Health Medicine Center
PATIENT REGISTRATION INFORMATION

1620 Riviera Ave., Walnut Creek, CA 94596 Phone: 925-935-7500
Fax: 925-935-7770 www.healthmedicinecenter.net

Last Name: First Name: Middle Name: DOB:

Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Soc SS#: E-mail: Drivers License #:

Male Female Minor Single Married Divorced Widowed Separated Life Partner

Occupation: Employer: Referred by?

Primary Insurance: Subscriber ID#: Group#:

Card Holder/Responsible Party: (If other person than yourself, please complete space below)

Soc SS# if diff: Relationship:

Home Phone: Cell Phone: Birth Date:

Secondary Insurance: Subscriber ID#: Group#:

Card Holder/Responsible Party: (If other person than yourself, please complete space below)

Soc SS# if diff: Relationship:

Home Phone: Cell Phone: Birth Date:

COPIES OF PRIMARY AND SECONDARY INSURANCE CARDS NEED TO BE ON FILE!

CONSENT FOR CARE

I, _____ hereby grant permission to the practitioners of Health Medicine Center (HMC) to perform examinations and therapeutic services, and discuss modalities & options that are considered necessary or advised for my diagnosis and care. I understand that the nature of the recommended treatments for my care will be explained to me. I can choose to comply with or deny any treatment. Practitioners who may treat me include, but are not limited to: medical doctors, nutritionists, acupuncturists, body workers, psychologists, nurses, and chiropractors. I understand that the chart of my treatments will be kept confidential under strict HIPAA rules. I authorize the practitioners of HMC to keep a collective record, which may be discussed by practitioners who have provided or may provide care for me. I further understand that I may view my medical record at any time.

AUTHORIZATION TO RELEASE INFORMATION: Health Medicine Center will release all necessary information in order to process any claims to insurance companies when requested by me, or mandated by Medicare. I understand that no personal or medical information will be released without my prior authorization and signature, unless it is requested through a subpoena.

_____ _____

Signature of Patient or Legal Guardian Date:

PRACTICE GUIDELINES AND PATIENT FINANCIAL POLICIES

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PLEASE INITIAL BELOW

_____ Emergencies: Our staff will make every effort to receive calls and respond promptly to any emergency during regular business hours. Dr. Saputo can also be reached via e-mail at drlen@doctorsaputo.com from 9 AM to 10 PM every day of the week. If you do not receive an immediate response, please call 911, or go to the nearest emergency room.

_____ Appointments: HMC requires a minimum of 24 hours notice to cancel or reschedule an appointment as a courtesy to other patients. Fees will be charged for missed or late appointment cancellation without 24 hours notice. This is calculated at 50 % of the regular fee of the time scheduled. A pattern of missed appointments may result in discharge from the practice.

_____ Telephone Consultations: Telephone consultations are available for most conditions, except for new illnesses and symptoms that require physical examinations. Phone consultations will be charged per time needed and require credit card payment via phone. There is no insurance billing for phone consultations.

_____ Financial Responsibility: The patient or responsible party will accept financial responsibility for all charges, whether or not paid by insurance. This includes all services rendered on my behalf or my dependants.

_____ Payment methods: HMC accepts cash, checks, Visa, and MasterCard.

_____ Medical records: The patient's medical record is the property of the practice. Copies of pertinent medical information are available upon 3-day prior request at a fee of $15.00. Records will be kept for the duration of time required by law.

INSURANCE / PERSONAL INJURY / WORKERS' COMPENSATION

_____ HMC has no contract with any insurance company. As such, HMC does not recognize a specific carrier's use of terms, co-payments, deductibles, or coinsurance. Patients are expected to pay full fees at the time of visit. HMC will submit your claim to your insurance, except to an HMO, but this will not guarantee reimbursement.

_____ Medicare Patients: Dr. Saputo is a non-participating Medicare provider. He will accept assignment for primary Medicare patients. You still will be responsible for deductibles or any non-covered services. Please do not submit any claims on your own to Medicare.

_____ Medicare Advantage Plans, Medicare as Secondary: Dr. Saputo will honor Medicare rates and will submit claims to the insurance, except to HMOs. Since these are not regular Medicare plans, we cannot guarantee reimbursement for our services. An additional form will be requires with patient's signature prior to treatment.

_____ Dr. Tiffany Baer is not a Medicare provider and not affiliated with any insurance. If you see Dr. Baer in our office you agree to pay in full at the end of each visit. If you wish we will submit to your insurance, except to an HMO, but this will not guarantee reimbursement.

_____ Personal Injury / Workers' Compensation: Although HMC agrees to treat various conditions, if the cause is related to an auto or work-related accident, prior authorization by the Insurance company handling your claim is required. The authorization needs to state the exact amount of treatments and charges allowed. An additional form will be requires with patient's signature prior to treatment.

_____ TriCare as Primary: HMC is not a TriCare insurance provider and is prohibited from submitting claims to TriCare, or providing the patient with a claim form. An additional form will be requires with patient's signature prior to treatment.

I acknowledge that the above information is true and correct. I have read and understand all the terms of this policy and by my initials above and my signature below, I attest that I fully understand each item and agree to the terms above.

_____ _____

Signature of Patient or Legal Guardian Date:

_____ _____

Signature of Witness: Date:

Updated 5-1-17

HIPAA Policy Acknowledgment

Health Medicine Center is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

You have the right to determine whether detailed messages may be left, including any protected health information, on the phone numbers of your choice. Please provide the following numbers where we can reach you and a decision as to whether or not a message may be left.

Home Phone: _____	Confirm Appointments OK?	YES	NO
	Detailed Message OK?	YES	NO
Work Phone: _____	Confirm Appointments OK?	YES	NO
	Detailed Message OK?	YES	NO
Cell Phone: _____	Confirm Appointments OK?	YES	NO
	Detailed Message OK?	YES	NO
E-mail: _____	Confidential Information OK?	YES	NO

Other person authorized to receive information: _____

Relationship to patient: _____ Phone: _____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the Health Medicine Center with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____ _____ _____

Patient's Name (print) **Patient's Signature** **Date**

_____ _____

Authorized Facility Signature **Date**

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: Initials: Reason:

6 year consent form / must be updated if not seen in a 2 year period

WAIVER FOR NON-COVERED MEDICAL SERVICES

- **97039 GY – Photon Stimulation**
- **97039 GY – Pulsed Electromagnetic Field Therapy (PEMF)**
- **97039 GY – Light Resonance**

Photonic Stimulation: This light therapy is used to treat soft tissue injuries, for pain relief, to promote wound healing, and as a therapy for arthritic conditions. The infrared light penetrates skin to promote increased blood flow and circulation, thereby providing safe, temporary relief where heat is indicated.

Pulsed Electromagnetic Field Therapy (PEMF): Pulsating magnetic fields can dramatically influence ion exchange at the cellular level and increase oxygen utilization of diseased or damaged tissues. Such effects on cellular dynamics allow cells to create energy necessary for function and repair. Published data have reflected therapeutic pulsating magnetic fields to be associated with better outcomes involving wound healing, tissue degeneration, pain, swelling, spasm, inflammation, mood, strength and mobility. **Disclaimer:** High Intensity PEMF is not a medical device in the U.S. It simply produces a pulsed magnetic field of varying strengths. It is not intended for the treatment, diagnosis or prevention of any disease or condition.

Precautions:

- Do not use, if you have an implanted electronic device including an implanted pacemaker or defibrillator or an implanted cochlear hearing device or other implants that are battery operated or magnetically charged.
- Other hearing aids may not work properly and should be removed when using the unit
- Remove all chain linked necklaces, automatic car key openers and any items with batteries.
- Keep cassette tapes and other electronic devices 3 feet or more away from the cables.
- Cell phones should be placed greater than 3 feet away from PEMF machine in current use.
- Do not sit on a metal chair while using the PMT-100.
- Do not use the PMT-100 if you are pregnant or about to become pregnant.
- Do not use during active bleeding, hemorrhaging or during heavy menstruation.

The PMT-100 will wear out any battery. Keep any magnetic media (i.e. credit cards) greater than 3 feet away from the cables of the PMT-100 or they can become demagnetized.

The above mentioned procedures are considered non-covered services. Dr. Saputo will NOT submit those treatments for reimbursement to Medicare or any other insurance.

False Claims Act 31 USC Sec. 3729
"Any person who knowingly presents a false claim for payment is liable to the United States Government for a civil penalty of not less than $5000 and not more than $10,000 plus 3 times the amount of damages…and no proof of specific intent to defraud is required."

Examples of Unethical or Illegal Coding:
*Coding services in a manner that makes them "covered" when they are generally "not covered" when reported correctly.
*Reporting code numbers or modifiers to increase payment when the documentation or circumstances of the actual service does not warrant it.
*Coding another condition as the principal diagnosis or reason for the service, when the majority of the patient's treatment is for a preexisting condition that is excluded from reimbursement by the health plan involved.

I understand that the above mentioned procedures are non-covered services and agree to make payment in full at the time of service.

PATIENT SIGNATURE DATE

HMC MEDICAL HISTORY INTAKE FORM

Best estimates are fine, if you cannot remember specific details. Please also bring copies of any current laboratory records, test results or any documents relating to your medical concerns to the appointment. Thank you!

Name: _____ Date of Birth: ____/____/____ Today's Date: ____/____/____

Primary Care Physician: _____ Date of last exam: ____/____/____

How did you hear about our office?_____ Referred by:_____

IF PROVIDED AREA IS NOT SUFFICIENT FOR YOUR ANSWERS, PLEASE CONTINUE ON A SEPARATE PAPER.

PRESENT HEALTH CONCERN(S) (Please rank by priority)

1._____ Onset:_____ Frequency:_____ Severity (Rate 1-10):_____
2._____ Onset:_____ Frequency:_____ Severity (Rate 1-10):_____
3._____ Onset:_____ Frequency:_____ Severity (Rate 1-10):_____
4._____ Onset:_____ Frequency:_____ Severity (Rate 1-10):_____
5._____ Onset:_____ Frequency:_____ Severity (Rate 1-10):_____

PERSONAL MEDICAL HISTORY (Include date or year of diagnosis. You may also attach a separate list.)
Example: Reflux/heartburn – started 2003; had scope procedure 8/05 with normal result; please be concise

_____
_____
_____
_____
_____
_____
_____
_____
_____

SURGICAL HISTORY (Major/minor procedures)

_____
_____
_____
_____

Have you ever been hospitalized? □ Yes □ No If yes, what for? _____
_____

ALLERGIES

intolerances to medications
(Example: penicillin – hives):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Intolerances (foods, environment)
Example: cow's milk – bloating

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

PRESCRIPTIONS

PLEASE INCLUDE DOSAGE, FREQUENCY, REASON FOR TAKING, WHEN STARTED OR ATTACH YOUR OWN LIST

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

SUPPLEMENTS or Over-The-Counter (OTC) medications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

FAMILY HISTORY

Which of your family members has had any of the following illnesses (Their age or age at death):

Anemia or Blood disease _____	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other:_____
Cancer _____	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other:_____
Diabetes _____	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other:_____
Depression _____	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other:_____
Glaucoma _____	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other:_____
Heart disease _____	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other:_____
High blood pressure _____	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other:_____
HIV disease / AIDS _____	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other:_____
Mental Illness / Depression _____	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other:_____
Migraine headaches _____	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other:_____
Stroke _____	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other:_____
Thyroid Disorders_____	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other:_____
Other:_____	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other:_____
Other:_____	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other:_____

FEMALES: GYNECOLOGICAL HISTORY

Pregnancies:____ # Deliveries:____ # Abortions: ____ # Miscarriages: _____ Date of last GYN visit / Breast exam:_____/_____/_____

Birth Control method: _____ ☐ None If yes, age started: _____Years taken: _____

Have you had a hysterectomy? ☐ No ☐ Yes, Date: ____/____/_____ Have you had a oophorectomy ☐ No ☐ Yes, Date: ____/____/_____

Are you currently using Hormone Replacement Therapy? ☐ No ☐ Yes, ☐ Estrogen, ☐ Progesterone, ☐ Testosterone Years taken: _____

Have you had an abnormal Pap Smear? ☐ No ☐ Yes, Diagnosis: _____ Follow up:_____

Have you ever had a breast biopsy? ☐ No ☐ Yes, Biopsy results: _____

1st day of most recent period: ____/____/____ Age at 1st period: _____ Frequency of periods: _____ Length of each: _____ days

Do you have any concerns about your periods? ☐ NA, Reason:_____ ☐ No ☐ Yes, _____

Are you: ☐ Pre-menopause, ☐ Peri-menopause, or ☐ Post-menopause? Any concerns or problems related to it? ☐ No ☐ Yes, _____

_____

_____

Last Breast Cancer Screenings

☐ Mammogram Date: ____/____/_____ Results: _____ ☐ Thermography Date: ____/____/_____ Results: _____

☐ Ultrasound Date: ____/____/_____ Results: _____ ☐ MRI Date: ____/____/_____ Results: _____

SOCIAL HISTORY

Tobacco: ☐ Yes, packs/day____ # of yrs _____ ☐ No ☐ Used to, # of years____ Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use: ☐ No ☐ Yes, # drinks/week _____ Is alcohol use a concern for you or others? ☐ No ☐ Yes, _____

Recreational Drug Use: ☐ No ☐ Yes, _____ Have you ever used needles? ☐ No ☐ Yes, how long _____

Are you interested in quitting? _____

EXERCISE

Do you exercise regularly? □ No □ Yes, How often: _____ What physical activities: _____

Physical limitations:_____

PHYSICAL AND EMOTIONAL WELL BEING

What do you do to relax? _____

Describe your sleep: include # hours/night _____

What are the major stressors in your life? _____

Do you feel depressed (occasionally/often)? _____

What triggers your depression? _____

PAIN

Are you currently experiencing any pain? □ No □ Yes, Please describe: _____

_____

On a scale from 1 to 10, how would you rate your pain? _____ How long have you been experiencing this pain? _____

Where is your pain? _____ What are you doing currently to ease the pain?_____

DIET:

Are you currently on a special diet? □ No □ Yes, Please describe: _____

How much water do you drink on a typical day? _____ How much Coffee _____ Soda _____ Other _____

SEXUALITY

□ Single □ Married/Life partner Sexually Active: □ Yes □ No □ Not currently Birth Control method: _____ □ None

Have you ever had any sexually transmitted diseases (STDs)? □ No □ Yes, _____Date____/____/_____

ANY OTHER CONCERNS / COMMENTS FOR THE DOCTOR

_____

_____

_____

_____

_____

_____

_____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature _____ Date ____/_____/_____