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Confidential New Patient Information

Date: _____

Last name: _____ First name: _____ MI: _____

SSN#____-____-_____ DOB: ___/___/_____ Age: ____ Sex: ____ Relationship Status: _____

Home address: _____

City: _____ State: _____ ZIP: _____

Home phone# (_____) _____-_____ Work# (_____) _____-_____ Mob# (_____) _____-_____

Occupation: _____ Employer/School: _____

Preferred Pharmacy: _____ Pharmacy Phone#: (____) ____-_____

Email address: _____@_____

Language preferred: _____ Race/Ethnicity: _____

Preferred mode to receive billing statements: ☐ By Mail ☐ E-bill

Emergency contact details

1. Last name: _____ First name: _____ Relationship: _____

Home phone# (_____) _____-_____ Work# (_____) _____-_____ Mob# (_____) _____-_____

2. Last name: _____ First name: _____ Relationship: _____

Home phone# (_____) _____-_____ Work# (_____) _____-_____ Mob# (_____) _____-_____

Insurance details

Primary insurance name: _____ Policy# _____

Secondary insurance name: _____ Policy# _____

Main reason for today's visit: _____

Other concerns: _____

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Physicians who care for you:	Specialty:	Phone#:

ALLERGIES:

MEDICATIONS: Please list all medications, supplements, vitamins or herbs you have taken within the last month

Medication:	Dose

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IMMUNIZATION HISTORY:

Immunizations and most recent date:

Chickenpox	Date: _____	MMR *(Measles, Mumps, Rubella)*	Date: _____
Flu Shot	Date: _____	Pneumonia	Date: _____
Gardasil/HPV/Cervical	Date: _____	Tdap *(Tetanus and pertussis)*	Date: _____
Hepatitis A	Date: _____	Tetanus	Date: _____
Hepatitis B	Date: _____	Zostavax *(Shingles)*	Date: _____
Meningococcus	Date: _____	Other	Date: _____

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date
_____ Abnormal

Last Mammogram Date
_____ Abnormal

Age of first menstrual period: _____

Date of last menstrual period or age of menopause:
_____

Number of pregnancies: _____ births: _____

miscarriages: _____ abortions: _____

Cesarean sections If yes, then number: _____

Bleeding between periods

Heavy periods

Extreme menstrual pain

Vaginal itching, burning, or discharge

Wake in the night to go to the bathroom

Hot flashes

Breast lump or nipple discharge

Painful intercourse

Sexually active

Current sexual partner is Female Male

Do you use condoms Yes No

Other Birth control method used:

_____

Interested in being screened for STD's

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PAST MEDICAL HISTORY

Please check all that apply:

Anxiety Disorder	Diverticulitis	Kidney Disease
Arthritis	Fibromyalgia	Kidney Stones
Asthma	Gout	Leg/Foot Ulcers
Bleeding Disorder	Pacemaker	Liver Disease
Blood Clots (or DVT)	Heart Attack	Osteoporosis
Cancer (type_____)	Heart Murmur	Polio
Coronary Artery Disease	Hiatal Hernia or Reflux Disease	Pulmonary Embolism
Claustrophobic	HIV or AIDS	Reflux or Ulcers
Diabetes – Insulin	High Cholesterol	Stroke
Diabetes - Non-Insulin	High Blood Pressure	Tuberculosis
Dialysis	Thyroid	Other _____

PAST SURGICAL HISTORY

Procedure:	year

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother(maternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Stroke Heart disease Hypertension Osteoporosis Genetic disease
Grandfather(maternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Stroke

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			Heart disease	Hypertension	Osteoporosis	Genetic disease		
Grandmother(paternal)	Y/N	_____	Alcoholism	Arthritis	Depression	Cancer	Diabetes	Stroke
			Heart disease	Hypertension	Osteoporosis	Genetic disease		
Grandfather (paternal)	Y/N	_____	Alcoholism	Arthritis	Depression	Cancer	Diabetes	Stroke
			Heart disease	Hypertension	Osteoporosis	Genetic disease		
Father	Y/N	_____	Alcoholism	Arthritis	Depression	Cancer	Diabetes	Stroke
			Heart disease	Hypertension	Osteoporosis	Genetic disease		
Mother	Y/N	_____	Alcoholism	Arthritis	Depression	Cancer	Diabetes	Stroke
			Heart disease	Hypertension	Osteoporosis	Genetic disease		
Brother/Sister	Y/N	_____	Alcoholism	Arthritis	Depression	Cancer	Diabetes	Stroke
			Heart disease	Hypertension	Osteoporosis	Genetic disease		
Brother/Sister	Y/N	_____	Alcoholism	Arthritis	Depression	Cancer	Diabetes	Stroke
			Heart disease	Hypertension	Osteoporosis	Genetic disease		
Other: _____	Y/N	_____	Alcoholism	Arthritis	Depression	Cancer	Diabetes	Stroke
			Heart disease	Hypertension	Osteoporosis	Genetic disease		

SOCIAL HISTORY

Education
Less than 8th grade
High school
2-year college
4-year college
Postgraduate

Caffeine
None
Occasional
Moderate
Heavy
# of cups/cans per day? ____

Tobacco
Do you use tobacco? Yes No
If not currently, did you ever use tobacco? Yes No
Cigarettes -____pks/day
Chew - ____/day
Cigars - _____/day
# of years____
Or year quit _____

Marital Status
Married
Single
Divorced
Separated
Widowed
Domestic partner

Alcohol
Do you drink alcohol? Yes No
If so, how often?
Occasionally
< 3 times a week
> 3 times a week
How many drinks per week?

Drugs
Do you currently use recreational or street drugs? Yes No
If yes, list: _____
_____
_____
_____
_____

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Sleep Hours of sleep _____ Difficulty falling asleep? Yes No Difficulty staying asleep? Yes No

Waking up fresh? Yes No

REVIEW OF SYSTEMS (Please check all that apply)

Cardiovascular
Arm Pain on Exertion
Chest Pain on Exertion
Chest Heaviness/Pressure on Exertion
Irregular Heart Beats (Palpitations)
Known Heart Murmur
Light-headed on Standing
Shortness of Breath When Lying Down
Shortness of Breath When Walking
Swelling (edema)

Neurological
Dizziness
Fainting
Headaches
Memory Loss
Migraines
Numbness
Restless Legs
Seizures
Weakness

Allergic/Immunologic
Frequent Sneezing
Hives
Itching
Runny Nose
Sinus Pressure

Hematologic/Lymphatic
Easy Bruising/Bleeding
Swollen Glands

Ears/Nose/Mouth/Throat
Bleeding Gums
Difficulty Hearing
Dizziness
Dry Mouth
Ear Pain
Frequent Infections
Frequent Nosebleeds
Hoarseness
Mouth Breathing
Mouth Ulcers
Nose/Sinus Problems
Ringing in Ears

Endocrine
Fatigue
Increased
Thirst/Hunger/Urination

Gastrointestinal
Abdominal Pain
Black or Tarry Stool
Blood in Stool
Change in Appetite
Frequent Indigestion
Hemorrhoids
Trouble Swallowing
Vomiting
Vomiting Blood

Constitutional
Exercise Intolerance
Fatigue
Fever
Weight Gain (____lbs)
Weight Loss (____lbs)

Musculoskeletal
Back Pain
Joint Pain
Muscle Aches
Muscle Weakness

Eyes
Dry Eyes
Irritation
Vision Change
Date of Last Exam: _____

Integumentary (Skin)
Changes in skin
Dry Skin
Eczema
Growth/Lesions
Itching/ Rash
Jaundice (Yellow Skin/Eyes)

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Affiliate Non- Disclosure and HIPAA Attestation

I _____ _____/_____/201__

Please print name

Acknowledge that I am legally competent and capable to sign this document on my won behalf and that II am affiliated with *RMG

*RMG affiliated care for many patients and traditional and innovative therapies. This document is to ensure all affiliates understand and abide by rules and regulation related to the dissemination of any information related to care, therapies, promotions or commercials gain in *RMG affiliates. Place initial next to each section read and agreed upon.

_____ 1a. Assessments: I understand that some evaluation, testing and applications in the care of patient are unique and warrant innovative status in patient care. For example, use of stem cells are a relatively new and there are laboratory tests and other studies that have indicated that it is a successful method of treatment. I understand that the transplantation stem cells although not a new procedure offers many possible future benefits to patients in treating diseases. I also understand that there are to be No discussion or dissemination of any patient care information outside the care of the patients.

_____ 1b. Administrative collections and commitment. I understand that *RMG affiliates collects necessary urine, blood products, fat tissue or bone marrow tissue; I understand that there is a risk of contamination when collecting or administrating tissues of the procedure. I commit to adhere to the highest infection control standards to minimize any and all risk of contamination to myself and others. I further commit to report immediately any potential contamination.

_____2. Disclosure of Health information. *RMG affiliates will use reasonable procedures to implement and safeguard the confidentiality of health information. I understand that health care providers may need such information to provide treatment and that government agencies may be entitled to obtain such information under applicable law regulations. I authorize *RMG affiliates to determine the proper disclosure of such information to healthcare providers and to government agencies as may be required under applicable law and regulation and will not of my own accord disclosure any patient information to anyone without the approval of *RMG affiliates. I agree to abide by all HIPAA provisions and have been given access to same.

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3. Promotion restriction: I understand only *RMG affiliates has at all times the right and or duty to disclose any/all patient information. I (Please print name) _____ relinquish my right for any /all commercial and or promotion of any/all treatment performed on me or on any/all patient's behalf. Any commercial promotion is prohibited. Any/all authorization must have the prior written consent of RMG affiliates or be subject to but not limited to liquidated damages of one million dollars.

4. Release from Liability. In consideration for *RMG affiliates agreeing to affiliate with me, I hereby for myself, my agents, attorneys, successors-in-interest, affiliates, representatives, heirs and assigns, irrevocably and unconditionally release and discharge RMG affiliates and their respective shareholders, directors, offices, employees, agents, affiliates and their respective legal representatives, estates, successors and assigns, from and against any/all claims, causes of action or rights, known and unknown, that may arise from or relate to the activities and services described in this Non-disclosure and Attestation.

_____	_____
Signature of patient	Date of birth
_____	_____
Patient's Name (PRINT)	Date
_____	_____
Witness	Date

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I hereby acknowledge that I understand that my Insurance coverage, including Medicare, may not pay for this Non-covered service, and that all services ancillary to this treatment may be also Non- covered services and Non-reimbursable. I agree to be responsible for payment at the time of service for all services, including Non-covered services.

_____ DOB__/__/_____,

Print Patient Name

_____ _____

Patient Signature Date

_____ _____

Witness Date

_____ _____

Medical Provider Date

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Cancellation Policy/No show Policy

For Doctors appointment, IV treatments, and Neurofeedback

1. Cancellation

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advanced, you will be charged a Thirty ($30) fee for all appointments. Please note that this will not be covered by your insurance company

2. Scheduled appointments

We understand delays can happen; however, we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.

3. No Show for Doctors Appointment's (includes IV therapies and Neurofeedback)

Due to full appointment book, last minute no shows can cause problems such as preventing other patients from getting treatment needed and or added expenses for the office and/or brain tuner.

If you are unable to give a 24-hour notice and do not show up for your appointment's, there will be a Thirty ($30) no show fee. Please not that this fee will not be covered by your insurance company

_____	_____	_____
Print Patient Name	Signature Patient/ Guardian	Date

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information (PHI) is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.
- We may also create and distribute de-identified health information by removing all reference to individually identifiable information.
- We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

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The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by
- you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if you're unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of _____ and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

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You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer (Dr. Whiteley) for more information, in person or in writing.

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I am a patient of _____. I hereby acknowledge receipt of_____ _____'s Notice of Privacy Practices.

Patient Name: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of _____'s Notice of Privacy Practices with respect to the patient.

Name: _____

Relationship to Patient: _____ Parent_____ Legal Guardian

Signature: _____

Date: _____

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