HC Medical Group

DEMOGRAPHICS

Mulberry Integrative Medicine

Name	
Address	
City, State and Zip	
Home Phone	
Cell Phone	
Email Address	

Date of Birth	
Social Security #	
Gender	o Male o Female
Marital Status	o Married o Widowed o Divorced o Partnered o Single
Ethnicity	o White o Hispanic o Latino o African American o Other
Preferred Language	o English o Spanish o Other
Contact Preference	o EMAIL o Phone o Mail

Primary Insurance and Number	
Secondary Insurance and Number	
Primary Cardholders Name	

I, (print name)_____ have received or reviewed a copy of this office's Notice of Privacy Practices located on the front glass window of this office.

*Print Name:*_____

*Date:*_____

*Signature:*_____

HC MEDICAL GROUP

INTAKE FORM

Today's Date:_____

Chief Complaint or primary reason for today's visit:

_____

_____

Onset of complaint (date): _____

Scale intensity (1 being low-10 being high)_____

Frequency and duration of complaint:_____

Do you have any allergies to Medications?(if yes, please describe allergy and reaction)_____

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING (Circle FOR YES, LEAVE BLANK FOR NO)

Limited joint mobility	Neck Pain
Joint pain	Back Pain
Muscle pain	Difficulty walking
Stiffness in joints or muscles	Trouble reaching above head
Tenderness in joints or muscles	Difficulty rising from sitting position

MEDICATIONS

o Please mark this circle if you are submitting this separately

Medication	Dose	Frequency

PAST MEDICAL: Please circle if you have experienced problems with any of the following:

Neck Pain	Cancer of the lung	Heart Failure
Back Pain	Cancer of the ovaries	Heart Murmur
Difficulty Walking	Cancer of the skin	High Blood Pressure
Trouble reaching above head	Cancer of the uterus	Kidney Problems
Difficulty rising from sitting	Abnormal Chest X Ray	Liver Disease
Irritable Bowel Syndrome	Cholelithiasis (gallstones)	Lymphoma
Migraine	High Cholesterol	Abnormal mammogram
Alzheimer's disease	Colon Problems	Melanoma
Anemia	Colonoscopy	Osteoporosis
Angina	COPD	Abnormal Pap Smear
Anxiety	Depression	Peptic Ulcer
Arthritis	Diabetes	Positive TB Skin Test
Atrial Fibrillation	Abnormal EKG	Seizures
Bladder Problems	Exposure to hazardous substances	Sexually Transmitted disease
Blood Clots	GERD	Sigmoidoscopy
Blood transfusion	Glaucoma	Stroke
Cancer of the breast	Hay Fever	Abnormal occult blood test
Cancer of the colon	Heart Attack	Thyroid Disease
Other:_____		TIA

Family History

Has anyone in your family had any of the following conditions: Please circle

Alcoholism	Cancer of prostate	Heart Disease
Anemia	Cancer of uterus	High Cholesterol
Arthritis	Cancer, unspecified	Hypertension
Asthma	Colon polyps	Osteoporosis
Cancer of Breast	Depression	Pulmonary Embolism (DVT)
Cancer of Colon	Diabetes	Stroke
Cancer of Ovaries	Glaucoma	Thyroid Disease

Surgical History-Please circle if you have had any of the following

Dilation and curettage	Coronary Artery Bypass Graft	Thyroidectomy
Aortic Valve Replacement	Deviated septum repair	Tonsillectomy
Appendectomy	Hemorrhoidectomy	Hip replacement
Back Surgery	Hysterectomy	Knee replacement
Bladder Surgery	Lasik	Trigger finger release
Breast Biopsy	Lens implants	Tubal ligation
Bunionectomy	Lobectomy	Mastectomy
Cardiac pacemaker	Lumpectomy of breast	Vasectomy
Carpal tunnel syndrome	Mitral Value Replacement	Other _____
Cataract Extraction	Myringotomy tube	_____
Cesarean Section	Ovarian Cyst removal	_____
Cholecystectomy	Prostate surgery	_____
Colectomy	Thryoid cysts	

Social History- Please circle any that apply to you

Alcohol Use	Former Smoker	Lives alone
Never Smoked	Other tobacco use	Has pets
Have Children	Passive smoker	Employed
Caffeine	Past drug use	Retired
Exercise	Current drug user	Receives disability
Current Every Day smoker	Seat belt use	Abused
Current some day smoker	Follows a diet	Sexually active

Please let us know of any other significant issues that may have not been covered in this intake: _____

Name:_____ Date:_____

Patient or legally authorized signature:_____

HC MEDICAL GROUP

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

To provide timely and accurate payment to HC Medical Group, Inc. for any services furnished the patient listed above by HC Medical Group, Inc. physicians and health care providers:

- I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists.
- I assign my right to receive payment of authorized benefits to HC Medical Group, Inc. .
- I request that payment of authorized benefits be made on my behalf to HC Medical Group, Inc. * for any services furnished the patient listed above by HC Medical Group, Inc. physicians and health care providers.
- I authorize HC Medical Group, Inc. to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided.
- If my Health Insurance Plan will not direct payment to HC Medical Group, Inc. , I agree to forward to HC Medical Group, Inc. all health insurance payments which I receive for the services rendered by HC Medical Group, Inc. and its health care providers.
- I authorize HC Medical Group, Inc. or any holder of medical information about me or the patient listed above to release to my Health Insurance Plan such information needed to determine these benefits or the benefits payable for related services.

I further acknowledge and agree:

- That I am responsible for all charges for services provided to the patient listed above which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan.
- That I agree to pay all charges which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan.
- I further agree that, if permissible by law, I will reimburse HC Medical Group, Inc. for all costs, expenses and attorney's fees that may be incurred by HC Medical Group, Inc. to collect those charges.
- That this financial form with assignment of benefits applies and extends to subsequent visits and appointments at HC Medical Group, Inc.

I certify that I have read and understand the above statements, that all of my questions have been answered to my satisfaction, and that I agree with each statement above.

_____	_____	_____
Patient/Person Legally Responsible	**Relationship to Patient**	**Date**

HC MEDICAL GROUP
a Subsidiary of Mulberry Integrative Medicine

Financial Policy and Patient Responsibility

Patient's Responsibility:

- To know their insurance policy. Patients should be aware of their benefit coverage including which physicians are contracted with their plan, covered and non-covered benefits, authorization requirements, and costs share information such as deductibles, co-insurance, and co pays. If you are not familiar with you plan coverage, we recommend you contact your carrier directly.

- To obtain a referral from their Primary Care Physician (PCP) and/or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.

- To pay their co pay at the time of service.

- To pay any Medicare deductible and co-insurance amounts not covered by their supplemental insurance.

- To promptly pay any patient responsibility indicated by their insurance carrier. A late charge of 1.5% per month (or 18% per annum) on unpaid patient balances will be added to accounts not paid within 90 days of receipt of insurance payment.

- To facilitate in claims payment by contacting their insurance carrier when claims have not been paid.

- A 60-day period will be extended for pending insurance payments, after which the patient may be held responsible for the balance.

Financial Policy Acknowledgement:
I have read and understood the above financial policy; I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered. I understand that payments can be made by cash, MasterCard or Visa. I agree that if my account is referred to a collection agency or attorney I will be responsible for all costs of collection on my account including attorney's fees, and any interest on money due.

Patient Name (please print)	Signature	Date