OMNI HEALTHCARE

Patient Information		
Last Name:	First Name:	Middle Name:
Date of Birth:	Social Security #	Sex: ____Male____Female
Street Address:		
City:	State:	Zip:
Home #:	Cell #:	Work #:
Marital Status: __Single __Married __Divorced __Widowed __Separated		Student Status: __Full Time __Part time __Not a Student
Email Address:		
Employment Status: ____Full Time ____Part Time ____Not Employed ____Self Employed ____Retired ____Military		
Race, Ethnicity & Language Information		
Race: ___White ___African American/Black ___Hispanic ___Asian ___American Indian/Alaska Native ___Native Hawaiian ___Other_____		
Ethnicity: ___ Hispanic/Latino ___Not Hispanic/Latino ___Other:_____		
Primary Language Spoken: ___English ____Spanish ___Other: _____		
Referring & Primary Physician Information		
Referring Physician Name:		
Street Address:		
City:	State:	Zip:
Phone Number:	Speciality:	
Primary Care Physician Name:		
Street Address:		
City:	State:	Zip:
Guarantor Information (Who is responsible for you financially if different from the patient)		
Name:		Relationship to Patient:
Street Address:		
City:	State	Zip:
Home #:	Cell #	Work #:
Date of Birth:	Social Security #	Sex: ____Male____Female
Email Address:		
Emergency Contact Information		
Name:	DOB:	Relationship to Patient:
Street Address:		
City:	State:	Zip:
Home #:	Cell #:	Work #:
Pharmacy Information		
Pharmacy Name:		
Pharmacy Address:		
City:	State:	Zip:
Phone #:	Fax #:	

Last Name:	First Name:	DOB:
Insurance Information		
Is your visit Related To: ___Auto Accident ___ Workers Compensation		
Primary Insurance Company:		Policy #:
Group Name:		Group #:
Policy Holder Name:		Effective Date:
Relationship to Patient:		Policy Holder Date of Birth:
Policy Holder Social Security #:		Policyholder Sex: ____Male____Female
Secondary Insurance Company:		Policy #:
Group Name:		Group #:
Policy Holder Name:		Effective Date:
Relationship to Patient:		Policyholder Date of Birth:
Policy Holder Social Security #:		Policyholder Sex: ____Male____Female

_____ _____

Signature of Patient/Legal Representative **Date**

New Patient History Questionnaire

Patient Name: _____ **Date of Birth:** _____ **Date**: _____

List previous surgical procedures.	
Name of Procedure	**Date of Procedure**

List all current prescribed, over the counter medications, and herbal remedies.		
Medication Name	**Dosage**	**Frequency**
List any allergies to medicine or dyes		
List all other allergies		

Health Maintenance	
Colonoscopy	Date of Exam:
Pap Smear	Date of Exam:
Mammogram	Date of Exam:
Dexa Scan	Date of Exam:
Annual Eye Exam	Date of Exam:
Annual Dental Exam	Date of Exam:

Do you currently use smokeless tobacco/ cigarettes/cigars? Yes____ No ____
If yes, which one and quantity/ day: _____
Do you drink alcohol? Yes____ No ____
If yes, indicate beverage and quantity/day: _____
Daily caffeine intake: Coffee: _____ Tea: _____ Soda: _____

Patient Name: _____ **Date of Birth:** _____ **Date**: _____

Other Medical History					
Mark (x) if you are currently experiencing or recently experienced any of the following:					
	Weight loss/gain		Vision problems		Difficulty swallowing
	Heart palpitation		Shortness of breath		Appetite problems
	Blood in urine		Joint pain/swelling		Rashes on skin
	Headaches		Sleeping problems		Thyroid problems
	Anemia		Immune problems		
Mark (x) if you have ever been treated for any of the following?					
	Heart disease		Vein/artery disease		High blood pressure
	Kidney disease		Liver disease		Epilepsy
	Depression		Diabetes		Thyroid disease
	Migraine headaches		Stroke		Elevated Cholesterol/ Tri.
	Cancer (Type):				
List other disease or conditions:					

Family History		
Please Indicate all conditions that apply to family members (NOTE RELATIONSHIP : brother, sister, father, mother, maternal aunt, paternal aunt, maternal uncle,paternal uncle, maternal grandmother, paternal grandmother, maternal grandfather, paternal grandfather)		
	High blood pressure	
	Asthma/Allergies	
	Headaches	
	Stroke	
	Seizures/epilepsy	
	Kidney problems	
	High cholesterol	
	Mental illness	
	Thyroid disorder	
	Heart disease	
	Diabetes	
	Chronic lung disease	
	Alcoholism/Substance abuse	
	Bleeding /clotting disorder	
	Ulcers	

_____ _____

Signature of Patient/Legal Representative **Date**

Consent Agreement

Patient Name: _____Date of Birth: _____

Consent for Treatment:
I give consent to my physician, other attending physicians and their assistants and designees, to provide me with such medical, surgical, diagnostic, or other treatment services judged necessary and/or appropriate. This consent includes my consent for diagnostic procedures and all medical treatment rendered at my physician's office under his/her instruction; including x-ray, laboratory procedures and other tests, treatments or medication, monitoring, and all other procedures or treatments that do not require my specific informed consent. I understand that in my course of diagnosis and treatment, cells,tissues, and/or parts may be removed from my body. I authorize my physician and his/her personnel to preserve or use such cells, tissues, or parts for teaching purposes and/or to dispose of any cells, tissues, or parts that are removed.

Authorization For Release of Medical Information:
I understand that my medical information, including complete medical records, test results, immunization records, and billing information, may be released to my insurance company, other medical professionals, other medical care institutions, and/or my patient portal for treatment and/or payment purposes.

General Acknowledgements:
I understand that the practice of medicine and surgery is not an exact science. I understand that medical and surgical treatment and diagnosis may involve risks of injury and even death. No guarantees have been made to me with respect to the results of my examinations and treatments. I understand and agree that I may be observed and/or receive care from medical, nursing, and other healthcare students in training at my physician's office. I understand that it is my responsibility to follow instructions about and make arrangements for follow-up care as directed by my physician. I understand that I may review and obtain a copy of my medical record, at my own expense, and that this review shall take place during regular business hours.

Minors/Dependents:
I understand that children under the age of 18 will require the signature of a responsible adult party on all registrations forms.

Communication and/or Disclosure
For ongoing communication regarding your healthcare and for your privacy, please select the following alternative or limitations below...

OMNI Healthcare May:

- Call you at home or cell? _____ Yes _____ No _____ Home _____ Cell
  If yes, Can we leave the following information on your home answering machine or voicemail:

  Appointment information _____ Yes _____ No
  Billing Information _____ Yes _____ No
  Medical Information _____ Yes _____ No
  Labs/Prescriptions _____ Yes _____ No

- Call you at work? _____ Yes _____ No
  If yes, Can we leave the following information on your work answering machine or voicemail:

  Appointment information _____ Yes _____ No
  Billing Information _____ Yes _____ No
  Medical Information _____ Yes _____ No
  Labs/Prescriptions _____ Yes _____ No

I give permission to share the following information with person (s) named below:

Name: _____ Relationship _____
Appointment information: ___Yes ___ No Billing Information: ___Yes ___ No Medical Information: ___Yes ___No

Name: _____ Relationship _____
Appointment information: ___Yes ___ No Billing Information: ___Yes ___ No Medical Information: ___Yes ___No

Name: _____ Relationship _____
Appointment information: ___Yes ___ No Billing Information: ___Yes ___ No Medical Information: ___Yes ___No

_____ _____
Signature of Patient/Legal Representative **Date**

_____ _____
Witness Signature **Date**

Patient Financial Policy

Patient Name: _____Date of Birth: _____

Thank you for choosing OMNI Healthcare as your Healthcare provider. The following is a statement of our financial policy, which we require you to read and sign prior to treatment.

Patient Financial Responsibility:
Copayments, coinsurance, deductibles, and fees for non-covered services are due at time of service. If no insurance is to be filed by OMNI Healthcare, or if OMNI Healthcare is not a participating provider, **full payment is due** at the time services are rendered. Payment arrangements will be made with a signed payment agreement and the approval of the office manager.

Insurance Claims:
Primary Insurance: OMNI Healthcare will file claims with the patient's insurance upon the patient's submission of proof of insurance; (insurance card indicating coverage identification number and group number). In the event the patient has insurance coverage but cannot provide documentation, payment is due at time services are rendered. Upon receipt of the insurance card, OMNI Healthcare will submit the claim indicating patient payment at the time of service. In the event OMNI Healthcare does not receive a valid insurance policy within the timely filing requirements of the insurance carrier the balance for services will be the responsibility of the patient/guardian.

Secondary Insurance: Claims will be filed to secondary insurance if adequate information is received at the time of service. However, if payment is not received in our office within 45 days after filing, the responsibility will be transferred to the patient and due upon receipt.

Worker's Compensation:
Workers Compensation will be filed if the patient notified OMNI Healthcare upon scheduling an appointment and supplies billing information upon arrival. Detail of the accident will be required and a workers compensation form will need to be completed.

Auto Accidents
Payment of visits for auto accidents will be due at time of service. OMNI Healthcare will provide a health insurance claim form and details of examination upon patient signature for release of records.

Accounts Past Due:
Payment from statement is due upon receipt. Delinquent accounts may result in small claims court, a collection agency, credit bureau reporting and/or discharge from practice. After 90 days, an account will be turned over to collections. The person will be financially responsible for all collection costs including attorney fees of not less than 30% and court costs. A patient may remit in full for all outstanding charges owed on an account and include amounts previously placed with the collection service. Under these circumstances, a physician may reserve the right to re-establish the patient to active status with the practice.

Medical Records:
If you request records from OMNI Healthcare, there will be a fee of $1.00 per page for the first 25 pages and a fee of $0.25 for every page after which must be paid prior to receiving your records.

Missed Appointments
Patients must call with at least 24 hours advance notice of an appointment to cancel or reschedule. If not OMNI Healthcare reserves the right to add a $25 fee to your account.

_____ _____
Signature of Patient/Legal Representative **Date**

_____ _____
Witness Signature **Date**

Office & Prescription Refill Policies

Patient Name: _____Date of Birth: _____Date: _____

- **Copays and Self Pay Payments**
  _____ Initial - Copays for insured patients are to be paid at time of check-in. Self-pay payments are to be paid in full at time of service for all uninsured patients.

- **Late Arrivals**
  _____ Initial - After 15 minutes, patients will be considered late. At that time, it is up to the provider's discretion to have the patient reschedule or be worked back into the schedule.

- **Broken appointment:**
  _____ Initial - Patients must call office with at least 24 hours advance notice of the appointment to cancel or reschedule. If not there will be a $25.00 charge added to your account. Patients with 3 or more broken appointments without good reason could result in dismissal.

- **Confirming appointments:**
  _____ Initial - It is our policy to confirm all appointments. It is the patient's responsibility to remember their own appointment. If the patient does not call or show for their appointment this is considered a broken appointment

- **Prescription Refills**
  _____ Initial
  We will require 48-72 hours for all prescription refills. This will include:
    - Patient phone in requests
    - Pharmacy refill requests
    - Patient walk in requests
    - Patient portal requests

******All pain medications must be picked up as they can no longer be called into the pharmacy.**

Thank you for your cooperation.

_____ _____

Signature of Patient/Legal Representative **Date**

OMNI HEALTHCARE

Date:_____

Request For Authorization or Additional Information

To:
Fax Number:
Phone Number:

From:
Fax Number:
Phone Number:

Patient Name:	Date of Birth:
Patient Appointment With:	Date of Visit:

_____ Our office received a referral for the patient listed above. The patient is scheduled for an appointment but an authorization is required by the patient's insurance in order to be seen. Please provide our office with an authorization for this patients visit.

_____ Our office received a referral for the patient listed above. Please fax the following additional information.

___ Consultation note
___ Discharge summary
___ Demographics
___ Imaging reports
- X-ray report(s)
- Ultrasound report(s)
- MRI report(s)
- CT report(s)
- Other_____

___ History & Physical
___ Most recent lab work
___ Procedure report(s)

Additional Notes:

Notice of Privacy Practices Acknowledgement Form

Patient Name: _____Date of Birth: _____

The Health Insurance Portability and Accountability Act (HIPAA) provides a safeguard to protect your privacy. Implementation of HIPAA requirements officially began April 14, 2003. Many of the policies have been *our* practice for years. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services- www.hhs.gov.

OMNI HEALTHCARE has adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding witch identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office,examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for handling charts, patient records, PHI (Protected Health Information) and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We do this by telephone, email, U.S. Mail, or by any means of convenience for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable and informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPPA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies for insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

The undersigned certifies that he/she read the foregoing, received a copy of the Notice of Privacy Practice, and is the patient, patients guardian, or legal representative.

_____ _____

Signature of Patient/Legal Representative **Date**

_____ _____

Witness Signature **Date**