

# New Patient Paperwork

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_ Sex: \_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unit/Apt # \_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_

Primary Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Text Message/Voicemail Reminders: [ ] Yes [ ] No

If under 18, person financially responsible: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_

Relationship to subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact & Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Physicians/Providers:

Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide the name and title of other practitioner(s) who participate in your care:

|  |  |
| --- | --- |
| Name: | Specialty: |
|  |  |
|  |  |
|  |  |

# Medication/Supplements:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name | Dose | Frequency | Reason | Date Began | Helpful |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

# Hospitalizations, Surgeries, Procedures:

|  |  |  |
| --- | --- | --- |
| Procedure | Provider | Year |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

# Family History:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Condition | Yes | No | If Yes, Which Relative? | Age of Diagnosis |
| Heart Disease |  |  |  |  |
| Stroke |  |  |  |  |
| High Blood Pressure |  |  |  |  |
| High Cholesterol |  |  |  |  |
| Diabetes |  |  |  |  |
| Thyroid Disease |  |  |  |  |
| Blood Disorders |  |  |  |  |
| Cancer |  |  |  |  |
| Osteoporosis |  |  |  |  |
| Rheumatoid Arthritis |  |  |  |  |
| Asthma |  |  |  |  |
| Mental Health Disease |  |  |  |  |
| Substance Abuse |  |  |  |  |

# Drug Allergies:

|  |  |  |
| --- | --- | --- |
| 1. | 2. | 3. |
| 4. | 5. | 6. |

# Current Medical Problems (Example: HTN, diabetes, arthritis, ect.):

|  |  |  |
| --- | --- | --- |
| 1. | 2. | 3. |
| 4. | 5. | 6. |
| 7. | 8. | 9. |
| 10. | 11. | 12. |

# Review of Symptoms: Please CIRCLE if you have experienced these symptoms in the past 3 months.

**General Heme/Lymph Gastro Neurological**

Fever Swollen Lymph Nodes Diarrhea Abnormal Gait

Night Sweats Bleeding Constipation Falls

Temperature Intolerance Blood Clots Heartburn Headaches

Excessive Thirst **ENT** Nausea Seizures

Weight Changes Hearing Loss Bloating Dizziness

**Skin** Ringing in Ears Abdominal Pain Weakness

Rash Nose Bleeds Blood in Stool Fainting

Lesion Changes Sinus Pain/Congestion Vomiting Numbness

Color Changes Sore Throat Flatulence Tingling

Non-healing Wounds **Genitourinary Pysch**

**Breast** Painful Urination Anxiety

Breast Pain Frequent Urination Depression

Breast Lump Incontinence Mood Swings

Nipple Discharge Waking to Urinate Memory Loss

**Eyes** Difficulty Urinating Mania

Eye Pain Decreased Sex Drive Insomnia

Redness Fertility Issues Suicidal Thoughts

Vision Changes Painful Intercourse **Musculoskeletal**

Discharge STDs Joint Pain

**Heart** Erectile Dysfunction Joint Swelling

Edema Irregular Cycle Neck Pain

Palpitations Heavy Bleeding Back Pain

Chest Pain Discharge **Lung**

Murmur Painful Cycle Coughing

Hot Flashes Wheezing

Shortness of Breath

# Women’s Preventive Health:

Date of Last:

Pap Smear: \_\_\_\_\_\_\_\_\_\_ Have you ever had an abnormal pap? Y / N:

If Yes, When/Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mammogram: \_\_\_\_\_\_\_\_\_ Bone Density Scan: \_\_\_\_\_\_\_\_\_ Colonoscopy: \_\_\_\_\_\_\_\_\_

# Men’s Preventive Health:

Date of Last:

Prostate Exam: \_\_\_\_\_\_\_\_\_ PSA Test: \_\_\_\_\_\_\_\_\_ Colonoscopy: \_\_\_\_\_\_\_\_\_

# Life-Style:

Do you use tobacco? Y / N If yes, what type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much per day? \_\_\_\_\_\_\_\_

Do you drink Alcohol? Y / N If yes, what type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_

Do you exercise regularly? Y / N

How many hours do you usually sleep per night? \_\_\_\_\_ Do you feel refreshed? Y / N

# Nutrition:

How many meals do you generally eat per day? \_\_\_\_\_\_\_

Are you currently on a special diet? Y / N Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vegetarian? Y / N Gluten-free? Y / N Do you drink soda? Y / N Diet or Regular

Do you have a healthy appetite? Y / N

How often do you have a bowel movement? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did someone refer you to Radiant? Y / N If yes, who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Everything I have written and answered in this form is true to the best of my knowledge. I will update this office when there are significant changes.



HIPAA Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act of 1998 (HIPAA), I have certain rights regarding my protected health information.

I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received and read your Notice of Privacy Practices Containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**General Consent to Treatment:** By signing below, I authorize the health care providers at Radiant, to conduct examinations, diagnostic tests and procedures to assess my health care conditions, and to provide care, services or therapies necessary to effectively diagnose and treat me. I understand that it is the responsibility of my treating health care provider(s) to explain to me the nature of proposed care, treatment, services, prescribed medications, suggested interventions, or procedures. Before I undergo particular procedures or tests, my provider(s) will explain the potential benefits, risks, or side effects, including potential problems that might occur during recuperation, the likelihood of achieving goals, reasonable alternatives, and the relevant risks, benefits, and side effects related to alternatives, including the possible results of not choosing to undergo the recommended treatment.

**Right to Refuse Treatment:**  In giving my general consent to treatment, I understand that I retain the right to refuse any examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my treating health care provider(s).

**Medical Education and Participation of Students and Trainees:** I understand that Radiant is dedicated to medical education, and that authorized, appropriately supervised students and trainees may observe and assist in my diagnosis, treatment and care, unless I expressly object to their participation in my health care.

**Integrative Acknowledgement:** By signing below, I understand that the practitioners at Radiant practice Integrative Medicine and the practices do not always align with traditional standard allopathic medicine; this includes encouraging patients to play an active role in their health, which typically entails following a custom-tailored diet and an active lifestyle along with recommending nutraceuticals and specialized lab testing that is often not paid for by insurance.

**Signed Consent:** By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

I hereby give my consent to treat minor child/children below, which is under the legal age of eighteen years of age, to receive medical care and/or treatment from the providers of Radiant. Any care deemed medically necessary may be provided with or without my presence:

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Print Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**PATIENT FINANCIAL POLICY**

Thank you for choosing Radiant Integrative Health. While your health and well-being are our primary concerns, we realize that the cost of healthcare is an issue for many patients. We offer the following information to help you understand our financial policies and aid you in planning for payment. Carefully review the information and please ask our staff if you have any questions.

**INSURANCE**

It is your responsibility to provide Radiant with current insurance information. We will ask you for your insurance card at your first visit and keep a copy for your records. We may request a copy at a later date in order to update your records, so please bring your insurance card to each visit. We will help you receive the maximum benefits your insurance allows, however, please remember that your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claims for you as primary care and provide necessary information, including primary and secondary insurance information changes, to your insurance company. Failure to provide complete insurance information may result in reduced insurance benefits for you. Not all services are covered through all insurance plans. Some health plans select certain services that they will cover. Your insurance company will make the final determination of your eligibility and benefits. If your health plan determines a service to be “not covered”, you will be responsible for the entire charge. Also, please be aware that if we are out-of-network for benefits, you will receive a bill and be responsible for the remaining balance. This balance is due upon receipt of your statement. If you are unable to pay the balance in full, we encourage you to promptly contact our office for assistance in creating a payment plan. Be aware that if your treatment requires labs, you may receive a bill from a third party.

**CO-PAYS**

Co-payments may be required by your insurance plan. All co-payments must be paid prior to your appointment at check in. If you do not have your co-payment, your appointment may be rescheduled.

**DEDUCTIBLES AND COINSURANCE**

For patients who have insurance plans that have applicable deductibles and coinsurance, be aware that you will be responsible for payment of the deductible or coinsurance applicable to procedures. It is also the patient’s responsibility to check with insurance carrier concerning deductibles and coinsurance.

**SELF-PAY ACCOUNTS**

Self-pay accounts are for patients without insurance coverage. It may also include patients covered by insurance plans that Radiant is not in network with or patients without an insurance card on file. It is your responsibility to know if care at Radiant is covered by your plan. If there is a discrepancy of your information, you will be considered a self-pay patient until you provide information proving otherwise.

**PAST DUE ACCOUNTS**

If your account is past due, please contact our office, so that we can assist you with a payment plan. If your account has been referred to a collection agency or attorney, you must pay the balance in full, including any collection fees. If you require further treatment and your account is in collections, the full balance will be due, and you will be required to pay the cost of the next visit in full, prior to being seen.

**RETURNED CHECKS**

A fee will be required for returned checks. This amount will be applied to your account, in addition to the insufficient funds amount. Your account may be assigned “self-pay” status, requiring upfront payments following a returned check.

**REFERRALS & PRE-AUTHORIZATIONS/NOTIFICATIONS/CERTIFICATES**

Your insurance company may require a referral from another physician and/or a pre-authorization, notification, or certification. While it is your responsibility to obtain these, someone in the office will help you if necessary. Please make sure that all referrals are in our office prior to your visit. Failure to obtain these may result in a lower payment or no payment from your insurance company, and the balance will be your responsibility.

**MINORS**

The parent(s) or guardian(s) presenting the child for treatment is responsible for full payment and will receive the billing statements. In addition, we may pursue payment from a non-custodial parent or guardian.

**PATIENT AUTHORIZATION, ACKNOWLEDGEMENT, AND AGREEMENT**

I hereby authorize payment of health insurance benefits and, if applicable, government benefits directly to Radiant for services provided to me. I authorize the release of my healthcare information necessary to process my claims. I further authorize the release of my healthcare information to other healthcare providers, hospitals, and facilities involved in my treatment. I understand, acknowledge, and agree that I am financially responsible for my deductible, co-pay, coinsurance, and any amount exceeding what my insurance company pays, except where exempt by contractual agreement. I understand that I am financially responsible for any balance remaining after my claim has been processed. I further understand that I am responsible for complying with any requirements that my insurance carrier may have regarding referrals, prior approvals, and pre-authorizations.

I HAVE READ THE PATIENT FINANCIAL POLICY AND/OR IT HAS BEEN FULLY EXPLAINED TO ME. I CERTIFY THAT I UNDERSTAND ITS CONTENTS, AND THATI AM COMPETENT TO EXECUTE IT OR THAT I AM AUTHORIZED TO EXECUTE IT ON THE PATIENT’S BEHALF.

Print Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**CANCELLATION AND NO-SHOW POLICY**

We understand that situations arise that may require cancellation of your appointment. It is therefore requested that if you must cancel, please give us a 24-hour notice. This will enable other patients who are waiting for appointments to be scheduled in your slot.

Appointments that are cancelled with less than a 24-hour notification may be subject to a $35 cancellation fee.

Patient who do not show up for their scheduled appointment without a 24-hour cancellation notice are considered a NO SHOW and will be charged at $35 NO SHOW fee.

The cancellation and NO-SHOW fees are the sole responsibility of the patient and must be paid in full before the patient can be seen again.

We understand that special circumstances may arise and cause you to cancel with less than a 24-hour notification. In this case, the cancellation fee MAY be waived by management approval.

Radiant believes that a good provider/patient relationship is based upon understanding and communication. Please sign below that you have read, understand, and agree to our Cancellation and No Show Policy.

Patient OR Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_