Diverse Medical Care

Date _____

Patient Information.

Name (First, MI, Last)_____ **Date of Birth** _____ **Age** _____

Street Address_____

City _____ **State** _____ **Zip** _____ **Marital Status:** M / W / S / D

If you are *seasonal*, what is the address we should forward to?

Street Address_____

City _____ **State** _____ **Zip** _____ **Social Security**_____

Home Phone (_____)_____ **Cell Phone** (_____)_____ **Work Phone** (_____)_____

Emergency Contact Name _____

Phone Number _____ **Relationship** __ _____

Medications/Supplements currently taking _____

_____

Allergies ( ) **YES** ( ) **NO if yes, please list (medication, food, environmental, etc.)** _____

_____

Pharmacy Name / Phone number _____

.....

Insurance Information

***PRIMARY* insurance company** _____ **( )HMO ( )PPO ( )POS**

Policy/ID # _____ **Group #**_____

Policy Holder _____ **Relationship to patient** _____

Policy Holder's DOB _____ **Social Security** _____

***SECONDARY* insurance company** _____ **( )HMO ( )PPO ( )POS**

Policy/ID # _____ **Group #**_____

Policy Holder _____ **Relationship to patient** _____

Policy Holder's DOB _____ **Social Security** _____

***TERTIARY* insurance company** _____ **( )HMO ( )PPO ( )POS**

Policy/ID # _____ **Group #**_____

Policy Holder _____ **Relationship to patient** _____

Policy Holder's DOB _____ **Social Security** _____

Diverse Medical Care

Past Medical History (Check all that apply)

_____ Headaches
_____ Constipation
_____ Fainting spells
_____ History of seizures
_____ Fatigue
_____ Thyroid Disease
_____ Diabetes
_____ Prostate Dysfunction
_____ Depression
_____ Arthritis
_____ High/Low Blood Pressure
_____ Angina (chest pain)
_____ Pneumonia
_____ Rapid/Irregular heart beat
_____ Congestive Heart Failure

_____ Rheumatic Fever
_____ Chronic cough
_____ HIV/AIDs
_____ Bronchitis
_____ Diverticulitis/diverticulosis
_____ Gall bladder disease
_____ Cysts/ Fibroids/ Tumors
_____ Kidney infection/stones
_____ Water Retention
_____ Painful urination
_____ Arthritis
_____ Bursitis
_____ Back Pain
_____ Neck Pain

_____ Heart Attack
if yes, when? _____

_____ Cancer
if yes, please describe _____

Surgical History with Dates _____

_____

Smoking

Have you ever smoked cigarettes, cigars or pipes? ( ) **YES** ( ) **NO** ***if NO, skip to alcohol section***

If you did or do now smoke cigarettes, cigars or pipes, how many per day? _____ ( ) **cigarettes** ( ) **cigars** ( ) **pipes**

If you stopped smoking, when did you stop? _____

Alcohol

Do you drink alcoholic beverages? ( ) **YES** ( ) **NO**

( ) **Occasional** ( ) **Often** **if often,** _____ **per week**

Do you do Recreational drugs? ( ) **YES** ( ) **NO**

if yes, please describe ***(We only need this information to better treat you)***

_____

_____ _____

Patient/Legal Guardian Signature **Date**

With signing this intake form, you acknowledge all of the information provided is correct to the best of your knowledge

Diverse Medical Care

Phone Message Consent

Unless Diverse Medical Care has your written permission to do so, we will not:

- **Leave messages with anyone except the patient.**
- **Leave information on an answering machine.**
- **Send emails and/or fax.**

I, _____, give ***Diverse Medical Care*** permission to leave phone messages, send emails or fax information regarding my medical care. I fully understand that this consent will stay in effect until otherwise documented in writing.

Cell phone (_____)_____

Home phone (_____)_____

Work phone (_____)_____

Fax (_____)_____

Email _____

I also give permission for my medical information to be released to the following:

1. _____ at (_____)_____
   Name of person / Relationship **Best phone number**

2. _____ at (_____)_____
   Name of person / Relationship **Best phone number**

_____ _____
Patient/Legal Guardian Signature **Date**

Diverse Medical Care

Notice of Privacy Practices

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

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and 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, significant rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse your personal health information.

Diverse Medical Care must use and disclose or share your health information as necessary for treatment, payment and health care operations to provide you with quality health care.

We are permitted to use and release your health information without authorization from you. Treatment includes sharing information with other health care providers involved in your personal care. We may also use your health information as required by your health insurance to determine eligibility or to obtain payment for your treatment.

Your health information may be used for the following purposes unless you otherwise ask for restrictions on specific uses or disclosures:

- Family members or close friends involved in your care or payment for treatment. *****
- Disaster relief agency if you are involved in a disaster relief effort. *****
- Appointment reminders
- Law enforcement, as required by federal, state or local law.
- Health oversight activities, such as audits, inspections and licensures.
- Lawsuits and disputes, in response to a court or administrative order, subpoena, discovery request or another law request.
- Coroners and medical examiners.

Note: Statements with the asterisk symbol (*****) indicate communications about your health information you are able to refuse.

Contact the office if:

- You have any questions about this notice;
- You wish to request restrictions on uses and disclosures for health care treatment, payment and/or operations; or
- You wish to obtain a copy of this notice

Diverse Medical Care

Notice of Privacy Practices Acknowledgement

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices which explains how your health information may be handled in various situations including your treatment, payment of services and our healthcare operations.

( ) I have received and read the Notice of Privacy Practices

_____ _____

Patient/Legal Guardian Signature **Date**

FOR OFFICE USE ONLY

Was the patient given a copy of the Notice of Privacy Practices? ( ) **YES** ( ) **NO**

Please explain why the Notice of Privacy Practices was not signed and our efforts to try and obtain the patient's signature.

_____

_____

_____

_____

_____

_____ _____

Signature/Title Date

Diverse Medical Care

Cancellation and NO SHOW Policy

PLEASE READ CAREFULLY

We understand that situations arise in which you must cancel or reschedule your appointment. It is therefore requested that if you must cancel or reschedule, that you provide at least a 24-hour notice. This will enable for another patient who is waiting for an appointment to be scheduled in that appointment slot. With cancellations of less than 24-hour notice, we are unable to offer that appointment slot to other patients.

Office appointments which are cancelled with less than 24-hour notification will be subject to a **$35.00** cancellation fee. Colonic cancellations with less than 24-hour notification will be subject to a **$50.00** cancellation fee.

Patients who do not show up for their appointment without a proper call to cancel an office appointment or Colonic will be considered as a ***NO SHOW***. Patients who No Show for an office appointment may also be subject to a **$35.00** fee and **$50.00** for a Colonic No Show.

The cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patients next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Please sign that you have read, understand and agree to our Cancellation and No Show Policy.

Patient/Legal Guardian (Print Name)	**Date of Birth**
Patient/Legal Guardian (Signature)	**Date**