart Attack
- Heart Murmur
- Irregular Heartbeat
- Diabetes
- Thyroid Disease
- Bleed Easily
- Bladder
- Stomach
- Glaucoma
- Arthritis/Joint Deformity
- Convulsions/Epilepsy
- Seizures
- Fainting
- Pacemaker
- Exposure to HIV/AIDS
- Artificial Joint _____
- 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? Yes No

If Yes, Who? _____

SURGICAL HISTORY

Please list any previous surgeries _____

SOCIAL HISTORY

Do you drink alcohol? Yes No

If Yes, _____ drinks per day

Do you use IV drugs? Yes No

If Yes, what type/how often? _____

Do you smoke? Yes No

If Yes, how much? _____

What is your occupation? _____

Are you pregnant? Yes No

If Yes, what is your Due Date? _____

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 provider 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 choice 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 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 receive 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.