Renewed MEDICAL HEALTH + Beauty Wellness Center

2825 E. BROADWAY BLVD.
P: (520)298-0005 | F: (520)367-5771

514 E. WHITEHOUSE CANYON RD.
P: (520)777-7831 | F: (520)777-7832

Patient Registration Form

Patient Name: _____ Gender_____ D.O.B._____
Last Name **First Name:** **Middle Initial**

Street Address: _____ City:_____ State_____ Zip_____

Home Phone: _____ Cell Phone:_____ Work Phone:_____

E- mail Address: _____ Social Security # optional:_____

Would you be interested in having communications sent to you via email address? (Examples appointment notifications, administrative updates, and health bulletins? ☐ Yes ☐ No

Ethnicity: _____ Race:_____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Insurance Information (please give insurance card at check in)

Responsible Party (if other than the patient) Relationship to Patient: _____

First Name: _____ Last Name:_____ D.O.B._____

Street Address: _____ City:_____ State_____ Zip_____

Home Phone: _____ Work Phone:_____ Email Address:_____

Primary Insurance

Insurance Company: _____

Mailing Address: PO Box _____ City:_____ State_____ Zip_____

Group Number: _____ Member ID (subscriber #):_____

Secondary Insurance

Insurance Company: _____

Mailing Address: PO Box _____ City:_____ State_____ Zip_____

Group Number: _____ Member ID (subscriber #):_____

Who to call for an emergency?

Name: _____ Address:_____

Home Phone: _____ Work Phone:_____ Relationship:_____

Missed Appointment Policy

Cancellation of an appointment

To be respectful of the medical needs of other patients, please be courteous and call the office at least 48hours in advance if you are unable to show up for an appointment. Our appointment times are in high demand, and your early cancellation will allow another patient access to timely medical care. To cancel, please call **(520) 298-0005** and speak with one of our schedulers. If it is after hours, please leave a detailed message on our voicemail.

No show policy

A "no show" is defined as a patient who misses an appointment without cancelling in a minimum of 48 hours in advance for all provider and Renewed appointments. A failure to be present at the time of an appointment will be recorded in the patient charge as a "no show." This includes arriving more than 15 minutes after the scheduled appointment time. In the event of a "no show" Renewed Medical Health "may" charge the credit card on file a $50 missed appointment fee. This fee "may" be charged for missed appointments or appointments cancelled with less than 48 hours' notice. This fee is **NOT** covered by insurance companies and remains the responsibility of the patient. We require that all patients have a credit or debit card on file. We allow two no show appointments before considering a patient for termination from the practice. Those arriving more than 10 minutes late to their appointment may be asked to reschedule.

By signing this statement, I acknowledge that I understand and agree to abide by the terms of the Missed Appointment Policy.

Signature: _____ **Date:** _____

Outstanding Balance & Credit Card on File Policy

Returned check policy

We require that all patients to have a credit or debit card on file. In the event of a check being returned for insufficient funds, we will charge the card on file for the returned check and a $25 returned check fee.

Outstanding balance policy

Any patient carrying an outstanding balance will be responsible for paying in full before seeing or being treated by a provider. Balances that reach 90-days past due will be referred to a collection agency. The collection agency will have the authority to collect the full outstanding balance due to us plus a 25% collection fee. Our providers cannot see patients in collections until they have paid the full balance due including the collection fee.

Credit card on file policy

The information will be held securely until your insurance/s have paid their portion and notified us of the remaining amount. This policy will in no way compromise your ability to dispute a charge or question your insurance company's determination of payment.

We are under HIPPA policies, which means we are under strict rules and guidelines for protecting patient's privacy and your credit card is considered protected health information.

By signing this statement, I acknowledge, understand and agree to abide by the terms of the medical practices Outstanding Balance and Credit Card Policy

Signature: _____ **Date:** _____

I certify that I am the authorized holder and signatory of the credit card referenced above. I hereby authorize Renewed Medical Health to charge the above credit card for collection of payment and charges for missed appointments within this form.

Printed Name: _____ **Date:** _____

Signature: _____

If you have questions or concerns, please ask to speak to an office manager.

Confidentiality Of Patient Medical Records &HIPPA Acknowledgment

We understand that information about you, your health, and your healthcare is personal. We are committed to protecting your personal health information (PHI). We request that you sign this form acknowledging that you have been given the opportunity to read and receive a copy of our policy regarding the confidentiality of patient medical records. This acknowledgment will be filed within your medical records.

I acknowledge that I have been given the opportunity to receive and read a copy of this organizations HIPPA privacy policy.

Printed Name: _____ **Date:**_____

Signature: _____

Patient authorization for disclosure of protected health information

You may elect to have your PHI provided to you by a message from the physician's office by signing this form in the space provided below. Once you have signed the form, future communication with you concerning your PHI via phone call, text or email may be provided to you and to the designated relative or friend on a voice mail at the number you provide to this office.

I understand my HIPAA rights and I request that this office leave messages, including those containing PHI, for me with either of the two individuals listed below on voice mail at the numbers noted below. I understand that it is my responsibility to keep the practice informed of any changes to this information.

Patient Name: _____ **Date:** _____ / _____ / _____

Phone Number: (___) _____ **Cell phone number**: (___) _____ **Work Number**: (___) _____

Email Address: _____

Relative / Friend 1) Name: _____ **Phone:** _____

Relative / Friend 1) Name: _____ **Phone:** _____

Emergency Contact

Name: _____ **Phone:** _____

Relationship to Patient: _____

Appointment reminder notifications

It's a busy work and that's why we offer a range of convenient ways to receive appointment reminders, via text or phone call. If you would like to be able to receive complimentary appointment reminder notifications, complete the needed information below to enroll. Once enrolled you will simply reply YES to confirm and NO to cancel the appointment. If you choose to cancel the appointment, you will need to call the office to reschedule at (520) 298-0005. Your information using this feature will not be shared.

Phone Number: (___) _____ **Cell number:** (___) _____

Email Address: _____ **Opt into Newsletter** ☐ Yes ☐ No

Patient Signature: _____ **Date:** _____ / _____ / _____

How did you hear about us?

☐ Media ☐ TV ☐ Social Media ☐ Radio ☐ Magazine ☐ Event ☐ Website

Friend/Relative Name: _____ Other: _____

Assignment Of Benefits: Medicare and Commercial Insurance

Health insurance policy

In order to be able to provide a higher level of service to all our patients and keep the cost down for specialty service items, we have structured our reimbursement schedules to include accepting insurance for provider time. All face-to-face provider time will be billed to your insurance, unless you request otherwise in writing. Co-payments are collected on the date of service. Some of our items and services such as hormone pellets therapy, our weight loss program and associated products, and nutritional supplements may not be covered by your insurance and payment is required on the date of service. It is your responsibility to understand your specific insurance policy and benefits coverage. Patients are responsible for deductible and coinsurance amounts, and items or services not covered by insurance. If you do not have insurance, we have a date of service fee schedule for cash paying patients. All self-pay patients will be expected to pay at the time of service with accepted method of payment. We accept cash, check, and all major credit cards. The cost of your doctor's visit is determined by services provided and the complexity of your visit. Parts of or all your visit may be covered by insurance, however you are primarily responsible for payment on all services rendered.

We perform a small number of procedures that are, at times, deemed experimental and/or not medically necessary by insurance carriers. It is the responsibility of each patient to understand his or her specific insurance policy and benefits coverage.

It is the policy of our Providers to discuss routine lab results at the next scheduled appointment. Patients with critical lab values or results that require information while incorporating patient confidentiality requirements. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignments.

I hereby authorize the release of medication information necessary to file a claim with my insurance company and assign benefits otherwise payable to me.

I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature: _____ **Date:** _____

Medical History

Date: _____

Name: _____ Age: _____ Date of Birth: _____

Name of Primary Care Provider (PCP): _____

Current/Past Specialty Providers: _____

List your top 3 concerns for today's visit:

_____

_____

_____

Allergic To:	**Reaction**

Allergic to: Latex: ☐ Yes ☐ No Lidocaine: ☐ Yes ☐ No Betadine: ☐ Yes ☐ No

Medication	**Dose**	**Reason for taking**	**Prescriber**

Preferred Pharmacy: _____ **Address:** _____ **Phone** _____

Past Medical History:

_____

_____

_____

GYN History (female):

Age of first menses: _____ First Day of last menses: _____

How many pregnancies: _____ Live births: _____ Miscarriage/Abortions: _____

Current Method of birth control: _____

If Menopause, Age: _____ Year _____

Previous endometrial ablation? _____ Previous hysterectomy? _____ Ovaries removed? _____

_____ _____ _____

GU History (Male):

History of impotence, BPH, prostate cancer or testicular cancer? If so please explain: _____

_____

Males/Females:

Any current or previous treatments with hormones? YES/NO If yes, describe including positive or negative effects_____

_____

_____

Preventative Health History: Please enter dates of most recent and details if abnormal.

Preventative Test	Date	Normal	Abnormal	History of Abnormal Details
PAP				
Mammogram				
Bone Density				
Colonoscopy				
Rectal Exam				
PSA				
Chest X-Ray				
EKG				
Exercise Stress Test				

Tetanus Vaccine: _____ Flu Vaccine: _____ Pneumonia Vaccine: _____

Tuberculosis Test: _____ Hepatitis Vaccine: _____ HIV Test: _____

Surgical and Hospitalization History:

_____

_____

_____

Family History:

List family members with the following health conditions. Please circle if cause of death.

☐ Heart Disease: _____

☐ Heart Attack before age 50: _____

☐ High Blood Pressure: _____

☐ Diabetes: _____

☐ Thyroid Disorder: _____

☐ Mental Illness: _____

☐ Genetic Disorder: _____

☐ Breast Cancer: _____

☐ Ovarian Cancer: _____

☐ Colon Cancer: _____

☐ Other: _____

Tobacco Use circle one, add details if needed

☐ **Has never smoked tobacco**

☐ **Former Smoker:** Year quit _____ Years smoking _____ Packs per day: ☐ ½ ☐ 1 ☐ 1½ ☐ 2

☐ **Current Smoker:** Desire Quitting? ☐ Yes ☐ No Years smoking _____ Packs per day: ☐ ½ ☐ 1 ☐ 1½ ☐ 2

Alcohol use:

Do you drink alcohol? ☐ Yes ☐ No if yes, how many drinks per week? _____

Do you have previous or current problems with alcohol? _____

Substance abuse:

Recreational drug use? ☐ Yes ☐ No Details _____

Prescription drug abuse? ☐ Yes ☐ No Details _____

Review of systems (ROS): circle all that apply

Constitutional: chills, fatigue, fever, weight change

Eyes: blurred vision, eye pain, photophobia

E/N/T: hearing problems, congestion, rhinorrhea, epistaxis, dental problems

Cardiovascular: chest pain, palpitations, fast heart rate, shortness of breath, edema

Respiratory: cough, painful breathing, coughing blood

Gastrointestinal: abdominal pain, heartburn, constipation, diarrhea, stool changes

Genitourinary: genital lesions, blood in urine, urinary frequency, painful urination, decreased libido

Female: abnormal vaginal discharge, abnormal vaginal bleeding, irregular menses, heavy menses

Male: erections less strong, difficulty urinating

Musculoskeletal: joint pain, back pain, muscle aches, decrease in strength or endurance, loss of height

Integumentary/breast: atypical moles, dry skin, itching, rashes, breast mass, nipple discharge

Neurological: dizziness, headaches, numbness/tingling, weakness

Hematologic/lymphatic: easy bruising, easy bleeding (not due to medication), swollen lymph nodes

Endocrine: hair loss, heat/cold intolerance, excessive thirst, excessive hunger, hot flashes, night sweats

Allergic/immunologic : allergies, frequent illnesses, HIV exposure, hives

Psychiatric/sleep: anxiety, depression, sleep disturbances, mood changes, irritability