PATIENT INFORMATION

Date _____

Name _____

DOB _____ **Email**_____

Address _____

City _____ **State** _____ **Zip** _____

SSN _____ **Pharmacy/City** _____

Home Phone # _____ **Cell Phone #** _____

Employer _____ **Employer Phone #** _____

Primary Insured Name _____ **DOB** _____

Primary Insurance_____ **Insurance Policy #** _____

Secondary Insurance _____ **How did you hear about us?** _____

_____ MALE _____ FEMALE _____ OTHER _____ S _____ M _____ D _____ W

Race/Ethnicity _____ **Primary Doctor** _____

IN CASE OF EMERGENCY

Name _____ **Relationship** _____

Address _____

City _____ **State** _____ **Zip** _____

Daytime Phone # _____ **Cell Phone #** _____

- Insurance is considered a method of reimbursing the patient for fees paid to the provider and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or balance not paid by insurance.
- In order to control your cost of billings, we request that Cardinal Healthcare's charge for office visits be paid at the conclusion of each visit. A $35 fee will be charged to your account for any checks returned for NSF.
- I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/or surgical benefits to which I am entitled to Cardinal Healthcare. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.
- In case that I do not have insurance, my insurance company denies or only partially pays my claim, I understand that I am fully responsible for any unpaid balance.

PATIENT SIGNATURE _____ **DATE** _____

LEGAL GUARDIAN SIGNATURE _____

HEALTH QUESTIONNAIRE

DATE _____

NAME_____ DOB_____

FAMILY MEDICAL HISTORY

Please list Maternal or Paternal

Alcohol / Drug Abuse:	☐ Yes	☐ No	
Anemia:	☐ Yes	☐ No	
Arthritis:	☐ Yes	☐ No	
Asthma:	☐ Yes	☐ No	
Cancer:	☐ Yes	☐ No	
Depression:	☐ Yes	☐ No	
Diabetes:	☐ Yes	☐ No	
Heart Attack:	☐ Yes	☐ No	
High Blood Pressure:	☐ Yes	☐ No	
High Cholesterol:	☐ Yes	☐ No	
Kidney Problems	☐ Yes	☐ No	
Liver Problems:	☐ Yes	☐ No	
Mental Illness:	☐ Yes	☐ No	
Stroke:	☐ Yes	☐ No	
Thyroid Disease:	☐ Yes	☐ No	

HISTORY OF PAST ILLNESSES

Have you had any of the following?

Childhood (Check all that apply) ☐ **Measles** ☐ **Chicken Pox** ☐ **Rheumatic Fever**

Adult (Check all that apply)

☐ **Anemia**	☐ **Arthritis**	☐ **Asthma**
☐ **High Blood Pressure**	☐ **High Cholesterol**	☐ **Abnormal Heart Rhythm**
☐ **Heart Failure**	☐ **Heart Attack**	☐ **Liver Problems**
☐ **Kidney Problems**	☐ **Alcohol/Drug Abuse**	☐ **Diabetes**
☐ **Stroke/ TIA**	☐ **Cancer**	☐ **Thyroid Problems**

Have you ever been hospitalized? _____ **When/What For?** _____

Have you ever had surgery?_____ **When/What For?** _____

LIFESTYLE & SOCIAL HISTORY

☐ **Weight Loss**	☐ **Weight Gain**	☐ **Seat Belts**	☐ **Bike Helmets**
☐ **Alcohol Use** (# of Drinks per week)	_____	☐ **Recreational Drug Use**	☐ **Special Diet**
☐ **Tobacco Use** (How long?)	_____	☐ **Exercise** (Frequency)	_____
☐ **If Cigarettes, how much per day?**	_____	☐ **<1 Pack** ☐ **1-2 Packs**	☐ **> 2 Packs**

PATIENT INFORMATION RELEASE FORM

DATE

NAME _____

DOB _____

I hereby authorize Cardinal Healthcare to contact and communicate by means of:

- ☐ Only Speak with Patient
- ☐ Only Speak with Designated Contact Person
  - Contact _____
  - Contact _____

- ☐ Approved to Leave Phone Messages
- ☐ Approved to Contact via Email

- ☐ Do NOT Leave Phone Messages
- ☐ Do NOT Contact at Work
- ☐ Do NOT Leave Medical Information on Phone Messages
- ☐ Do NOT Contact at Home

I hereby authorize Cardinal Healthcare to share my personal health information with:

- ☐ NO ONE other than myself and those required by law
- ☐ My Spouse
  - Name _____
- ☐ My Parents
  - Name _____
  - Name _____
- ☐ My Children
  - Name _____
  - Name _____
  - Name _____
  - Name _____
- ☐ My Friend
  - Name _____
- ☐ Other
  - Name _____

Patient/Legal Guardian Signature _____

Date _____

FINANCIAL POLICY

DATE

NAME _____

DOB _____

Thank you for choosing our office for your healthcare needs. We are committed to providing you and your family with the highest quality care. The following is a statement of our financial policies and your signature on this document indicates that you agree to the policies and will responsible for its terms.

INSURANCE COVERAGE

- Your healthcare insurance is a contract between you and your insurance carrier. If you have any questions about your insurance, we ask that you please contact your insurance carrier directly.
- Please make sure you give us a copy of your current insurance card at each visit.
- If a referral is required by your plan, your insurance carrier will require office notes, so you will need an office visit before a referral can be generated. This is a requirement by most insurance carriers and is not necessarily a requirement by our office, but will expedite your needs.

CO-PAYMENT

- Your healthcare insurance carrier is who decides the amount you pay at the time of your visit. This fee is required by your insurance company, per your plan, and is printed on your card.
- All co-pays are to be paid at the time of service upon checking in. If you do not have your co-pay, your appointment will be rescheduled. We accept cash, credit card and personal checks.

OUTSTANDING BALANCE

- If your account has an "outstanding balance", you will be expected to pay before your visit.
- If your account is greater than 90 days overdue, we will send your account to collection agency. You will receive a final notice first, giving you 15 days to bring your account current, before sending to collection agency. You will be responsible for any charges or attorney fees associated with collection agency.
- You are responsible for payment of any balance not paid by your insurance plan as designated by your insurance carrier.

MISSED APPOINTMENTS

- If you need to cancel your appointment, we kindly ask for 24-hour notice or when office opens on day of your appointment. A $25.00 "no show" missed appointment fee will be applied to your account if fail to keep your appointment without adequate notification. Exemptions to the policy will be determined by Cardinal Healthcare management based on situational factors.

RETURNED NSF CHECKS

- All returned (non-sufficient funds) checks will have a $35.00 charge applied to the account and no further checks will be accepted, only cash or credit card.

FORM FEES

- Any form or letter required by our staff to complete will be charged $20.00 for up to 4 pages, $10.00 for single page forms. These forms/letters include but are not limited to; Disability, Leave of Absence, FMLA, Work/School Physicals, Jury Duty excuses, DMV, and 504-requests.
- We require up to 5 days to complete forms/letters and payment is due at time of pick up.

PATIENT SIGNATURE _____ **DATE** _____

TRIAGE FORM

DATE TIME

NAME _____

DOB _____ **PHONE #** _____

PHARMACY _____ **ALLERGIES** _____

- Reason for Being Seen Today _____
- Symptoms _____
  - When did symptoms start? _____

CIRCLE ALL THAT APPLY TO YOUR MEDICAL HISTORY

Diabetes	Heart Problems	High Blood Pressure	Bleeding Disorder	Lung Disease
Thyroid Disorder	Immune Disease	High Cholesterol	Cancer	Stroke

- Current Medication List _____
  - _____
  - _____
  - _____
  - _____

INITIAL EACH STATEMENT IN ACKNOWLEDGEMENT OF INFORMATION

_____ I acknowledge the medical information above to be true, accurate, and complete.
_____ Please remember that insurance is considered a method of reimbursing the patient for fees paid to the Provider and is not a substitute for payment. In the case that I do not have insurance, my insurance denies, or partially pays my claim; I understand that I am fully responsible for any unpaid balance. I acknowledge that Cardinal Healthcare is out of network with some insurances, I understand that regardless of my insurance or out of network status, I am responsible for any amounts due to Cardinal Healthcare after processing of an insurance claim.
_____ I have received and understand Cardinal Healthcare's HIPPA and Privacy Practices information.

PATIENT/GUARDIAN SIGNATURE _____

CARDINAL HEALTHCARE STAFF TO COMPLETE

HEIGHT _____	WEIGHT _____	O2 LEVEL _____
B/P _____	PULSE _____	TEMP _____