Patient Partnership Agreement

Take a proactive role in your health. I understand that I am responsible for my health and that I am entering into this partnership to help achieve the best possible health for me. My physician will make recommendations regarding certain health screenings during my annual health exam appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears, etc.) in order to optimize my health and detect any potentially serious health conditions. I understand that if I don't complete these screenings I place myself at risk.

Keep follow up appointments and reschedule appointments 48 hours prior to appointment date. I understand that my physician will want to know how my health changes after my appointment and throughout the year. Regular visits with my physician provide opportunities for ongoing assessments of my health.

Call the office when I do not hear the results of any diagnostic tests. I understand that my physician's goal is to report all my diagnostic test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my results.

Inform my doctor if I choose not to follow the recommended treatment plan. I understand that after examining me, my physician may make certain recommendations based on his or her assessment. This might include prescribing medication, referring me to a specialist, ordering diagnostic tests, or even asking me to return to the office within a certain time period. I understand that not following my treatment plan can have serious negative effects on my health. I will inform my physician whenever I decide not to follow recommendations so that my physician may fully inform me of any risks associated with my decision to not follow treatment plan recommendations.

Privacy Preferences

As your health partner, we often have to communicate sensitive, personal health information. This information is protected by federal privacy laws and serves as:

- A basis for planning my care and treatment
- A means of communication between health professionals on my team
- A tool for routine health care operations such as assessing quality and outcomes
- A source of information for creating my bill for health service

Please indicate your privacy preferences below:

1. List the individuals whom may share your personal health information with:

2. List the physical address that we can send your personal health information:
   ☐ Same as Home Address ☐ Different Address ____

3. May we leave personal health information on a voicemail? ___yes ____no

   If "yes" what is the preferred phone number? ☐ Home ☐ Cell ☐ Other ______________________

In addition, I acknowledge by my signature below that I have the right to be provided a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. Should any further questions, comments, or concerns arise please do not hesitate to contact our offices.

______________________________ ______________________________ ______________
Print Name Signature Date

OC Sports and Wellness Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care. Your clear understanding of our practice financial policy is important to our professional relationship. We make every effort to keep our fees reasonable. Payment of your bill is considered part of your overall treatment. In order to keep healthcare costs to an absolute minimum, we have adopted the following policies.

Fees are standard and based on the complexity of your visit. Payment in full is required at the time of your visit and can be made with cash, personal check, Visa, MasterCard, American Express or Discover

Insurance co-payments are due at the time of service. If you are unable to pay your co-payment at your visit, your appointment may need to be rescheduled.

Not all services are a covered benefit in all policies, so it is very important that you understand the provisions of your individual policy. Insurance companies select certain services that they will not cover therefore we can't guarantee payment of all claims by your insurance company. Reduction or rejection of your claim does not relieve you of your financial responsibility.

PLEASE NOTE: Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses are made based on medical information, not based on coverage by insurance companies. To request a diagnosis change solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and is considered insurance fraud.

Required at check in:

1. Verify personal contact information
2. Present current picture ID
3. Payment of any outstanding balance
4. Payment of today's visit

We will verify your coverage at each visit. If we're unable to do so, you will be considered self-pay & will be responsible for your visit.

Medicare

We gladly accept patients with Medicare and will bill our services at the allowed rate. Medicare regulations require that you sign an Advanced Beneficiary Notice (ABN) at every visit. This form helps to explain which service Medicare may not cover and may be your responsibility. Lab work will require a separate ABN signature.

Annual physicals and Well Woman Exams

Please verify that your insurance will cover these preventative services before making your appointment. Depending on your age and the plan, these services may not be covered. Also, some insurance companies are very strict in enforcing time limits between visits and may not cover your visit if you are even one day early.

Returned check charge – Non sufficient funds checks are subject to a $25 fee (in addition to fees from your bank)

Collections charge – Accounts that are not paid within 60 days from the due date may be sent to an external collection agency. In addition to your outstanding balance, a $10 collection fee will be added to cover our cost. In addition, you may be removed from our practice.

Lab charges- Depending on your insurance, you may get a separate bill from the lab facility that performs your lab work. These charges should be discussed directly with the lab facility. It is your responsibility to let the technician know what lab is preferred through your insurance company.

No Show and Cancellation Policy – We will access a $50.00 charge for all missed appointments and cancellations with less than a 24 hour notice.

Patient name:_____________________________ Patient Signature: __________________________ Date: _____________

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Registration Form

PATIENT INFORMATION

Last Name First Name Middle		Marital Status Single / Married / Divorced / Widow
Street Address City State Zip		
Birthdate	Sex Male Female	Social Security #
Email Address (for the patient portal and newsletters		Occupation
Home Phone ( )	Cell Phone ( )	Work Phone ( )
If Minor, Legal Guardian Name:		Guardian Phone ( )
Emergency Contact	Relationship	Phone

How did you hear about our clinic? Family Friend Physician Search Health Ins Other	What features in a clinic do you value most? _______________ Same Day Appts Online Scheduling No Wait Extended Hours

INSURANCE INFORMATION

Primary Insurance Name Primary Insurance ID # Phone Number Subscriber Name	Secondary Insurance Name Secondary Insurance ID # Phone Number Subscriber Name

Statement of Insurance Eligibility

Many individuals use health insurance to pay a portion of their health services. We require that each individual paying for their health services with health plan benefits sign a form declaring their eligibility as well as acknowledging that they are still responsible for payment of their health services should they be found ineligible for any reason.

I certify and declare that I am eligible for health plan benefit coverage as demonstrated by my presenting of my health ID card and that I have chosen OC Sports and Wellness top provide health services to me.

Furthermore, I certify and declare that if I am found ineligible for health plan coverage, I will be financially responsible for all costs incurred during the delivery of health services and agree to pay these charges to OCSW.

If I do not have health insurance, I agree to pay in full for services rendered on the day I receive them unless payment plan has been previously agreed upon.

____ _____________________

Patient/Guardian Signature Date

Health History

Drug Allergies – List all medications you are allergic to	Reactions:

Medications – List all medications you are currently taking and the doses	

Supplements – List all supplements and vitamins you are currently taking on a regular basis	

Family History – Fill in information about your immediate family	
Father: Living Deceased [Age of death ______] Health Conditions:	Mother: Living Deceased [Age of death ______] Health Conditions:
Brother: Living Deceased [Age of death ___] Health Conditions:	Sister: Living Deceased [Age of death ___] Health Conditions:
Brother: Living Deceased [Age of death ___] Health Conditions:	Sister: Living Deceased [Age of death ___] Health Conditions:

Social History – Please answer the following questions	
Do you Smoke? Yes No If Yes, How much per day? ________	Do you have prior smoking history? Yes No
On Average, how many alcoholic beverages do you consume per **WEEK**? Zero 1-2 3-4 5-6 7 or more	
On Average, how many caffeinated beverages do you consume per **DAY**? Zero 1-2 3-4 5-6 7 or more	
On Average, how many hours do you sleep per **NIGHT**? Less than 4 hours 4-6 hours 6-8 hours 8 or more hours	
On Average, how many days per **WEEK** do you exercise? None 1-2 days 3-4 days 5-6 days 7 days per week	
What is your average stress level? None Mild Moderate High	

What are your current health conditions/issues/concerns?