**Family Wellness Center**

**DR. SAMUEL O. LEON**

**560 W GRANGEVILLE BLVD, SUITE C, HANFORD, CA. 93230**

**PHONE: (559) 583-1110 FAX: (559) 583-1121**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Sex: M / F (Circle One) Married / Single / Divorced / Widow

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address if different from above:

 (Street) (City/State/Zip)

Cell Phone #: (\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ Home #: (\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ Other: (\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_

E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***How did you hear about our practice***? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Person responsible for bill or parent (Complete only if different from patient)**

**Primary Insurance Information**

Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I.D. Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guarantor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_ \_-\_ \_\_\_-\_\_\_\_\_\_

Relationship to Patient: (please check): ( )Self, ( ) Spouse, or ( ) Parent Date of Birth: \_\_ \_-\_\_ \_-\_\_ \_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_

**Who to call for an emergency:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

What medical Conditions do you have? Select all that apply, or write in if not listed:

Diabetes\_\_\_ High Blood Pressure\_\_\_ Thyroid Disorder\_\_\_ Heart Disease\_\_\_\_ High Cholesterol\_\_\_\_
Arthritis \_\_\_\_ Cancer\_\_\_\_ Kidney Disease\_\_\_\_ Glaucoma \_\_\_ Asthma\_\_\_\_ Allergies\_\_\_\_
Migraine Headache \_\_\_\_ Anemia\_\_\_\_ Bronchitis/Emphysema\_\_\_\_ Obesity\_\_\_\_ Acid Reflux \_\_\_\_\_

 **Women Only**: Age of first menstrual cycle\_\_\_\_\_\_ Date of last period \_\_\_\_\_\_\_
 Do you have a history of irregular menstrual cycles?\_\_\_\_\_\_\_\_ (Y / N)
 Are you currently on birth control?\_\_\_\_\_\_\_ If yes, what type / name?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Number of pregnancies? \_\_\_\_\_\_\_\_ # of live births? \_\_\_\_\_\_\_\_\_\_\_ # of Miscarriages?\_\_\_\_\_\_\_
 Have you had an abnormal Pap result? \_\_\_\_\_\_\_\_\_ If yes, when? (year)\_\_\_\_\_\_\_\_
 How often do you self-breast exam? (circle one) Never Rarely Weekly Monthly

**SURGICAL & HOSPITALIZATION HISTORY**

**List all of surgeries or hospitalizations (with cause) and the year:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL**

How much do you smoke?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many years?\_\_\_\_\_\_\_\_\_\_\_\_\_\_
How much alcohol (including beer) do you drink in week?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Have you used or currently use recreational drugs? YES\_\_\_ NO\_\_\_ If yes how long\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Please list people you currently live with:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Are you: \_\_\_\_Single \_\_\_\_Married \_\_\_\_Divorced \_\_\_\_Other?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Is your health (check one) \_\_\_\_Excellent \_\_\_\_Good \_\_\_\_Poor

**FAMILY HISTORY**

Please list if any family members have had the following illness. Please list their relation to you.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Family Member | Current Age | Living? (Y /N) | Medical Conditions | Cause of Death (if deceased) | Age at Death |
| Mother |  |  |  |  |  |
| Father |  |  |  |  |  |
| Sister |  |  |  |  |  |
| Sister |  |  |  |  |  |
| Brother |  |  |  |  |  |
| Brother |  |  |  |  |  |

*\*\*Continue on bottom of page if more\*\**

**HEALTH MAINTENANCE**

**Please list the year of your last screening test below: (please indicate if there were any abnormal results)**

PAP smear: \_\_\_\_\_\_\_\_\_\_ Mammogram: \_\_\_\_\_\_\_\_\_\_ Colonoscopy: \_\_\_\_\_\_\_\_\_\_ Eye Exam: \_\_\_\_\_\_\_\_\_\_

Cholesterol Test: \_\_\_\_\_\_\_\_ Prostate Exam: \_\_\_\_\_\_\_\_\_ Dental Exam: \_\_\_\_\_\_\_\_\_\_ Blood Work: \_\_\_\_\_\_\_\_

**Immunizations/vaccine- Please list the year of your last:**

Tetanus Shot: \_\_\_\_\_\_\_\_ Flu Shot: \_\_\_\_\_\_\_\_ Pnemovax (Pneumonia shot): \_\_\_\_\_\_\_\_ Hepatitis A\_\_\_\_\_\_\_\_ Hepatitis B: \_\_\_\_\_\_\_\_ Chicken Pox: \_\_\_\_\_\_\_\_ TB Skin Test:\_\_\_\_\_\_\_\_\_

**Medications currently taking (with dosage):**

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dosage** | **The time(s) of the day you take it** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Allergic reactions to medicine or foods: Please list the TYPE OF REACTION.**

Medication / Food Allergy Reaction

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial & Health Services Policy**

Welcome to *Family Wellness Center*. We are pleased you have chosen our practice for your medical care. We ask that you **carefully read** and sign the following statement. We must emphasize that, as your medical care provider, our relationship is with you and **not** your insurance carrier. As a courtesy to you, we will file your claim with your insurance company. However, **you are the sole responsible party for all charges incurred and guarantee payment** thereof. If we are contracted with your insurance company, including Medicare, we will accept assignment**. You will be responsible for your payment portion at the time of service**. F**ailure to provide current, accurate billing information will result in all charges for service becoming the sole responsibility of the patient/responsible party.** You are expected to understand your benefits coverage and responsibilities**. All co pays, co-insurance and deductibles are due and payable at the time services are rendered.** If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payment at the time services are rendered.

*In consideration of the services performed by Family Wellness Center you agree to abide by the terms of this Financial Statement.*

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Patient Initials*****PATIENT AUTHORIZATION**

I certify that I, and /or my dependent(s), have insurance coverage with **(insurance company)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

And assign directly Family Wellness Center all insurance benefits, if any, otherwise payable to me for services rendered. I request payment form all insurance’s including Medicare be made directly to Family Wellness Center. I authorize the use of my signature on all insurance submissions. Family Wellness Center may use my health care information and may disclose such information to the above name insurance carrier for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

**PRESCRIPTION MEDICATION POLICY**
Family Wellness Center is committed to providing quality health care services for our valued patients. In keeping with this commitment, we discourage any potential issues of fraudulent use or abuse of controlled medications. It is our policy here at Family Wellness Center, which **no Schedule I or Schedule II pain medications will be prescribed** from our facility. If an intense course of pain management is warranted, we will assist patients with transitioning their healthcare to a Pain Management specialist.

*I certify that the above information I have provided on this form is correct. By signing, I understand and will follow the policy stated in this contract.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Signature of Patient, Parent or Guardian**  **Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Print Name of Patient Parent or Guardian**

Protected Health Information (PHI) / HIPAA

**Patient Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WE ARE PERMITTED TO USE, AND MAY BE REQUIRED, TO DISCLOSE YOUR PHI UNDER SPECIAL CIRCUSTANCES:**

1. **Disclose Required By La**w: Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law, including health oversight activities, court or administrative orders or similar legal proceedings.
2. **Public Health Risk:** Our practice may disclose your PHI to public health authorities who are authorized to collect information for such purposes as maintaining vital records, preventing or controlling disease, injury, or disability; or notifying a person regarding potential exposure to a communicable disease.
3. **Serious Threats to Health of Safety**: Our practice may disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.
4. **Deceased Patients:** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
5. **Organ Donor:** Our practice may release PHI to a medical facility for tissue procurement of transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

Our practice may contact you or your authorized representatives (see authorization form attached) to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The practice will routinely contact patients via telephone at home and /or work, via mail at home, and unless otherwise requested, may leave messages on the appropriate voic3e mail or answering service regarding appointments and billing questions.

**There will be no information given over the phone or fax in reference to lab results. Each patient is given this information during their examination, and they are to schedule a follow-up visit to obtain lab results.**

**In addition an advanced fee will be accessed for copy and mailing of all medical records information.**

**There will be a fee of $15 dollars to complete medical forms containing 1-2 pages, and $25 for forms that contain 3 or more. Medical forms such as: school physicals, work physicals, itemized statements, and any other form(s) which may require the use of your medical record to complete your request.**

**FAMILY WELLENESS CENTER**

**Samuel O. Leon, MD.**

**560 W. Grangeville Blvd, Ste #C**

**Hanford, CA. 93230**

**(559) 583-1110- Tel**

**(559) 583-1121- Fax**

INSURANCE COVERAGE WAIVER

 I understand that my eligibility for coverage by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 cannot be confirmed at this time. I wish to receive medical service from **Dr. Samuel O. Leon,**

if it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Legal Guardian Date

 **Family Wellness Center**

560 W. Grangeville Blvd, Ste C

Hanford CA 93230

Phone (559)583-1110

 Fax (559)583-1121

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I authorize Family Wellness Center to deliver or cause to be delivered the following types of messages by voice call or text messaging using an automatic telephone dialing system or an artificial prerecorded voice:

* Appointment Reminders
* Visit recalls
* Situation/seasonal services suggestions (such as flu shots, etc.)

I authorize such message to be delivered to the following phone number (s):

(\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_

Cellphone

(\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_

Landline

I understand that by signing the agreement, I am authorizing Family Wellness Center to deliver or cause to be delivered or cause to be delivered to me certain text messages and / or voice calls and that I am not required to sign this agreement in order to receive services from Family Wellness center.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Date