Natural Healing Arts Medical Center

Patient ID:_____

***2215-A 59th Street West, Bradenton, FL 34209** **Phone: (941)761-4994 Fax: (941) 761-7224**
***2030 Bee Ridge Rd, Sarasota, FL 34239** **Phone: (941) 954-3700 Fax: (941) 923-3882**

New Patient Information

(Please Print All Answers)

Name: _____ Age:_____ Sex: _____Date: _____

Address: _____ City: _____State: _____Zip: _____

Phone: _____ Work:_____ Cell: _____

Best Time to Call: _____Which #_____Email: _____

Social Security # (required) _____/_____/_____DOB:_____ Family Doctor:_____

□ Married □ Single □ Sep □ Divorced □ Widowed Spouse's Name: _____

Employer: _____ Spouse's Employer: _____

Employers Address: _____ Spouses Birthdate: _____

Employers Phone:_____ Spouses Social Security (optional):_____

Parents Employer if Patient is Minor/Child: _____

Parents SSN# if Patient is Minor/Child: (required) _____Emergency: _____

Relationship:_____Phone:_____

HEALTH INSURANCE INFORMATION

Name of Insurance: _____Group Number: _____

Name of Insured: _____Policy Number: _____

Insured DOB: _____

ACCIDENT INSURANCE INFORMATION

Name of YOUR Auto Insurance Company: _____

PIP Claims Adjustors Name:_____Phone:_____ext_____

Accident Claim Number: _____Policy Number:_____

Attorney Name: _____Phone: _____

PLEASE PROVIDE US WITH A COPY OF YOUR DRIVERS LICENSE AND INSURANCE CARDS

Welcome to our multi-disciplinary group practice, offering medical care, chiropractic, pain management injections, physical therapy, rehabilitation, acupuncture, massage therapy, nutritional and mental health counseling. We will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery. Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

Your signature on this document fully authorizes our staff & doctors to perform any examination, diagnostic tests and/or treatments as well as we may consider medically necessary & to release all information pertinent to your health, insurance, or benefits to any & all applicable parties on your behalf. Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability, religious or political beliefs; these quality healthcare services will be delivered with dignity and concern.

Your signature on this document confirms that you have read, understand and agree to comply with all terms & conditions regarding your responsibilities to this Facility and that you grant the physicians, therapist and/or all staff of this facility to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of your bill and/or for issues that concern the facility operations and responsibilities. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in awhile.

Patient Signature: _____Date:_____

Patient Representative: _____ Date: _____

HEALTHCARE PRIVACY NOTICE-INFORMED CONSENT

This office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patients working together as a team to obtain the maximum results. Patient's satisfaction is a vital interest to our staff.

This facility is required by law to abide by the terms of this Health Care Privacy Notice as well as other applicable federal and state laws governing privacy practices in healthcare. Our facility may change and/or modify the terms of this Notice at anytime without additional notices to you except to publically post in our Facility and/or make available to patients any updated notices. **Photocopy of this notice is available to you upon request**. The term Facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this Facility.

Our facility and staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographics information that may identify you and that may be related to your present, future and past physical or mental health condition and the care and treatment you receive from our practice. This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstanding or concerns to the Compliance Officer of this Facility.

Our Facility may use and disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctor and staff of this Facility for the purpose of your care and treatment, paying your healthcare bills, and to support the operations of this practice. Your doctor and the staff will take all reasonable and necessary measures to maintain the confidentiality of your PHI.

The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your healthcare. The request must be in writing, allowing your provider up to 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee, which will be in compliance with State law. **Natural Healing Arts reserves the right to charge $1.00 per page for the first (25) pages and $.25 for every page thereafter; mailing fees may apply if you request that your records mailed to you.** Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you. .

You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the provider has a right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization in writing at any time, except in the event that the provider has acted as indicated in the doctors Authorization Notice.

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. **You can obtain a complaint form from the Compliance Officer and/or the Office of Civil Rights may be reached at: http://www.hhs.gov/ocr/civilrights/complaints/index.html**. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated and comprehensive Health Care Privacy Notice is available for your review in this Facility.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms and conditions, credit policies and Informed Consent and fully understand and have had all of my questions answered to my satisfaction.

A photocopy of this document shall be considered as effective and valid as an original

Patient Signature: _____Date:_____

Patient Representative: _____ Date: _____

Patient ID:_____

FINANCIAL POLICY

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage and liability. Our Facility and staff are NOT responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligation or arrangements between you and your attorney, insurance company, liable or third party payer are between you and said person or party.

1. Our facility will file initial insurance claims for you. Secondary claims submissions and/or additional reports and/or documents sent on your behalf may result in an additional filing and/or medical report charges, which you will be responsible for paying. (These fees and payments will be discussed prior to so that proper payment can be made prior to any further services being rendered).
2. Co-pays, Deductibles and all Non-Covered Services charges will be due at the time of service. Due to our office being a multi-disciplinary practice all providers are subject to separate co-pays. For your convenience this office accepts: **Cash/Check/Debit/Credit Cards.**
3. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
4. A service charge is computed by a "periodic rate" of 1 ½% per month. 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collections related expenses, attorney fees, court & filing fees.
5. Returned checks, debit and credit charges made payable to the facility for insufficient funds, stop payments or other expenses of non-payment will be assessed a $30.00 charge.

MEDICARE PATIENTS/MEDICARE REPLACEMENT POLICIES

Natural Healing Arts is a multidisciplinary practice that uses both Eastern and Western philosophies to treat our patients. Patients who qualify for Medicare and those Medicare replacement policies will be limited to the services that are covered under their healthcare insurance. We try to do our very best to notify these types of patients in advance by having you sign an ABN form (Advance Beneficiary Notice). This form outlines the services that ARE and are NOT covered in our office. Please be sure and inquire with our front desk if you have NOT received one of these forms.

MEDICARE PATIENT CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given to me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or related Medicare claim(s). I request that payment of authorized benefits be made on my behalf; I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and co-insurance.

ASSIGNMENT OF BENEFITS

I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay. It is further agreed that any credit or balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said physician by the insured or his/her family.

_____ _____

Print Patient Name: NHAMC Witness Signature

_____ _____

Signature of Patient/Representative: Date:

Patient ID:_____

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SYMPTOM SURVEY

What is your chief problem or symptom? _____
What caused the problem or symptom to occur? _____
When did the problem or symptom begin? _____
Have you seen another doctor for this problem? □ NO If yes, who _____
What test/procedures have been performed? □ X-Ray □ MRI □ Surgery □ Hospitalization □ _____
Have you had this problem or symptoms in the past? ? □ NO If yes explain_____
Have you tried any other treatments for this? □ NO If yes explain_____
Is the problem or symptoms getting worse? □ NO If yes explain_____

✓ ALL OF THE ITEMS THAT APPLY TO YOU NOW AND IN THE PAST:

□ Arthritis/Gout	□ Depression	□ Pregnancy	□ Seasonal Allergies	□ Headache
□ Eye Pain-Strain	□ Dizziness/Balance	□ Seizures	□ Ringing in the Ears	□ Blurred Vision
□ Anxiety	□ Difficulty Walking	□ Elevated Stress	□ Fears/Trauma	□ Headache
□ Jaw Pain	□ Bleeding Gums	□ Neck Pain/Spasm	□ Chronic Fatigue	□ Heart Disease
□ Gall Stones	□ Swallowing Difficulty	□ Thyroid Problem	□ Chest Pain	□ Chest Congestion
□ Anemia	□ Hypertension	□ Stroke	□ Kidney Stones	□ Pancreatitis
□ Sleep Disruption	□ Irregular Heart beat	□ HIV/AIDS	□Asthma/Bronchitis	□ Mid-Back Pain
□ Should/Elbow Pain	□ Wrist/Hand Pain	□ Low Back Pain	□ Hip/Knee/Leg Pain	□ Foot/Ankle Pain
□ Abdominal Pain	□ Diabetes	□ Groin/Rectal Pain	□ Female Disorder	□ Urinary Problems
□ Skin Problems	□ Broken Bones	□ Digestive Problems	□ Nausea-Vomiting	□ Irregular Bowels

PATIENT & FAMILY HISTORY

What is your occupation? _____ □ Full Time □ Part Time
What is your employment status? □ Working □ Sick Leave □ Unemployed □ Retired
□ Temporary Disability □ Permanent Disability Last day of work_____

Do you use tobacco? □ NO □ YES Explain: _____
Do you consume alcohol? □ NO □ YES Explain: _____
Do you have a history of substance abuse? □ NO □ YES Explain: _____
List all Past Surgeries _____
List all Drug Allergies _____
List all current and past medications/drugs _____

Drug Name: _____ _____
_____ _____
_____ _____

List all Physicians you have seen in the past 5 years?
Name: _____ For What: _____
Name: _____ For What: _____
Name: _____ For What: _____
Name: _____ For What: _____

FAMILY HISTORY:

Father	**□ Living**	**Age: _____**	**□ Deceased-Cause of Death: _____**
Mother	**□ Living**	**Age: _____**	**□ Deceased-Cause of Death: _____**
Brother	**□ Living**	**Age: _____**	**□ Deceased-Cause of Death: _____**
Brother	**□ Living**	**Age: _____**	**□ Deceased-Cause of Death: _____**
Sister	**□ Living**	**Age: _____**	**□ Deceased-Cause of Death: _____**
Sister	**□ Living**	**Age: _____**	**□ Deceased-Cause of Death: _____**

Other Problem(s) not listed _____

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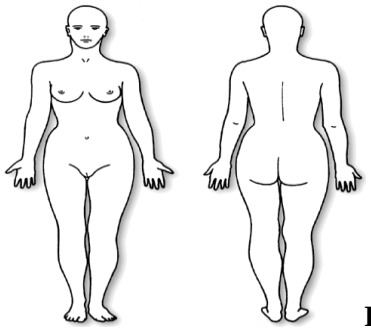
PAIN DRAWING

Circle location(s) of your symptoms on body drawing. Outline using the symbols for the type of sensation

Describe your pain below (check all that apply)

Pain:	**XXXXXX**
Numbness:	**++++++**
Burning:	**////////**
Ache:	**********



L **R**

□ Recurring **□ Tingling**
□ Stabbing **□ While Resting**
□ Dull Ache **□ Daily**
□ Sharp **□ Deep Ache**
□ Throbbing **□ During Exercise**
□ Nightly **□ _____ Onset of Pain: □ Sudden □ Gradual**

On a scale of 1 to 10 how would you rate your pain level today? _____ (1=Mild, 10=Intense)

What if anything gives you relief? _____

IF YOUR PROBLEM OR SYMPTOMS ARE DUE TO AN AUTO ACCIDENT PLEASE COMPLETE BELOW

□ Auto Accident Date: _____ Time: _____(AM)(PM) Location: _____

Were You **□ Driver** **□ Passenger**
□ Unconscious **□ Treated in ER**
Wearing Seat belt **□ YES □ NO**
Transported by Ambulance **□ YES □ NO**

Vehicle Damage: □ Mild-Moderate □ Severe-Totaled Was the vehicle towed? □ YES □ NO

Police Report: □ None □ Yes with Police Department

Activities **□ No Restrictions** **□ Missed_____ days work or school?**

□ I had no symptoms prior to the accident

ATTESTATION STATEMENT

By signing my name below, I agree that I have answered these above questions to the best of my acknowledgment and I have had read to me or I have read and have read and fully understand these questions as it relates to my health.

Patient Signature: _____Date:_____

Doctor Signature: _____Date: _____

Patient ID:_____

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RELEASE OF INFORMATION & PASSWORD

According to the Federal Government and the Privacy Act, this form will protect you private information from being given to anyone without prior permission.

Please provide us with a password that no one else will able to identify. This password will give us security when contacting you or should you contact us for health or financial information. Please choose one of the following questions and provide us with the answer.

Thank you!

1. What is your mother's maiden name? _____
2. What street did you live on as child? _____
3. What was the first car you owned? _____

Patient Signature: _____Date:_____

Patient Representative: _____ Date:_____

I hereby authorize the following person(s) to access any and all health information regarding my account. For example, this would include anyone such as a spouse or child. They will have to present the appropriate ID or know your password to obtain any information. Please list the individuals below. Any changes to this form will need to be done in writing and made to the attention of the Practice Manager.

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

***** IF YOU CHOOSE NOT TO LIST ANYONE THEY WILL NOT BE ABLE TO OBTAIN ANY INFORMATION WITHOUT YOUR WRITTEN CONSENT. WE APPRECIATE YOUR HELP WITH THIS MATTER.**

_____
NHAMC Witness Signature

Patient Id: _____