HEALTH HISTORY **1/2020**

Patient Name_____ **Birthdate** _____/_____/_____

To help us meet all your healthcare needs, please fill out **both sides** of this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Today's date_____
Place of birth _____
Highest level in school _____
Occupation _____
Marital status _____
Hobbies _____
Exercise/recreation _____
Habits:
Smoking (type & amount/day) _____
If former smoker, date quit _____
Alcohol (type & amount/day) _____
Caffeine (type & amount/day) _____
Street drugs (type & amount/day) _____
Usual weight _____
Date of last dental exam _____
Please list all allergies (foods, drugs, environment)
_____
_____

When was your last physical exam? _____
Name of doctor _____ Phone _____
Please list all serious illnesses, operations, and other hospitalizations you have Experienced and Indicate years these occurred: □ none
_____
_____
_____
Please list all medicines you are currently taking (include nonprescription drugs): □ none
_____
_____
_____
Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred): □ none
_____
_____
_____
_____
_____

Chief Complaints

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

_____
_____

Past Medical History
Have you ever had the following: (Circle 'yes' or 'no', leave blank if uncertain)

Measles…….No	Yes	Migraine headaches……..No	Yes	Hives or Eczema…….....No	Yes
Mumps……..No	Yes	Tuberculosis…….....No	Yes	AIDS or HIV+…….…..No	Yes
Chickenpox……..…..No	Yes	Diabetes……No	Yes	Infectious Mono……..…..No	Yes
Whooping Cough……..……...No	Yes	Cancer……...No	Yes	Bronchitis……....No	Yes
Scarlet Fever…….…...No	Yes	Polio……...No	Yes	Mitral Valve Prolapse……....No	Yes
Diphtheria…….....No	Yes	Glaucoma……..No	Yes	Stroke……..……..No	Yes
Smallpox…….…..No	Yes	Hernia…….……..No	Yes	Hepatitis……..…….No	Yes
Pneumonia…….…..No	Yes	Blood or Plasma Transfusions……..No	Yes	Ulcer……..No	Yes
Rheumatic Fever…….…No	Yes	Back Trouble……..…...No	Yes	Kidney Disease……....No	Yes
Arthritis……..……..No	Yes	High or Low Blood Pressure……...No	Yes	Thyroid Disease……..No	Yes
Venereal Disease…….....No	Yes	Hemorrhoids……...No	Yes	Bleeding Tendency……..No	Yes
Anemia…….……...No	Yes	Date of last Chest X-Ray:_____		Any other disease (please list)	
Bladder Infections…….…..No	Yes	Asthma……..…..No	Yes	_____	
Epilepsy……...No	Yes			_____	

Family History

Has any blood relative had any of the following: (Circle 'yes' or 'no', leave blank if uncertain)

		Relationship			Relationship
Cancer	No	Yes_____	Stroke	No	Yes_____
Tuberculosis	No	Yes_____	Epilepsy	No	Yes_____
Diabetes	No	Yes_____	Allergies	No	Yes_____
Heart Disease	No	Yes_____	Anemia	No	Yes_____
High Blood Pressure	No	Yes_____	Bleeding Tendency	No	Yes_____
Asthma	No	Yes_____	Chronic Lung Disease	No	Yes_____
Drug or Alcohol Problem	No	Yes_____	Mental Illness	No	Yes_____
Leukemia	No	Yes_____	Migraine Headaches	No	Yes_____
Obesity	No	Yes_____	Thyroid Disease	No	Yes_____
Ulcer	No	Yes_____	Depression	No	Yes_____
High Cholesterol	No	Yes_____	Kidney Disease	No	Yes_____
Glaucoma	No	Yes_____	Gout	No	Yes_____

Do you have now or have you had within the past year: (Circle 'yes' or 'no', leave blank if uncertain)

Weakness or paralysis	No	Yes	Shortness of breath	No	Yes	Joint pain or stiffness	No	Yes
Tire easily or weakness	No	Yes	Bloody sputum	No	Yes	Swollen joints	No	Yes
Recent weight changes	No	Yes	Wheezing	No	Yes	Muscle cramps or spasm	No	Yes
Change in appetite	No	Yes	Chest pain or discomfort	No	Yes	Sleeplessness	No	Yes
Sensitivity to cold or heat	No	Yes	Purple fingers or lips	No	Yes	Seizures	No	Yes
Persistent fever	No	Yes	Swelling of hands, feet or ankles	No	Yes	Depression	No	Yes
Night sweats or hot flashes	No	Yes	Difficulty breathing	No	Yes	Memory loss	No	Yes
Skin rash	No	Yes	Palpitations or fluttering of the heart	No	Yes	Poor coordination	No	Yes
Skin trouble or changes	No	Yes	Leg cramps on walking or at night	No	Yes	Dizziness or fainting spells	No	Yes
Change in nails or hair	No	Yes	Enlarged veins	No	Yes	A living will or advance directive	No	Yes
Headaches	No	Yes	Difficulty swallowing	No	Yes	**Men only:**		
Easy bleeding or bruising	No	Yes	Heartburn	No	Yes	Discharge from penis	No	Yes
Double vision	No	Yes	Frequent belching	No	Yes	Pain or lump in testicles	No	Yes
Blurred vision	No	Yes	Abdominal cramping	No	Yes	Impotence	No	Yes
Eye pain	No	Yes	Nausea	No	Yes	**Women only:**		
Infected eyes	No	Yes	Vomiting	No	Yes	Age period began:_____		
Do you wear glasses or contacts	No	Yes	Vomited or coughed up blood	No	Yes	How many days do periods last:_____		
When was your last eye exam:_____			Chronic diarrhea	No	Yes	How many days between periods:_____		
Ringing in ears	No	Yes	Chronic constipation	No	Yes	Is the flow heavy	No	Yes
Discharge from ears	No	Yes	Rectal bleeding	No	Yes	Do you bleed or spot between periods	No	Yes
Ear pain	No	Yes	Black tarry stools	No	Yes	Do you have pain or cramps	No	Yes
Decrease in hearing	No	Yes	Dark urine	No	Yes	Do you have pain or cramps	No	Yes
Frequent nosebleeds	No	Yes	Yellow jaundice	No	Yes	Date of last period:_____		
Frequent colds	No	Yes	Frequent urination (day)	No	Yes	Date of last pelvic exam:_____		
Sinus trouble	No	Yes	Frequent urination (night)	No	Yes	Date of last mammogram:_____		
Loss of smell	No	Yes	Increase in thirst	No	Yes	Any itching in vaginal area	No	Yes
Persistent hoarseness	No	Yes	Painful urination	No	Yes	Pain with intercourse	No	Yes
Sore throat	No	Yes	Leakage of urine	No	Yes	Type of birth control used:_____		
Sore tongue or gums	No	Yes	Difficulty in starting urine	No	Yes	Currently pregnant	No	Yes
Lump or discharge from breast	No	Yes	Blood in urine	No	Yes	Number of pregnancies _____		
A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	No	Yes	Lack of sex drive	No	Yes	Number of full term births _____		
			Hemorrhoids	No	Yes	Number of preterm births _____		
			Backaches	No	Yes			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

X_____ _____

Signature of patient or parent if minor

Center for

Holistic
Medicine

CONSENT TO TREATMENT
I acknowledge that I have requested healthcare services. The doctors and practitioners of the Center for Holistic Medicine are authorized to perform any healthcare service deemed necessary. Many of the therapies offered at the center are considered unconventional and may be deemed "unproven" by the Food and Drug Administration. I understand that there is no obligation to accept or complete any therapeutic recommendations.

ASSIGNMENT OF BENEFITS
I hereby assign all benefit payments for services rendered under the terms of my insurance policy to be paid to the Center for Holistic Medicine.

PRIVACY POLICY
With patient consent, Center for Holistic Medicine may use and disclose protected health information to carry out treatment, payment, and healthcare operations only. Please turn now to the end of this new patient packet. Take a few minutes to read Privacy Practices Notice and understand your rights and our responsibilities. Then please sign that form and keep the second copy for yourself.

I have read and signed the Center for Holistic Medicine's Privacy Practices Notice and I hereby consent to the following (*please initial where you consent to the following*):

_____The Center for Holistic Medicine may **call my home, cell, work**, **or other (please circle your choice/s)** designated number and leave a message, recorded or with a person, regarding items that assist the practice in carrying out treatment, payment, and operations.

_____The Center for Holistic Medicine may **mail to my home** or other designated location any items that assist the practice in carrying out treatment, payment, and operations.

_____The Center for Holistic Medicine may **e-mail to my home** or other designated location any items that assist the practice in carrying out treatment, payment, and operations.

I have read the Center for Holistic Medicine Consent to Treatment, Assignment of Benefits, and Privacy Policy and thoroughly acknowledge, understand and agree to all of the above information.

Patient Name:_____ Relationship to Patient (if minor) _____

Signature: _____Date _____

OUR FINANCIAL POLICY

Thank you for choosing the Center for Holistic Medicine as your health care center. We are committed to your successful treatment. Please understand that full payment of your account is considered part of your treatment. The following is provided to help us serve you better by avoiding misunderstandings concerning payment for professional services.

Forms of Payment We accept cash, personal checks, Visa, MasterCard, and Discover.

Regarding Insurance It is your responsibility to find out what health services your insurance benefits will cover. Taking charge of this and educating yourself is part of your healing process.

> **"In-Network" Plans.** The Center for Holistic Medicine is "In-Network" with Blue Cross/Blue Shield PPO plans. All other plans are "out-of-network". Certain practitioners may be "In-Network" on by additional policies such Aetna or United Health Care, please ask the office staff about this. All **co-payments and non-covered services are due at the time of service**. You are responsible for payment of all services your insurance company may deny.
>
> **"Out-of-Network" Plans.** We require **full payment at the time of services.** We can submit the claims for you.
>
> **HMO Plans.** We **do not accept** any HMO insurance policies.

It is your responsibility to understand your benefits and the reimbursement policies of your insurance company. **We do not verify insurance benefits.** It is vital that you provide us with correct and current insurance information so that your claims may be filed properly. **All charges become your responsibility 90 days after insurance claims have been submitted.**

Non-Covered Services, Please be aware that some or all of the services provided may be non-covered services and not considered "reasonable and necessary" under the Medicare Program or other medical insurance. It is important, therefore, that you find out what services your health insurance will pay for prior to treatment.

Missed Appointment. Our policy is to charge for missed appointments **unless cancelled at least 48 hours in advance.** You will be billed for the cost of a normal office visit of your health care practitioner.

Late Fees. It is important for you to pay for your treatment in a timely manner. We send out monthly statement letting you know your balance due. Each statement has a "statement date" on it. If payment is not received within one month of the statement date, you will be charged the balance due plus a $10 late fee. If you require payment arrangements, you must contact the office within one month of the first statement date to avoid a late fee. The following month you will then receive another statement with your most recent balance due including the late fee and any new charges. Again, if payment is not received within one month of the statement date, another $10 late fee added to your balance due. After 90 days (3 months) the balance due will be charged to your credit card.

If you do not make payment arrangements with the office staff for a large outstanding balance due past within 90 days (four months), you will be referred to a collections agency and will be charged a $25 collections fee. Other financial charges include a $35 returned check fee. Patients whose accounts are not in good standing will be asked to pay their balance prior to receiving additional services.

I have read, understand, and agree to this Financial Policy.

Patient Name:_____ Relationship to Patient (if minor) _____

Signature: _____ Date: _____

Center for Holistic Medicine

Patient Care Payment Agreement

I agree to the following:

For charges billed to insurance

- CHM will charge the credit card below for services not reimbursed by my insurance company after 60 days.
- CHM will collect my outstanding balances including co-pays, co-insurance, deductible and non-covered services on the credit card below.
- CHM will refund any over payment to the credit card below.

For charges not billed to insurance

- If I cancel an appointment with less than 48 hour notice, CHM will collect the normal office visit fee on my credit card below.
- If I make a payment by check that has insufficient funds, CHM will collect the non-payment, plus $35.00 returned check fee, on the credit card below.

If the card number provided is invalid or does not accept charges, I understand that I may be subject to late fees and further collections.

SIGNATURE:_____DATE:_____

Please provide your credit card information below:

NAME ON CARD: _____

3 DIGIT SECURITY CODE: _____

MASTERCARD VISA DISCOVER

CARD NUMBER _____ EXPIRATION DATE: _____