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PATIENT INFORMATION

Date: _____

GENERAL INFORMATION

Patient Last Name:	Patient First Name:	Patient Middle Name:
Patient Mailing Address:	Patient Home Phone:	Patient DOB:
	Patient Cell Phone:	Patient Email Address:
	Patient Work Phone:	Sex:
Insurance Carrier:	Policy Number:	Group Number

Primary Care Provider:	Referring Provider:
Reason for today's visit: ☐ Physical ☐ New Patient Appointment	Any specific concerns?

MEDICAL HISTORY

Do you have a history of any of the following (check all that apply)

☐ Diabetes Mellitus or Pre-Diabetes
☐ Thyroid Disease
☐ Osteoporosis
☐ Heart Disease
☐ Lung Disease
☐ Stroke or TIA
☐ Kidney Problems
☐ Eye Problems
☐ Cancer / Hematologic Issues
☐ High Blood Pressure
☐ High Cholesterol
☐ Blood Clots
☐ Eating Disorders
☐ Weight Management Concerns
☐ Depression/Anxiety
☐ Insomnia
☐ Sleep Apnea
☐ Incontinence or Recurrent UTI
☐ Menopausal Symptoms
☐ Allergies to Medications
☐ Other Allergic Reactions/Intolerances

Please provide date and description for any of the above where you answered YES.

PREVENTIVE CARE (IF APPLICABLE)

Have you had the following preventive care testing? *(check all that apply)*

☐ Mammogram
☐ PAP
☐ Colonoscopy
☐ Bone Density
☐ EKG or Other Cardiac Testing
☐ Sleep Apnea Test

Have you received the following vaccines?

☐ Flu Annually
☐ Pneumococcal 23 polyvalent (PNVAX
☐ Pneumococcal 13 polyvalent (Prevnar)
☐ Shingles
☐ Hepatitis B
☐ Hepatitis A
☐ TDAP or Tetanus Booster
☐ MMR Booster or Titers Checked
☐ Travel Vaccines (IPOL, Typhoid, etc.)

OB/GYN (FOR WOMEN ONLY)

Number of pregnancies: _____ Number of deliveries: _____ Delivery Year(s): _____

Children's birth weights: _____

Complications: _____

History of postpartum depression? Yes No Do you have regular periods? Yes No

Current form of birth control: _____

LIFESTYLE

Current or past occupation: _____

Current work status: Actively working Working at Home Retired Care-taking Disabled Unemployed

Who do you live with? _____

Relationship status: Single Married Partnered Widowed Separated Divorced

If married or partnered, how many years have you been in the relationship? _____

Are you sexually active? Yes No

If yes, with whom? _____ Men _____ Women _____ Both

If yes, protection used? Yes No If yes, what method? _____

Do you have any concerns or questions? _____

Have you ever smoked? _____ If yes, how many years? _____ How many packs per day? _____ Currently? _____

How much alcohol do you drink each week?

Wine: _____ glasses per week Beer: _____ bottles/cans per week Liquor: _____drinks per week

Have you ever had an issue with heavy drinking? Yes No

Do you use any recreational drugs (marijuana, cocaine, etc.)? Yes No

If yes, which ones? _____

Do you take vitamins or any nutritional/herbal supplements? Yes No
If yes, which ones? _____

What do you do for exercise? Please include activity, duration, and frequency.

How many hours do you sit per day? _____

Have you ever been the victim of trauma or abuse (including sexual, emotional, physical abuse or neglect and/or being a victim of an accident, violent crime, or a natural disaster)? Yes No

If yes, is this an active issue in your life that you would like to address while you are here? Yes No

Rate the amount of stress in your life: ☐ None ☐ A Little Bit ☐ Moderate ☐ Quite a Lot ☐ Extreme

How well do you manage stress? ☐ Not at All ☐ A Little Bit ☐ Moderate ☐ Quite well ☐ Excellent

What are the main sources of stress in life? (personal, professional, financial)?

What are your methods of coping with the stress in your life?

What makes you feel connected to the larger world? -Describe your spiritual or religious practices if any (i.e., meditation, prayer, time in nature, worship attendance)

Do you have a Racial/Culture heritage that is important to you? _____

What are your health goals? What are your overall goals for improving your health and your life?

FAMILY HISTORY

Do any members of your family (including parents, grandparents, children, siblings, aunts, uncles) have any of the following conditions?

☐ Diabetes
☐ Heart Disease
☐ Stroke
☐ Peripheral Vascular Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Thyroid Disease
☐ Osteoporosis
☐ Retinal Problems
☐ Cataracts or Glaucoma
☐ Protein in Urine
☐ Kidney Disease
☐ Nerve Damage
☐ Foot Ulcers
☐ Frequent Infections
☐ Liver Disease
☐ Cancer or blood disorders
☐ Mental Health Disorders
☐ Depression
☐ Anxiety
☐ Overweight or Obesity
☐ Other

Please explain.

SURGICAL HISTORY

List all surgeries you have had and the approximate year of surgery.

MEDICATIONS

List all medications (including OTC) that you are currently taking (name, frequency, dosage).

What doctors or other medical providers do you see?

REVIEW OF SYSTEMS

Please complete relevant sections. Check if you can answer 'yes' to any of the following symptoms. If yes, explain

CONSTITUTIONAL

☐ Loss of Appetite
☐ Chills/Fever
☐ Fatigue / General Weakness
☐ Night Sweats
☐ Unintended Weight Change

SKIN/LYMPHATIC SYSTEM

☐ Changes in Hair or Nails
☐ Skin Lesions/Rash
☐ Swollen Lymph Glands

HEAD/NECK

☐ Dizziness
☐ Headache
☐ Neck Pain

ENMT

☐ Vertigo
☐ Hoarseness
☐ Bleeding Gums
☐ Decreased Hearing
☐ Frequent Nosebleeds
☐ Oral Lesion
☐ Taste Disturbance
☐ Ringing in Ears

EYE

☐ Change in Vision
☐ Dry Eyes
☐ Eye Pain

RESPIRATORY

☐ Cough
☐ Coughing Up Blood
☐ Shortness of Breath
☐ Wheeze
☐ Snoring

CARDIAC/VASCULAR

☐ Calf Pain
☐ Chest Pain
☐ Decreased Exercise Tolerance
☐ Palpitations
☐ Leg Swelling
☐ Varicose Veins
☐ Shortness of Breath When Lying Flat

ENDOCRINE

☐ Thyroid Trouble
☐ Cold Intolerance
☐ Heat Intolerance

GASTROINTESTINAL

☐ Abdominal Pain
☐ Change in Bowel Habits
☐ Change in Stool Color/ Blood in Stool
☐ Constipation/Diarrhea
☐ Pain or Difficulty Eating
☐ Heartburn > 1x Week
☐ Hemorrhoids
☐ Nausea/Vomiting

GENITOURINARY

☐ Change in Urine Stream
☐ Painful Urination
☐ Erectile Dysfunction
☐ Genital Lesion
☐ Blood in Urine
☐ Night Urination
How Many Times/Night?
☐ Penile Discharge
☐ Testicular Pain
☐ Urinary Incontinence
☐ Post Menopausal Bleeding

BREAST

☐ Lump/Mass
☐ Pain
☐ Nipple Discharge
☐ Redness or Rash

MUSCULOSKELETAL

☐ Back Pain
☐ Joint Pain
☐ Joint Redness/Stiffness
☐ Muscle Aches

HEMATOLOGIC

☐ History of Anemia
☐ Blood Transfusion History
☐ Bleeding/Bruising Tendency

NEUROLOGIC

☐ Loss of Coordination
☐ Memory Loss
☐ Seizure
☐ Focal Weakness/
Change in Sensation

PSYCHIATRIC

☐ Mood Change
☐ Safety Concerns at Home
☐ Significant Relationship Trouble
☐ Anxiety/Depression
☐ Decreased Attention Span
☐ Eating Disorders
☐ Irritability
☐ Sleeping Problems
☐ Substance Abuse

Please explain any checked symptoms.

OTHER

Do you have any other concerns or symptoms not listed above?

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FINANCIAL AGREEMENT

1. RELEASE OF INFORMATION FOR REIMBURSEMENT

To the extent necessary to obtain reimbursement, Comprehensive Wellness may disclose any portion of the patient's record, including his/her medical records, to any party the patient has identified as liable for any portion of Comprehensive Wellness' charges, including but not limited to, insurance companies, healthcare service plans, workers' compensation carriers, social security administration and peer review organizations.

2. FINANACIAL AGREEMENT

Our clinicians are out-of-network with insurance carriers so payment is expected at the time of visit. We will bill insurance if you have a PPO plan. HMO plans won't be billed as they don't accept out-of-network claims. We're unable to bill Medicare since our clinicians have opted out of Medicare but will supply, upon request, a copy of our itemized bill. The undersigned agrees that he/she is obligated to cover the cost for any services rendered by Comprehensive Wellness regardless of any or no payout from his/her insurance carrier. It is the undersigned's responsibility to know and verify insurance benefits.

3. MISSED APPOINTMENT CHARGE

Patients that do not show up for scheduled appointments without communicating with Comprehensive Wellness will be charged at least a minimum of $50 and up to the cost of the appointment charge. Comprehensive Wellness requires patients to call if they miss an appointment or need to reschedule no later than 24 hours in advance (on weekdays) in order to avoid a "No Show" charge.

The undersigned acknowledges he/she has read and understands the Financial Agreement, Assignment of Insurance Benefits, Health Care Service Plan obligation and all other applicable provisions above and received a copy thereof, and is the patient, the patient's legal representative or is duly authorized as the patient's general agent to execute the above and accept the terms.

_____	_____	_____
Signature of Patient/ Legal Representative/Agent	*Date/Time*	*Relationship to Patient*

Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative.

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits, Health Care Service Plan obligation, and all other applicable provisions above.

_____	_____	_____
Financially Responsible Party	*Date/Time*	*Phone Number of Financially Responsible Party*

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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION: RELEASE OF RECORDS

This form is used to authorize the release of protected health information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Completion of this document authorized the discloser and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

DATE: _____

Name of patient: _____ DOB: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize _____ to release to

_____ (persons/organizations authorized to *receive* this

information) at _____ (address, street, city, state, zip code).

The following information is to be released:

a. [ ] Assessment/History and Physical. Date(s) of service: _____
[ ] Discharge Summary. Date(s) of service: _____
[ ] Lab Tests. Date(s) of service: _____
[ ] Radiology Reports. Date(s) of service: _____
[ ] Entire Record. Date(s) of service: _____
[ ] Other. Please specify needed information and date(s) of service if known.

_____

b. I specifically authorize the release of the following information (check as appropriate):

[ ] Mental health treatment information[1] (a separate authorization is require to authorize the disclosure or use of psychotherapy notes).
[ ] HIV test results
[ ] Alcohol/drug treatment information
[ ] Genetic information/testing

Patient's initials

_____ I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization, I am authorizing the release of such information unless specified otherwise above.

_____ I understand my treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

_____ Any facsimile, copy, or photocopy of this authorization shall authorize you to release the records requested herein.

PURPOSE

The purpose of the release of this information is:

[ ] insurance or other third party reimbursement
[ ] continuity of medical care
[ ] pending legal action
[ ] at the request of the patient
[ ] other (specify): _____

RESTRICTIONS

According to the federal and state regulations, if the medical information requested relates to AIDS/HIV treatment or treatment in a federally recognized chemical dependency unit, then the information will be accompanied by a statement limited disclosure to third parties as required by law.

I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I realize that the office and its employees have a responsibility to maintain the confidentiality of the medical records in its possession. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. The office will not be held responsible for any subsequent disclosure by the recipient of the health information.

I release the Comprehensive Wellness Medical Providers and employees of Comprehensive Wellness of any liability that may arise as a result of any subsequent disclosure of my health information by the recipient.

MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment r eligibility for benefits.[2]

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time but I must do so in writing and submit it to the following address: Comprehensive Wellness, 110 La Casa Via, Suite 205, Walnut Creek, California, 94598.

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. I have a right to receive a copy of this authorization.[3]

Information disclosed pursuant to this authorization could be re-disclosed by the recipient.

If this box [ ] is checked, the requester will receive compensation for the use or disclosure of my information.[4]

SIGNATURE

_____	_____	_____
Signature of Patient/Legal Representative/ Spouse/Financially Responsible Party	*Date/Time*	*Relationship to Patient*
_____		_____
Printed Name of Patient/Legal Representative/ Spouse/Financially Responsible Party		*Date/Time*

[1] If mental health information covered by the Lantrmman-Petris-Short Act is requested to be released to a third party by the patient, the physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party, however.

[2] If any of the HIPAA-recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual or a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment, or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or)iii) to create health information to provide to a third party or for the disclosure of the health information to such third party. Under no circumstance, however, may an individual required to authorize the disclosure of psychotherapy notes.

[3] Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures.

[4] The requester is to complete this section of the form.

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INFORMATION DISCLOSURE & COMMUNICATION

Completion of this document authorized the disclosure and/or use of health information about you. The purpose is to give your health care provider permission to leave certain health information on your phone messaging service. Failure to provide all information requested may invalidate this authorization.

DATE: _____

Name of patient: _____ DOB: _____

Preferred Phone Number: _____ Preferred Email Address: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize a representative of **Comprehensive Wellness** to call the telephone number listed above and leave a detailed verbal message or voicemail message with the following individuals:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I authorize the following information to be conveyed in these messages:

[ ] test and other exam results

[ ] only the following records or types of health information (including any dates):

_____

[ ] details about my next appointment (physician name and date)

[ ] I DECLINE. Please do not leave any messages.

[ ] I Prefer email communication at the email address listed above when possible.

This authorization expires one year from the completion date of this form.

MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.[1]

If the health information is being disclosed or used, I may inspect or obtain a copy of this health information.

I may revoke this authorization at any time but I must do so in writing and submit it to the following address: Comprehensive Wellness, 110 La Casa Via, Suite 205, Walnut Creek, California, 94598.

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. I have a right to receive a copy of this authorization.[2]

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by state law and may no longer be protected by federal confidentiality law (the Health Insurance Portability and Accountability Act of 1996, also known as HIPAA).

SIGNATURE

_____	_____	_____
Signature of Patient/Legal Representative/ Spouse/Financially Responsible Party	*Date/Time*	*Relationship to Patient*
_____		_____
Printed Name of Patient/Legal Representative/ Spouse/Financially Responsible Party		*Date/Time*

[1] If any of the HIPAA-recognized exceptions to this statement apply, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment, or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

[2] Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures.

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ONLINE COMMUNICATION
SAFE USE AND HIPAA

Online communication is a form of communication using web sites or e-mail applications that apply encryption technology designed to protect the transmission of confidential information. These include the John Muir Health patient portal, communicating with practitioners via Comprehensive Wellness email addresses, and using our online scheduling interface. Online communication is an additional option for communication along with telephone, mail, and in-person. It is not meant to replace other forms of communication with the Medical Provider.

Initial

_____ The details of online communication have been explained to me in terms I understand.

_____ Alternative methods of communication (i.e., telephone, in-person, mail) are still available to me.

_____ I understand that all medical communications carry some level of risk. While the likelihood of risks associated with the use of online communication in a secure environment is substantially reduced, the risks are nonetheless real and very important to understand. These risks include, but are not limited to:

- It is easier for online communication to be forwarded, intercepted, or even changed without my knowledge.
- Online communication is easier to falsify than handwritten or signed hard copies. Backup copies may exist on a computer or in cyberspace, even after both of us have deleted our copies.
- I will use a secure network. I will not use standard e-mail or e-mail systems provided by employers. I understand that employers have a right to inspect and keep online communication transmitted through their system.
- Online communications become part of my medical record.

_____ I agree to take precautions to keep online communication confidential, including but not limited to the following:

- I will keep my password confidential.
- I will not store messages on an employer-provided computer.
- I will not leave messages on my screen for others to read.
- I will review my messages before sending to make sure that they are clear and that all relevant information is included.
- I will update my contact information as soon as it changes.

_____ I understand that I am responsible for taking steps to protect myself from unauthorized use of online communication. The Medical Provider is not responsible for breaches of confidentiality caused by an independent third party or me.

_____ I agree to follow the procedures that the Medical Provider implements to allow him/her to verify my identity in connection with online communication. I acknowledge that failure to comply with these procedures may terminate our online communication.

_____ **I understand that online communication cannot be used for emergencies or time sensitive matters.**

_____ I understand that online communication cannot be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.)

_____ I have informed the Medical Provider of other treatments I do not want transmitted via online communications. I understand that is my responsibility to determine if an unanswered online communication was received.

_____ I acknowledge that I have read and fully understand this consent form, including the risks associated with the online communication.

_____ The Medical Provider has answered all of my questions.

Again, please note that online communication should never be used for emergency communications or urgent requests. These should occur via telephone or by using existing emergency communications tools.

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature.

For online communications between _____ and his or her staff and _____ (patient name).

_____	_____	_____
Signature of Patient/Legal Representative/ Spouse/Financially Responsible Party	*Date/Time*	*Relationship to Patient*
_____		_____
Printed Name of Patient/Legal Representative/ Spouse/Financially Responsible Party		*Date/Time*

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TELEMEDICINE (EXCLUDING EMAIL)

Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve patients' health status. Telephone, videoconferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs, continuing medical education and nursing call centers are all considered part of telemedicine.

Initials

_____ I would like to have the option of telemedicine visits with Comprehensive Wellness when clinically appropriate.

_____ I understand the concept of telemedicine, as well as the particular electronic medium to be used.

_____ I understand telemedicine visits are not reimbursable by Health Care Service Plans at this time and that I am responsible for the fee associated with a telemedicine visit.

_____ I understand that although there has been great progress made in technology, this telemedicine encounter may still be in the experimental stage.

_____ I understand that there may be limitations to image quality or other electronic problems that are beyond the control of the health care providers.

_____ The nature and potential risks of this telemedicine encounter have been explained to me.

_____ I understand that in lieu of this telemedicine encounter, I may seek health care elsewhere where I might have face-to-face contact with the health care provider.

_____ I understand that the telemedicine encounter may be a one time occurrence and that treatment and follow-up will remain the responsibility of my Medical Provider.

_____ The Medical Provider has answered all of my questions.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

_____	_____	_____
Signature of Patient/Legal Representative/ Spouse/Financially Responsible Party	*Date/Time*	*Relationship to Patient*

_____	_____
Printed Name of Patient/Legal Representative/ Spouse/Financially Responsible Party	*Date/Time*

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EMAIL NEWS & EVENTS

Please complete the following to receive regular updates about news and events at Comprehensive Wellness – as well as our bi-monthly newsletter. We promise that we will never share or distribute our mailing list.

Patient Last Name:	Patient First Name:
Email Address:	
☐ By signing below, I give Comprehensive Wellness permission to send regular updates about news and events at Comprehensive Wellness to my email address. Patient Signature:	

REFERRAL INFORMATION

We would love to know how you learned about Comprehensive Wellness.

☐ Another Clinician ☐ Website ☐ Ad

☐ Family ☐ Social Media ☐ Event/Presentation

☐ Friend ☐ Postcard ☐ Other: _____

Who can we thank for referring you? _____

: