Rancho Wellness

YOUR MEDICAL HOME

Patient name:_____ Date of birth:_____

Address:_____

City:_____ State:_____ Zip code:_____

Home #:_____ Cell#:_____ Work #:_____

Patient sex: M F

Email:_____

Marital status:_____ Ethnicity:_____

Name of emergency contact person:_____

Relation:_____ Phone #:_____

Do you have medical insurance? Y N

If so name of insurance:_____

Member ID#:_____ Group #:_____

List any allergies to medications/food/products or other items:

_____

List current medications along with dosage and how often they are taken:

_____

Past medical history:_____

_____

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Past hospitalizations/ surgeries:_____

_____

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Do you smoke? Y N If so how many packs a day:_____

Do you consume alcohol? Y N If so how many days a week:_____

Do you currently or have you used illicit drugs? Y N

If yes, please not type of drugs and current status:_____

What is your current occupation:_____

AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS: Many of our patients allow family members such as their spouse, parents or others to call and request medial and/or billing information. Under HIPAA requirements we are not allowed to give this information to anyone without the patients consent.

Initials:_____

1._____ relation to patient:_____

2._____ relation to patient:_____

3._____ relation to patient:_____

PROTECTED HEALTH INFORMATION: We are required by law to maintain the privacy and security of your PHI. We are also required to provide you with our Notice of Privacy Practices (available upon request) which describes our legal responsibilities and your rights regarding the use and disclosure of your PHI. Initials:_____

RANCHO WELLNESS FINANCIAL POLICY: Knowing your insurance benefits, including co-pays, yearly deductibles and co-insurances, is your responsibility and these are to be paid at the time of the visit. If you have a yearly deductible that has not been met, a credit card will be kept on file securely, and a deposit towards that visit will be collected at the time of visit. If there is a remainder balance for your visit, once we receive an explanation of benefits, the credit card on file will be charged automatically ONLY AFTER 45 days from the time a statement is sent to you and we have not received payment. If for some reason, your insurance

pays 100% of the claim, you will have a credit on your account that can be used for future visits or can be credited back to you. Initials:_____

CANCELLATION/NO-SHOW POLICY: We understand that there may be times when you miss an appointment due to emergencies. We URGE you to call 24 hours prior to cancelling your appointment. Failure to do so may results in a charge of $35. If you 'NO-SHOW' or 'SAME DAY CANCEL' for two consecutive appointments or cancel for a total of four appointments without notification, you WILL be discharged from care. Initials:_____

By signing my FULL NAME below, I am consenting to all of the information on this form. Signature:_____
Date:_____