Children's Center for Holistic Heart Health

4 Forest Avenue, Suite 203, Paramus, NJ 07652
Phone: 551-276-2710 Fax: 201-820-3375

Patient Intake Form
Date: _____
Personal Information:
Name:
_____
Address:
_____
City: _____ State: _____ Zip Code: _____
Cell Phone: _____ Work/Home Phone: _____
SSN: _____ Gender: M or F or Binary Age: _____
Date of Birth: _____
Marital Status: _____ Email: _____
Parent's Name: _____Occupation: _____
Reason for Visit: Chief Complaint (Why are you here?):
_____
Primary Care Physician, address and phone:
_____
Local Pharmacy:
_____
Mail Order Pharmacy:
_____
Emergency Contact Information:
Name of Person: _____ Phone: _____
Relationship with the person: _____
Insurance/ Billing Information:
Primary Insurance: _____ Relationship with patient: _____
Policy Number: _____ Group Number: _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____
Subscriber's ID/Policy Number: _____ Group Number: _____
Secondary Insurance Name: _____ Relationship to patient:_____
Subscriber's Name: _____Subscriber's Date of Birth: _____
Subscriber's ID Policy Number: _____ Group Number_____

Signature of Responsible Person: _____
Date: _____

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Medical History Form

Date: _____

Patient's Name: _____

DOB: _____

Past Medical History: (Circle all that apply and explain):

Congenital Heart Disease Asthma Breathing problems Diabetes High blood pressure
Growth problems Feeding problems

List here if not mentioned above:

_____

_____

Birth History:

Birth order: _____ Weeks of gestation:_____ Birth weight:_____

Vaginal Delivery/C-section: _____ Hospital of birth:_____

Pregnancy complications if any: _____

Medications (please list name, dose, and frequency:

Past Surgical History:

_____ _____

_____ _____

Allergies: No Drug Allergies (Circle it if no drug allergies)

_____ _____

_____ _____

Social History: (Circle all that apply)

- School _____ Grade_____ Siblings _____
- Leisure activities/Sports: _____
- Tobacco exposure or personal history of smoking: _____
- Alcohol/Illicit drugs: _____

Family History:

Relationship	**Condition**
Father	_____
Mother	_____
Brother	_____
Sister	_____
Grandparents	_____

Symptoms in last 6 months (Circle if symptoms present):

No Symptoms

1 Constitutional Fever, fatigue

2 Eyes Droopy eyelid, double vision

3 Ear, Nose, Throat – ENT Hearing loss, difficulty in chewing/swallowing, nasal congestion/discharge

4 Endocrine – Hormone Weight gain/loss, Heat/cold intolerance

5 Cardiovascular – Heart Chest pain, shortness of breath, excessive sweating, palpitations, dizziness, fainting

6 Respiratory – Lung Shortness of breath, cough, chest congestion

7 Gastroenterology – GI Constipation/diarrhea, nausea, vomiting

8 Renal – Kidney Swelling of feet, foul smelling urine, blood in urine

9 Extremities Swelling, redness on legs

10 Skin Rash, ulcer, itching

11 Hematology Easy bruising, enlarged glands

12 Psychiatry Depression/anxiety, mood swings

13 Neurology Seizure, passing out episode, confusion, tingling, numbness

14 Musculoskeletal Neck pain, lower back pain

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Patient Name: _____ Date of Birth: _____

Financial Policy

o Copays, deductibles and outstanding balances are due upon arrival. Payments are due at the time services are rendered. We accept Cash, Credit/Debit Cards, HSA Cards, and Checks. There will be a $35 service charge for NSF of a returned check.

o It is the patient's responsibility to inform our office if you need to cancel or reschedule an appointment at least 24 hours in advance. There will be a $25 No Show/ Same Day Cancelation fee if done without a 24-hour notice.

o Patients are responsible to pay for any test/injections or procedures that insurance does not cover.

o It is the patient's responsibility to verify with their insurance about what service and treatment plans are covered by their insurance. If we submit claims and insurance rejects or denies the claim, the patient will be responsible for the payment.

o All payments and balances due must be paid within 30 days of receiving a statement in the mail. No new appointment can be created until this balance is paid in full. If payment is not paid within 3 billing cycles, then the patient will be discharged from the practice. Once a patient has been discharged from this practice, he cannot be treated by this office any longer. This includes but is not limited to medication refills and filling out any paperwork.

o If we turn the pending balance on account to the collection agency, the fees associated with the collection agency will be the responsibility of the patient.

o There is a $ 35 charge for ALL forms needed to be filled out by the doctor.

Medication Refills

o We cannot fill any medication refills if you do not come for your follow-up appointment.

o Due to the high volume of telephone refill requests, we ask all patients to have all their medicines refilled at the time of their visit. If you call us after your visit, a fee of $ 25 will be charged.

o All referrals/pre-certifications and authorizations will be called in by our nurse 48 hours after your appointment.

Updated Patient Information and Insurance

o You must bring all your insurance cards to your appointment. We re-verify insurance coverage at every visit.

o Please be sure to inform staff of any changes to your address, phone number, or insurance as soon as possible. We cannot give you any important information regarding your health if we do not have this.

o If you have new insurance, please call our office as soon as you get your new ID number so that we can verify BEFORE you come to your next appointment. This allows us to get you in quicker as less time will have to be spent on verifying your insurance. It is the patient's responsibility to verify that our office accepts their insurance. If your insurance denies any payment, it is the patient's responsibility to pay for their visit.

Photo Consent

o By signing this form, you are authorizing our practice to obtain photo documentation so that we may be able to properly identify you for medical treatment.

Patient or Responsible Person: _____ Relationship: _____
Signature of Patient or Responsible Person: _____ Date: _____

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Due to recent federal privacy guidelines (HIPAA), Children's Center for Holistic Heart Health (C2H3) is not allowed to release information to anyone other than the patient (or guardian of the patient) unless there is explicit authorization given to authorize C2H3 permission to discuss personal medical information with someone other than the patient or guardian of the patient. Please fill this form to allow us to discuss your information with the people of your choosing as listed below.

I, give Children's Center for Holistic Heart Health permission to release/ discuss personal health information, which includes the pickup of prescriptions and/or financial information
to/with:
Name: Relationship: Phone:

Name: Relationship: Phone:

Name: Relationship: Phone:

Name: Relationship: Phone:

I understand that I may revoke this authorization at any time by sending a written notification to C2H3. **By signing this form, all previous lists of allowable contacts become invalid.**

Patient Signature: Date:
Witness Signature: Date:

I, decline to give C2H3 permission to release/ discuss my personal health and/or financial information to anyone other than myself.

Patient Signature: Date:
Witness Signature: Date:

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Authorization for Disclosure of Protected Health Information (PHI)

Patient Name: _____ Patient DOB: _____ Address: _____ City: _____ State: _____ Zip: _____
Social Security Number: _____ Telephone: _____

I hereby AUTHORIZE Children's Center for Holistic Heart Health to
Release Information to AND/OR Obtain Information from
Name of Person/Company: _____
Phone Number: _____ Fax Number: _____
Address: _____ City: _____ State: _____ Zip: _____

Please Select Information to be Disclosed:
All my PHI (medical records) Lab Reports Progress Notes Diagnosis
History and Physical Billing/ Financial Information Medication List
Other:
Purpose of Disclosure of Information:
Continuation of Care My Personal Use Litigation Other:

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the address listed above. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before they received my written notice of revocation.

By signing this authorization, I hereby authorize the entities listed above to disclose my personal health information. I understand that information contained in my PHI may include information related to sexually transmitted disease(s), 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. By signing this authorization, I understand that my PHI described herein may be disclosed by the entities above to receive and use my PHI and that my PHI described herein may no longer be protected by federal privacy regulations.

Patient Name: _____Date: _____
Legal Representative: _____Date: _____
Relationship to Patient: _____
Witness: _____Date: _____

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ASSIGNMENT OF BENEFITS, AGREEMENT, AND GUARANTY

I authorize C2H3 to release any information regarding services rendered to me to third party payers in consideration of payment for my care or to other healthcare providers involved in my care. I understand payment of all insurance benefits, basic and major medical for this period of service must be made directly to C3H3. If the check must be made out to me, I understand the check must be sent to this address: Children's Center for Holistic Heart Health, 4 Forest Avenue, Suite 203, Paramus, NJ 07652.

I understand that C2H3 must collect for all charges not covered by insurance payments. Payment for all collection costs, securing, or attempting to collect necessary otherwise is the financial responsibility of the patient or guardian. Patients who are considered a legal adult are financially responsible for all services rendered.

C2H3 NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

I acknowledge that a copy of the Notice of Privacy Practices for C2H3 has been made available to me. In connection with the notice, I also acknowledge that I have been provided with an opportunity to ask any questions regarding the notice and its contents.

EXPRESS PERMISSION TO CONTACT PATIENT BY CELL PHONE

I agree in order for C2H3 to service my account or collect monies I owe C2H3 their/our agents may contact me by any telephone number associated with my account, including wireless telephone numbers, which can result in charges to me. C2H3 may also contact me by sending text messages or emails, using any email address I provided. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing divides as applicable. I have read this disclosure and agree that C2H3, its employees, and/or agent may contact me as described above.

Patient/ Legal Rep Signature: Date:

Legal Rep Relationship to Patient Date:

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Patients' Rights and Responsibilities

Please Keep for Your Records

1. Care shall be provided impartially without regard to race, creed, sex, or national origin.
2. Patients are entitled to considerate, respectful, and dignified care always.
3. The patient has the right to receive care in a safe setting.
4. Patients are entitled to personal and informational privacy as required by law. This includes the right to:
a. Refuse to see or talk with anyone not officially affiliated with C2H3.
b. Wear appropriate personal clothing, religious, or other symbolic items that do not interfere with prescribed treatments or procedures.
c. Examination in reasonably private surroundings, including the right to request a person of one's own gender present during certain physical examinations.
d. Have one's medical records read and discussed discreetly.
e. Confidentiality regarding one's individual care and/or payment sources'
f. Data Privacy Rights as described in the Notice of Privacy Practices.
5. Patients and/or patients legally designated representatives have the right of access to information contained in the patient's medical record, within the limits of the law and in accordance with C2H3 policies.
6. Patients of C2H3 have the right to know the identity and professional status of all persons participating in their care.
7. Patients are entitled to know the status of their condition including diagnosis, recommended treatment and prognosis for recovery.
8. Patients have the right to be free from physical restraints which are not medically indicated or necessary.
9. Patients have the right, in collaborating with their physicians to make decisions involving their health care, including acceptances or refusal of medical care or treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
10. Patients are entitled to formulate advance directives and appoint a surrogate to make healthcare decisions on their behalf of the extent permitted by law.
11. Patients are entitled to receive an itemized detailed explanation of charges related to services rendered on their behalf.
12. Patients will not be transferred to another facility or location without explanation of the necessity of such action.
13. A patient's guardian, next of kin, or legally authorized responsible person may exercise, to the extent permitted by law, the rights delineated on behalf of the patient if the patient has been judged incompetent in accordance with the law, or procedure, or is unable to communicate his/her wishes regarding treatment or is a minor.
14. Patients have the right to appropriate assessment and management of pain.
15. Patient have the right, subject to the patient's consent, to receive visitors whom they designate, including, but not limited to, a spouse, domestic partner (including same-sex domestic partner), another family member, or a friend. Patients have the right to withdraw or deny any such consent at any time. 16. Patients are responsible for providing C2H3 with complete and accurate information regarding present and past illnesses and operations, hospitalizations, medications, and other health related issues, including any unanticipated changes in their condition.
17. Patients are responsible for following recommended treatment plans prescribed and/or administration.
18. Patients who refuse prescribed treatments or do not follow their practitioner's instructions assume full responsibility for the consequences of such actions.
19. Patients are responsible for ensuring prompt and complete payment of their account at C2H3.
20. All patients must follow C2H3 rules and regulation relative to patient care and conduct. This includes consideration and respect for the rights and property of other patients and C2H3 providers and staff, as well as responsibility for the actions of their visitors and guests.

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Patient Credit Card on File Agreement

Preauthorized Credit

We have implemented a policy which enables you to maintain your credit card information securely on file with Children's Center for Holistic Heart Health, LLC. In providing us with your credit card information, you are giving us permission to automatically charge your credit card on file for your co-pay, deductible etc. at the time of service. By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

Co-pays & deductible (not met) are due at time of the office visit.

Outstanding Balance: If your insurance provider has paid their portion of your bill [or any other patient(s) you have listed on this form] and there is an outstanding balance owed, we will notify you via phone and/or email. If we do not receive a response from you or your payment in full within 5 days, at that time, any balance owed will be charged to your credit card. A copy of the charge will be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed below.

I authorize _____, to charge co-pays and outstanding balances on my account to the following credit card:

Visa	MasterCard	American Express	Discover
☐	☐	☐	☐

Credit Card Holder's Name: _____

Card number _____ CVV number: _____

Expiration Date: _____

If you wish to leave this credit card on file for other patient(s), please print name(s) below:

Patient Full Name: _____
(Please Print)

Patient Full Name: _____

Patient Full Name: _____

Patient/Parent Signature: _____ Date: _____