NEW PATIENT GENERAL INFORMATION FORM

Name (First)________________(Middle)____________(Last)_________________________

SS#___________________ Date of Birth_________________Gender____M________F

Street Address ____

City ________________________ State __________________ ZIP Code _______________

Home Phone # ____________________ Work # __________________Cell # _____________

Email Address _______________________________ Marital Status ___________________

Occupation _________________________ Employer____________________________

Pharmacy ___________________________________ Pharmacy Phone___________________

Emergency Contact _________________________ Relationship___________________________

Emergency Contact Phone___________________________

How did you hear about us?

AUTHORIZATIONS: I understand that payment for services provided by LA Wellness Boutique will be my responsibility. My insurance carrier will not be billed for these. In addition, my signature below constitutes my consent for treatment.

By signing below, I understand and agree that in the event of default, I am legally liable for all costs of collection including collection fees, court costs, and all other costs related to the collection of this debt.

Signature ____________________________________ Date_______________

Print Name __________________________________

NEW PATIENT MEDICAL INFORMATION FORM

Name____DOB_______________________

ALLERGIES (medications/food/environment)	Reaction (rash/hives/throat swelling/needing hospitalization)

Have you EVER had any of the following (check all that apply)?
Please list any other conditions you have been diagnosed with in the empty boxes.

CONDITION	No	Yes	CONDITION	No	Yes	CONDITION	No	Yes
Asthma			Diabetes			Sinus problems		
COPD			Kidney problems			Hayfever		
Pneumonia			Recurrent UTIs			Eczema		
Pulmonary embolism			Kidney stones			Anxiety		
Heart failure			Prostate problems			Depression		
High blood pressure			Bleeding problem			Psyciatric illness		
High cholesterol			Leg or other clot			Insomnia		
Heart attack			Liver problems			Sleep apnea		
Atrial fibrillation			Gastric reflux			Arthritis		
Migraines			Stomach ulcers			Autoimmune problem		
Chronic headaches			Diverticulosis/itis			Blood transfusion		
Stroke			Chronic constipation					
Seizures			Thyroid problems					
Brain hemorrhage			Breast problems					
Cataract			Menopause					
Glaucoma								
Cancer		Type & Year:			Current status:			

OBGYN history

	No	Yes	Year	Total Number of Pregnancies
Painful Periods				#Full Term: #Pre Term: #Miscarriages: #Abortions:
Painful Sex				
Heavy Flow				
Abnormal PAP				Treatment given:
Menopause				Current symptoms:
Hysterectomy				Reason:
Birth Control				Method:

Please list ALL active treating physicians (i.e. pulmonologist, oncologist, cardiologist, etc.)

Doctor's Name	Specialty

Please list ALL your current medications (prescription/over the counter) and supplements

Medication	Dose	How often	Reason

Past Surgeries/hospitalizations/serious injuries	Year

Immunization	Year	Immunization	Year
Hepatitis B Series		Last Pneumonia Vaccine	
Gardasil Series		Last Flu Vaccine	
Tetanus Vaccine		Last Shingles Vaccine	

Health Maintenance and other special testing/screening: Please list any other relevant tests.

Test	Year	Result
Complete Physical		
Colonoscopy		
Cologuard		
Mammogram		
Pap Smear		
Bone Density		
Prostate exam		
EKG		
Cardiac calcium score		
Stress Test		
Carotid doppler		
Aneurysm ultrasound		
Skin Cancer Screen		
Tuberculosis Test		
Lung cancer screening CT		
Eye Exam		
Diabetes foot exam		
Smoking cessation program		

Social History	No	Yes	
Married			Spouse's name:
Children			Ages:
Retired			Prior occupation:
Smoking			/packs per day Year quit:
Alcohol			Drinks/day Drinks/week
Caffeine			Drinks/day
Recreational Drugs			Which ones:
Sexually Active			Circle: Hetero Lesbian Gay Bisexual Transgender

Family History	Specify if Mother (M)/Father (F)/Sibling (S)/Grandparent (G)
High blood pressure	
High cholesterol	
Heart Attack	
Heart Disease	
Diabetes	
Kidney disease	
Lung disease	
Liver disease	
Blood disease	
Blood clot	
Stroke	
Brain aneurysm	
Migraine	
Dementia	
Seizures	
Glaucoma	
Macular degeneration	
Depression/Anxiety	
Arthritis	
Cancer Type: Age diagnosed:	

Review of symptoms

Symptom	N	Y	Symptom	N	Y	Symptom	N	Y
General			**Respiratory**			**Neurologic**		
Fever			Cough			Headaches		
Chills			Shortness of breath			Dizziness		
Fatigue			Easily winded			Poor concentration		
Sweats			Chest congestion			Arm/Leg weakness		
Weight gain			Coughing up blood			Numbness/Tingling		
Weight loss			Wheezing			Tremor		
Insomnia						Memory problems		
			Gastrointestinal			Confusion		
Head/Eyes/ENT/Neck			Belly pain			Passing out spells		
Poor vision			Nausea/Vomiting					
Double vision			Vomiting blood			**Muscles/Joints/Bone**		
Light sensitivity			Constipation			Joint pain/swelling		
Itchy/Dry/Red eyes			Bloating			Neck pain		
Runny/Blocked nose			Diarrhea			Back pain		
Nosebleeds			Black stools			Muscle cramps		
Ear pain/pressure			Blood in stool					
Ringing in ears			Decreased appetite			**Skin**		
Decreased hearing			Trouble swallowing			Rash		
Spinning sensation			Heartburn			Dry/itchy skin		
Snoring			Yellow eyes/skin			Change in a mole		
Dry mouth			Rectal pain			Wound		
Hoarse voice			Stool incontinence					
Sore throat						**Blood/Lymphatics**		
Facial/sinus pressure			**Genitourinary**			Easily bruise/bleed		
Neck stiffness			Frequent urination			Swollen glands		
Neck lumps			Urinary incontinence					
			Urinary urgency			**Endocrine**		
Cardiovascular			Burning urine			Excessive thirst		
Chest pain			Urinating at night			Heat/cold intolerance		
Palpitations			Pelvic pain			Hair/skin changes		
Sleep upright			Change in libido					
Leg swelling			Painful sex			**Psychiatric**		
Leg pain with walking			Abnormal periods			Depression		
			Genital itch/discharge			Anxiety		

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

LA Wellness Boutique is committed to providing you with the best possible care. In order for us to achieve this goal, we need your assistance and understanding of our financial policy. Please read the following carefully. As it is an agreement that you are responsible for payment, and will pay in a timely manner.

- All professional services rendered by LA Wellness Boutique are charged to the patient. Patients are responsible for all fees regardless of insurance coverage. LA Wellness Boutique does not file any insurance claims and does not code visits for any insurance.
- Non-members: All payments are due at the time of service. We accept cash, checks and credit cards for your convenience.
- Members will be billed monthly for membership services and for any incidentals incurred from an office visit. There is an option to pay 1 years membership upfront for a discounted amount. To cancel a membership, just call us during regular business hours before the 1st of the following month and we will cancel your membership. Monthly membership fees are not prorated. A cancelled membership cannot be reinstated, the patient is offered care at non-member pricing, if account is up to date.
- In order to release our medical records, we must receive a release signed by the patient or legal guardian.
- There is a $50 fee on any returned checks that will be electronically debited from your account.
- Any lab work will be billed by the vendor. There is an option to use your insurance to cover your lab costs. The vendor will require your insurance information and it is for this reason that we keep a copy of your insurance of your chart with us.
- By providing us with your landline or cell phone number(s), you give your consent for us, our agents, and to our collection agents, to contact you at these numbers, or at any number that is later acquired for you, and, to leave live, or pre-recorded messages regarding any accounts or services. Providing us a telephone or cell number is not a condition of receiving our services, however.

Agreement to Accept Financial Responsibility

I, _________________________________ ,acknowledge that, at my request, LA Wellness Boutique has provided or will provide me with professional services, and I agree to the above financial policy. I also understand that if I fail to comply with this agreement, and if my account becomes past due, it will become eligible for collections activity. I understand that any expense incurred by LA Wellness Boutique in its efforts to collect remittance will be added to my bill and become my responsibility. Patients will not be seen by the provider until account is up to date.

I hereby understand that the providers of LA Wellness Boutique will not furnish medical information to any insurance carrier for payment. I understand that I am responsible for the total of fees incurred during my office visit.

After an initial 12 month contract is completed, members may cancel membership at any time by requesting a membership cancellation form which should be received before the 1st of next month billing cycle. Fees will NOT be pro-rated.

I am a Medicaid/Medicare recipient and I knowingly decline to have LA Wellness Boutique file a Medicaid/Medicare claim for services provided on this date. I elect to pay the self-pay price for services rendered on this date. I have been notified of costs prior to service. (Please initial box to indicate agreement)

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Patient Name____

Patient/Guarantor Signature_____________________________________

Relationship to Patient____

Date____

HIPAA and Office Privacy Policy

Patient Name ______________________________ DOB_________________

I understand that under HIPAA, I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan, and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Conduct normal healthcare operations, such as quality assessments and provider certifications.

I have been informed by you or your Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization at any time to obtain a current copy of the Notice of Privacy Practice from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practice.

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

I understand that I may revoke this consent in writing at any time, except to the extent you have taken action relying on this consent.

PATIENT AUTHORIZATIONS

Please write the name of the person to whom you wish us to disclose your health information:

___Spouse:_________________________________

___Parents:_________________________________

___Children:________________________________

___Other:___________________________________

___May leave on answering machine/voicemail

___May correspond by electronic means, including text, email, video call, FaceTime, Zoom and Skype

___DO NOT release any medical information to anyone

Signed:____________________________________ Date _____________

(Relationship to patient ____)

This authorization will expire one year from the signed date or may be changed by the responsible party at any time.

Your answers to the following questions will assist LA Wellness Boutique to respect your wishes regarding your medical care. This information will become part of your medical record.

Do you have a living will? Yes No

If yes please provide us with a copy for your medical record.

Do you have a durable power of attorney for health care? Yes No

If yes please provide us with a copy for your medical record.

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Name of Patient (please print)

____

Signature of Patient

____

Date

____

Signature of LA Wellness Boutique Representative