Holistic HEALTH CLINIC
a place of healing

NEW PATIENT INTAKE FORM

First Name:	**Middle Initial:**	**Last Name:**
DOB:		**Gender/Pronouns:**
Preferred Name:		**Email:**
Home address:		
City:	**State:**	**Zip Code:**

Phone Numbers: *Please check the preferred contact for you*

❑ **CELL:** ❑ **WORK:**

Social Media contact:

How did you hear about us and whom may we thank for referring you?

Please list your reasons for visiting our clinic. What do you want your provider to know?

MEDICAL HISTORY

Please list all current medical conditions and dates of diagnosis:

Please list any Hospitalizations and/or Surgeries, and provide dates:

PRESCRIPTION MEDICATIONS AND SUPPLEMENTS

Name	Dose/Frequency	Reason	Prescriber

Please list any **Allergies** (Drugs, Foods, Environmental, etc.)

Please list any **Food Sensitivities and/or Dietary Restrictions**

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FAMILY HISTORY

Are you adopted? **YES NO**

Please list any known medical conditions of your:

Biological Mother

Biological Father

Siblings

Other

SOCIAL HISTORY

Please outline your past or present use of the following substances:

	Current Use Y or N	Quantity per day	Quantity per week	Past use Y or N	Do others have concerns about your usage?
Tobacco					
Alcohol					
Recreational Drugs					
Caffeine					

- Exercise habits: What type(s) and how often?

Work Status:

Currently Working/ Disability / Not currently working/ Retired/ Student / Homemaker / Other

Relationship Status: Single / Married / Widowed / Other

Living Situation: Live alone / Live with family / Live with roommates / Other

CARE TEAM – *Please list all other physicians involved in your care*

Name	Role/Specialty	Phone	Fax

*Were you referred to our clinic by one of your providers? _____

SCREENING EXAMS:

If applicable, please provide the DATE AND RESULTS of the most recent exam(s)

-Routine Physical Exam

-Well Women Exam (pap test and/or HPV screening)

-Mammogram (>45 years old)

-Colonoscopy (>50 years old)

-Bone Density Screening (DXA, >65 years old)

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REVIEW OF SYSTEMS

Y: A symptom you are ***currently*** experiencing
N: A symptom you have ***never*** experienced
P: A symptom you have experienced in the ***past***

GENERAL							
Fever/chills	**Y**	**N**	**P**	Fatigue	**Y**	**N**	**P**
Change in weight	**Y**	**N**	**P**	Difficulty sleeping	**Y**	**N**	**P**
SKIN							
Rashes/itching	**Y**	**N**	**P**	Acne	**Y**	**N**	**P**
HEENT							
Headaches	**Y**	**N**	**P**	Ringing in ears	**Y**	**N**	**P**
Impaired vision/hearing	**Y**	**N**	**P**	Sinus congestion/pain	**Y**	**N**	**P**
RESPIRATORY							
Cough/Wheezing	**Y**	**N**	**P**	Shortness of breath	**Y**	**N**	**P**
Asthma	**Y**	**N**	**P**				
CARDIOVASCULAR							
Chest pain	**Y**	**N**	**P**	Edema/swelling	**Y**	**N**	**P**
Palpitations	**Y**	**N**	**P**	Murmurs	**Y**	**N**	**P**
GASTROINTESTINAL							
Heartburn	**Y**	**N**	**P**	Nausea/vomiting	**Y**	**N**	**P**
Abdominal pain	**Y**	**N**	**P**	Gas/bloating	**Y**	**N**	**P**
Diarrhea/ Constipation	**Y**	**N**	**P**	Hemorrhoids	**Y**	**N**	**P**
MUSCULOSKELETAL							
Joint pain	**Y**	**N**	**P**	Muscle spasms/Cramping	**Y**	**N**	**P**
Weakness	**Y**	**N**	**P**	Joint stiffness/Reduced Range of Motion	**Y**	**N**	**P**
NEUROLOGICAL							
Memory loss	**Y**	**N**	**P**	Seizures	**Y**	**N**	**P**
Tremors	**Y**	**N**	**P**	Numbness	**Y**	**N**	**P**
Vertigo	**Y**	**N**	**P**	Weakness	**Y**	**N**	**P**
Loss of consciousness	**Y**	**N**	**P**	Confusion	**Y**	**N**	**P**

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ENDOCRINE							
Excessive thirst	**Y**	**N**	**P**	Excessive sweating	**Y**	**N**	**P**
Thyroid disease	**Y**	**N**	**P**	Blood sugar dysregulation	**Y**	**N**	**P**

MENTAL/EMOTIONAL							
Depression	**Y**	**N**	**P**	Stress/Tension	**Y**	**N**	**P**
Anxiety	**Y**	**N**	**P**	Insomnia	**Y**	**N**	**P**

URINARY							
Pain with urination	**Y**	**N**	**P**	Incontinence	**Y**	**N**	**P**

MALE REPRODUCTIVE							
Testicular swelling/pain	**Y**	**N**	**P**	Sexual/erectile dysfunction	**Y**	**N**	**P**
Weak urine stream	**Y**	**N**	**P**				
Sexually active?	**Y**	**N**	**P**	Contraception?			

FEMALE REPRODUCTIVE							
Breast tenderness/lumps	**Y**	**N**	**P**	Vaginal irritation/discharge	**Y**	**N**	**P**
Pain with intercourse	**Y**	**N**	**P**	Change in libido	**Y**	**N**	**P**
Abnormal menstrual cycle	**Y**	**N**	**P**	Pain with menses	**Y**	**N**	**P**
Sexually active?	**Y**	**N**	**P**	Contraception?			
Pregnancy(s)? Dates:							

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Client Responsibility and Clinic Policy Agreement

We ask that every patient read and sign their agreement to the following. You can request a copy for your records.

- If you are planning to use insurance for your services, we must receive your insurance information at least **2 business days prior** to your appointment. Please be prepared to provide identification and insurance card (if applicable) at the time of each visit.
- To better serve our patients who may be waiting to see their provider, we require a 24-hour notice if you need to cancel or change your appointment. If you find yourself 15 minutes or more late for your appointment, please call the office to reschedule. **Cancellations made less than 24 hours from the appointment may be charged a $50 fee for the first absence and the full amount of the visit for all missed appointments thereafter.**
- You are **responsible for knowing the terms and coverage of your insurance plan**. If you have insurance that the practitioner "accepts," it does not guarantee payment will be made from your insurance company. You will then be personally responsible for the balance.
- Patients are seen **by appointment only.** In the case of an urgent medical need patients can call the office to be scheduled for an emergency visit. Our clinic is not equipped with an on-call physician. In the case of an after-hours, urgent medical need, established patients of Dr. Young can call 760-938-6453, and she will reply within 24 – 48 hours.
- If you need a **refill of your medication**, you can call the clinic or communicate with Dr. Young on your ChARM portal. **Please allow 2-3 business days** as we process your request.
- Payments for dispensary items are due at the time of service; cash, check, credit or debit cards are accepted.
- Though advice or recommendations may be declined, neither the individual providers, nor Holistic Health Clinic will be held accountable for anything that may happen as a result of your refusal.
- You may authorize that medical information including, but not limited to, lab results, be communicated via voicemail or email by indicating and initialing:

Phone for voicemail: _____ Initials: _____

Email: _____ Initials: _____

By signing below, you acknowledge your understanding of the terms and conditions listed above and agree to adhere to the policies of the clinic and physician.

Signature of Patient/Guardian of Patient: _____

Printed Name: _____ Date: _____

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HIPAA COMPLIANCE

The Health Insurance Portability and Accountability Act, also known as HIPAA, was created in 1996 by the US Congress to protect the privacy of your health information. The act prohibits your health care providers from releasing your health care information unless you have provided your health care provider with a HIPAA release form.

Unless you have provided a signed release form, your health care providers are prohibited from discussing any aspect of your medical information with anyone who is not directly involved in your care.

I understand that a record will be kept of all health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or myself, or unless required by law. I understand that I may look at my medical record and request a copy of it. I understand that my medical record will be kept no longer than ten years after the date of my last treatment. I understand that my practitioner will answer any questions I have.

PRIVACY POLICY: Due to HIPAA Privacy Regulations, our office is required to offer you a notice of our privacy practices. This document lets you know what steps we take in protecting your health information. Please ask the front office staff if you would like a copy.

_____ Do **not** want a copy _____ Received a copy

By signing I agree that I have read and understand the above:

_____

Signature **Date**

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EMPOWERING YOU AS THE PATIENT

Here at the Holistic Health Clinic we encourage our patients to be empowered by knowing their insurance policy and the details their health plan offers. We have found that you, as the insured, have more accessibility to information such as: copayments and coinsurances, plan limitations, etc. You also have the right to appeal any incorrect information provided by your carrier. If you are not familiar with your plan, please contact your insurance directly. To assist you in your research we have provided a list of our facility's identifying information below:

Tabor Sun Chiropractic (DBA Holistic Health Clinic)
Tax ID: 32-0181185 Group NPI: 1720542749

Practitioner NPI	Common CPT Codes
Dr. James Andy Cruz - 1912951682	98941, 97014, 97010, 97110, 99203
Dr. Michelle Young - 1457789661	99204, 99214, 97140, 97810, 97811, 97026
Dr. Donald Fuegy - 1366451973	98941, 97014, 97010, 97110, 99203
Sharon McNichols - 1740234103	99203, 97810, 97811, 97026
Brittany Henderson - 1740508332	97124
Gregory Angnos - 1952676942	97124
Jonathan Pierce - 1699217828	97124

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Financial Policy and Patient Responsibility

Patient's Responsibility:

- To know their insurance policy. Patients should be aware of their benefit coverage including which physicians are contracted with their plan, covered and non-covered services, authorization requirements, and costs share information such as: deductibles, co-insurance, and copayments. If you are not familiar with your plan coverage, we recommend contacting your carrier directly.
- To obtain a referral from their Primary Care Physician (PCP) and/or obtain authorization for treatment from their insurance *prior* to receiving services if that is a requirement of their plan. ***Any non-covered services are the financial responsibility of the patient.***
- To inform the front office of any changes to insurance and provide updated insurance cards.
- To promptly pay any accrued charges labeled "patient responsibility" as indicated by their insurance carrier to our biller, Efficient Medical Billing Service (EMBS).
- To facilitate in claim payments by contacting their insurance carrier when claims have not been paid.

Financial Policy Acknowledgement:

I have read and understand the above financial policy. I understand and agree that regardless of my insurance coverage, I am ultimately responsible for the balance due on my account for any and all services rendered; including non-covered services and/or supplements that are denied by my insurance carrier. I understand that payments can be made by check, credit or debit card to "EMBS". I agree the if my account is referred to a collection agency or attorney, I will be responsible for all costs of collection on my account including but not limited to attorney's fees, and interest accrued on overdue balances.

Signature **Date**

Printed Name

COVID-19 Assumption of Risk and Waiver

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Tabor Sun Chiropractic dba Holistic Health Clinic (HHC) has put in place preventative measures to reduce the spread of COVID-19; however, HHC **cannot guarantee** that you or anyone accompanying **you will not become infected with COVID-19**. By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 by attending HHC and that such exposure of infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at HHC may result from the actions, omission, or negligence of myself and others, including, but not limited to, Holistic Health Clinic employees, providers, other patients and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself and if applicable, those accompanying me. This risk is included but is not limited to: personal injury, disability, illness, damage, loss, liability or expense of any kind that I/ we may experience or incur in connection with my attendance at Holistic Health Clinic. On my behalf, and on the behalf of my children, I hereby release covenant and promise not sue, discharge or file claim against any of Holistic Health Clinic's staff, agents or representatives relating to the novel coronavirus. I understand and agree that this release includes any claims based on the actions, omission, or negligence of HHC staff, agents and representatives whether a COVID-19 infection occurs before, during or after participation in any interaction.

_____ _____

Signature of Patient or Guardian of Patient under the age of 18 Date

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