Longfellow Holistic Health Center

PATIENT NAME: _____ **DOB:** _____
(First, Middle , Last)
If under the age of 18: PARENT / GUARDIAN: _____ PARENT CONTACT # _____

_____ _____ _____ _____
Street Address **Apt #** **City/Town** **State** **Zip**

Check Preferred Contact
☐ Home Phone: **( )** _____ ☐ Cell Phone: **( )** _____ cell carrier: _____
☐ Work Phone: **( )** _____ ☐ Email Address: _____
Do you want to receive appointment reminders via text or email? **Yes/ No** **Text Message/ Email/ Neither**

Demographics (Please Circle)
Patient Gender Male/ Female/ Other **Marital Status** Single/ Married/ Other
Patient Status Employed /FT/ PT/ Student /Retired

CURRENT HEALTH INFORMATION

1. Your purpose for today's appointment (Be Specific): _____
_____
2. When did this condition begin (Onset Date): _____
3. Other practitioners seen for this condition: _____ Date: _____
4. Have Diagnostic tests been taken? What test?: _____ _____
5. Is this condition related to a work- related injury? Yes*/ No * If yes, please request WC/Auto Accident Form
6. Is this condition related to an auto accident? Yes*/ No * If so, please request WC/ Auto Accident Form

WORK ENVIRONMENT

Occupation: _____ Employer: _____
Employer Address: _____ Work Phone Number: _____

EXERCISE ACTIVITY

1. Types and frequency of exercise: _____
2. How has your condition affected your activity: _____
_____

HEALTH INFORMATION:

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE EVER HAD:
☐ Arthritis ☐ Cancer ☐ Epilepsy ☐ High Blood Pressure ☐ pacemaker ☐ Diabetes ☐ asthma
Other conditions: _____
1. Please list current medications dosage/freqency:(Please request a separate list if necessary): _____
_____
2. Allergies: Tape / Latex / Medication: _____
3. Major Surgery/Operations: _____
4. Primary Care Physician: _____ Date of Last Visit: _____
5. Referring Physician (If not PCP): _____
6. Hospitalizations (other than above): _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____
Member ID: _____ Member ID: _____
Group #: _____ Group #: _____
Name of Subscriber: _____ Name of Subscriber: _____
DOB of Subscriber: _____ DOB of Subscriber: _____
Patients's relationship to subscriber: _____ Patients's relationship to subscriber: _____

PATIENT'S SIGNATURE: _____ **DATE:** _____

PARENT/GUARDIAN'S SIGNATURE: _____ **DATE:** _____

DBA Longfellow Holistic Health Center

FINANCIAL POLICY, EXCLUSIVE & IRREVOCABLE ASSIGNMENT & LIEN, CONSENT TO TREATMENT AND CANCELLATION POLICY

PRIVACY NOTICE ACKNOWLEDGMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the ***Health Insurance Portability and Accountability Act*** of 1966 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of the ***Notice of Privacy Practices for Protected Health Information*** from the practitioners at Longfellow Holistic Health Center. Initial here_____

FINANCIAL POLICY

I will be personally responsible for full payment of all outstanding balances. I understand and agree that any outstanding balance owed by me to any or all provider(s) of Longfellow Holistic Health Center (hereafter referred to as LHHC) over (30) days will be subject to a $1^1/_2$% monthly interest rate (18% per annum). I understand and agree that any outstanding balance over sixty (60) days may be subject to collection activities. In the event that suit becomes necessary to collect any outstanding balance due, I agree to be responsible for all reasonable collection fees (with a minimum collection fee $50.00), court fees and attorney's fee incurred.

I understand that I am financially responsible for all charges whether or not assigned or paid by any third party and I shall be personally responsible for any unpaid balance due over thirty (30) days. I hereby authorize LHHC to make inquires, endorse drafts and to release information to my insurance carrier, employer or attorney about my case. Initial here_____

EXCLUSIVE & IRREVOCABLE ASSIGNMENT & LIEN

I hereby irrevocably assign to any or all provider(s) of Longfellow Holistic Health Center, all my right, title and interest in and to a portion of all insurance of indemnification benefits of any or all types, including but not limited to an automobile Personal Injury Protection coverage and an automobile Medical Payment Coverage to which I may be entitled to the extent of the amount of the bill for services rendered to me. I hereby irrevocably grant a lien to LHHC on any settlement, claim, judgement, verdict or on any of the above-mentioned insurance benefits that may be due to me. I irrevocably authorize and direct my attorney of record to pay directly to LHHC such sums as may by due and owed for services rendered to me, and to withhold such sums from such settlement, claim, judgement, verdict or any other above insurance benefits that may be due to me as may be necessary to protect LHHC adequately.

I hereby irrevocably assign payments to, authorize and direct the immediate payment of said benefits directly to LHHC and request and direct my insurance company to pay LHHC such sums as may be due to them upon receipt of an itemized statement for services rendered to me. It is further understood and agreed that payment of said itemized statement by my insurance company as herein directed by me, shall be considered the same as if paid directly to me. I understand and agree that I am personally responsible to LHHC for the full amount of my bills from the proceeds of the settlement or disposition of my case.

I do hereby authorize LHHC to furnish my insurance carrier or attorney with a full report of the case history, examination, diagnosis, treatment and prognosis of myself, including but not limited to dates of service and charges incurred. I fully understand that I am directly and fully responsible to LHHC for all bills submitted for services rendered to me, and that this agreement is made solely for the additional protection of LHHC and in consideration of their awaiting payment. And I further understand and agree that such payment is not contingent on any settlement, claim, judgement or verdict by which I may eventually recover said fees. Initial here_____

APPOINTMENT REMINDERS AND HEALTH-CARE INFORMATION AUTHORIZATION

Longfellow Holistic Health Center practitioners and/or Longfellow Holistic Health Center staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be an interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine or given to the family member or person answering your phone. By signing this form, you give us authorization to contact you by phone.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclosed based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we used to obtain reimbursement for your care.

You may inspect or copy the information that we used to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (164.524).

This notice is effective as the date listed below. The authorization will expire seven years after the date on which you last received services from us.

_____(Initial)- I **DO** authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

-OR-

_____(Initial)- I **DO NOT** authorize you to use or disclose my health information in the manner described above. I realize that Longfellow Holistic Health Center's practitioner's representatives will not call me at my home or office to notify me of rescheduling a missed appointment or the cancellation of any future appointments. I am also acknowledging that I have received a copy of this authorization.

_____	_____
Patient's Printed Name	Date
_____	_____
Patient's Signature	Longfellow Holistic Health Center Representative
_____	_____
Personal Representative Printed Name	Personal Representative Signature

CANCELLATION POLICY

Longfellow Holistic Health Center's purpose is to provide quality health care. We request at least 24 hour notice to change or to cancel an appointment (messages can be left on our answering machine). Less than 24 hour notice is an inconvenience to our other patients needing care and usually a late cancelled appointment cannot be filled. Therefore, we must charge for all missed appointments and those appointments cancelled with less than 24 hour notice.

I have truthfully completed the attached Vital Information Questionnaire. I have fully read, understood and completely agree to the above stated Longfellow Holistic Health Center Financial Policy, Exclusive & Irrevocable Assignment & Lien, and Cancellation Policy. A photocopy of this agreement shall be considered as effective and valid as the original.

PATIENT'S SIGNATURE:_____ **DATE:**_____

PARENT/GUARDIAN'S SIGNATURE:_____ **DATE:**_____