

# Institute for Progressive Medicine

4 Hughes, Suite # 175 Irvine, CA 92618 Tel:(949) 600-5100 Fax: (949) 600-5101  
www.iprogressivemed.com

## Medical Doctor New Patient Packet

PLEASE BRING COMPLETED FORMS TO YOUR FIRST APPOINTMENT

(Please Print Clearly)

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Driv. Lic. # \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_  
(First, Middle Initial and Last)

Primary Reason for Visit: \_\_\_\_\_

Sex: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Primary Telephone No. (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  home  cell

Secondary Telephone No. (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  home  cell  work

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Telephone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Spouse/Partner Name: \_\_\_\_\_ Spouse/Partner Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Payment must be made at the time of service. We only accept Medicare (provided you have not assigned your benefits to an HMO). We can not accept HMO, EPO Medi-Cal or private PPO insurances for office visits.**

Who is financially responsible for this bill? \_\_\_\_\_

I will be paying today with: Cash \_\_\_\_ Check \_\_\_\_ Visa/MC \_\_\_\_ Medicare PPO \_\_\_\_ (covered services)

### Who may we contact in the case of an emergency?

Name: \_\_\_\_\_ Tel: \_\_\_\_\_

If you are a minor (under 18) or dependent, please provide us with your guardian information:

Name of Guardian: \_\_\_\_\_ Tel: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify the information above is true and correct to the best of my knowledge. I will notify IFPM of any changes in the status of the above information.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature (if minor): \_\_\_\_\_ Date: \_\_\_\_\_

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Patient name (Last, First)

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### **Referral Information**

How did you hear about us? Please choose the referral type and fill in the information below.

- Healthcare practitioner (name) \_\_\_\_\_
- Friend or Family (name) \_\_\_\_\_
- Website (name) \_\_\_\_\_
- Search Engine
- Print Media (name) \_\_\_\_\_
- Mailer \_\_\_\_\_
- Other (please specify) \_\_\_\_\_

### **Notice of Privacy Practices**

The Institute for Progressive Medicine is required by law to follow the privacy practices established by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. In addition we will not sell, distribute or otherwise share your personal contact information with any third party for marketing and promotional purposes. A copy of our full privacy policy is available in the reception area.

### **Patient Contact Information**

Staff at the Institute for Progressive Medicine may contact you by mail, e-mail or telephone to relay important information about your health such as appointment reminders, laboratory results, doctor recommendations and prescription information.

To maintain the privacy of our patients, we employ a special telephone system that requires authentication using a unique identification number (social security number) and your primary telephone number (designated by you on page 1 of this packet). A staff member will discuss the use of this system with you and provide a copy of instructions to take home. If you have questions at any time on how to use this system, please feel free to contact us.

Patient name (Last, First)

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### Office Policy

We recognize and appreciate that health care can involve a major financial commitment. We aim to provide you with effective services and treatments. As a patient of the Institute for Progressive Medicine, you are responsible for the total charges incurred for each visit or any balances not paid by your insurance company to your practitioner. Charges for cash services are to be paid at the time of each visit. Payment is due upon receipt of a statement including charges for deductible, co-pay, or non-covered services. **If your insurance does not remit payment within sixty (60) days, the balance will be due and payable by you.** All patients are required to sign a copy of the standard arbitration form included in this packet before they may see a doctor or receive any services.

We accept Visa, MasterCard, personal checks and cash as forms of payment. There will be a \$35.00 dollar charge for all returned checks. **We are contracted providers for Medicare only.** We do not accept Medi-Cal, HMO, EPO or other private insurance. You will be required to sign a waiver if you wish to be seen and are covered under Medi-Cal and/or an HMO. **At this time, we are unable to accept any insurance (including Medicare) for visits with a naturopathic doctor (N.D.)**

If you have a private insurance our office staff can provide you with the necessary paperwork (super-bill, procedure and diagnosis codes) you will need to submit for reimbursement to your insurance. Please remember that you have the primary relationship with your insurance company and you are responsible for the total amount owed at the time of your visit. **We are unable to submit a bill for you if we are not a contracted provider for your insurance.**

All appointments made with a doctor or IV nurse are confirmed via telephone two days in advance. Doctors' appointments not canceled with **AT LEAST 24 HOURS NOTICE** will be charged a **\$50.00** missed appointment fee. Appointments with the IV nurse that are missed without prior notice given to reception will be charged a **\$25.00** missed appointment fee. This charge is directly payable by you and cannot be submitted to your insurance. **We make every effort to see all scheduled appointments. However, we reserve the right to reschedule your appointment if you arrive more than 15 minutes after your scheduled appointment time.**

Phone consultations are not billable to Medicare and payment is required at the time of the scheduled appointment.

Payment for all supplements, IVs, and non-covered treatments (e.g. acupuncture, prolotherapy, etc.) is due at the time of service. Most insurance companies do not cover these services. You have the right to refuse any service recommended by our staff.

Mail order supplements are sent via UPS. Payment must be received before any items can be shipped to you.

I have read, understand and agree to the above stated policies of The Institute for Progressive Medicine.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

Patient name (Last, First)

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### **STATEMENT OF PATIENT AWARENESS AND RESPONSIBILITY**

- I am aware that any therapy, no matter how well designed and carried out, may fail to alleviate my symptoms and improve my health.
- I agree to make every effort to pursue the program mutually agreed upon with my physician.
- I expect to be informed of those therapies most relevant to my condition, both conventional and alternative, realizing that I have the choice to accept, refuse or terminate them at any point.
- I understand that unforeseen difficulties may arise in the course of treatment.
- I am responsible to seek professional medical attention from a medical or naturopathic doctor employed at the Institute for Progressive Medicine, or another facility for any worsening of my condition, including consideration of hospitalization, invasive procedures or treatment in the emergency room.
- I am aware that many medical conditions require additional treatment and that follow-up visits are often necessary.
- I am aware that I will not be told to avoid seeing other physicians. I understand that I may be referred to another physician for treatment and that other options for medical care are available to me.

\_\_\_\_\_  
**Patient Name (please print)**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Date**

Patient name (Last, First)

## INSTITUTE FOR PROGRESSIVE MEDICINE

### MEDICARE BILLING INFORMATION

**(For Medicare patients only)**

Medicare Subscriber # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Effective Date: \_\_\_/\_\_\_/\_\_\_

Is your Medicare Insurance Primary or Secondary? \_\_\_\_\_

If secondary, list primary insurance information:

Insurance Name: \_\_\_\_\_ Name of Insured \_\_\_\_\_

Group No. \_\_\_\_\_ Subscriber No. \_\_\_\_\_

DOB of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Is your Medicare Connected with an HMO? \_\_\_\_\_

*In order to bill Medicare, we must have a copy of your driver's license, Medicare and secondary (if any) insurance cards. Please be prepared to give your card(s) to the receptionist. If you do not have your Medicare card with you, please ask the receptionist to assist you in calling Medicare at (800) 772-1213 to verify your Medicare coverage.*

### MEDICARE ASSIGNMENT OF BENEFITS

**(For Medicare patients only)**

I request that payment of authorized Medicare benefits be made on my behalf to the Institute for Progressive Medicine for any services furnished to me by a physician practicing as part of that group. I authorize the holder of any medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

### MEDI-CAL/MEDICAID POLICY

The Institute for Progressive Medicine is a Medicare provider. We are happy to bill Medicare for any eligible charges you have after receiving services. However, the Institute for Progressive Medicine is NOT a Medi-Cal/Medicaid provider. Therefore, if you have Medi-Cal or Medicaid as a secondary insurance, you will be responsible for all remaining co-insurance and/or deductible expenses after Medicare remits payment.

Do you have Medi-Cal/Medicaid as your secondary insurance?    \_\_\_ YES    \_\_\_ NO

If you answered "YES" to the above question, please complete the following:

I, \_\_\_\_\_, have read the Medi-Cal/Medicaid policy above for the Institute for Progressive Medicine and I understand that as a Medical/Medicaid patient I will be responsible for all secondary costs after Medicare pays for the services I receive in this office.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

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 Patient name (Last, First)

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### **Laboratory Billing Information**

Our doctors may order laboratory or other diagnostic testing for you. Some laboratory testing is performed in our private laboratory and other tests must be sent to an outside laboratory for processing. It is your choice whether or not to receive laboratory testing recommended by your doctor.

Although we do not bill insurance other than Medicare PPO for office visits, as a courtesy to our patients we will bill most PPO insurances (some exclusions apply) for in-house laboratory testing ordered by your doctor at the Institute for Progressive Medicine. We can not accept HMO, EPO, Medi-Cal or Medicaid insurance plans for laboratory testing or any other service, visit or procedure at the Institute for Progressive Medicine.

Some specialized outside laboratory testing is payable by the patient directly to the company performing the testing, unless specific provisions are made by the laboratory to accept insurance. A minimal sample processing fee may apply for outside laboratory tests.

If you would like us to bill insurance for in-house laboratory testing, please fill in the following information:

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 Name of Insurance

---

 Patient Signature

---

 Name of Insured (if different than patient)

---

 Group Number

---

 Subscriber ID Number

---

 D.O.B of Insured

---

 Relationship to the Patient

### **More on Insurance Billing**

There are a great many insurance companies, each with a variety of different plans serving the patients in our practice. It would be an impossible task for our staff to know which labs and services are covered or deemed by the insurance company to be medically necessary for each patient at the time of service.

We feel confident that we provide services during your visit that are appropriate and important for your age and/or condition. Your insurance company might not always agree. They may deny coverage of certain labs or services as medically unnecessary or because your specific policy may not provide coverage for certain services.

It is the patient's responsibility to understand their individual insurance policy and coverage. If you are unsure about coverage for a particular test or procedure, please contact your insurance company directly.

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**FAMILY HEALTH** Please give the following information about your immediate family:

| RELATIONSHIP     | AGE<br>IF<br>LIVING | AGE<br>AT<br>DEATH | STATE OF HEALTH OR CAUSE OF DEATH |
|------------------|---------------------|--------------------|-----------------------------------|
| FATHER           |                     |                    |                                   |
| MOTHER           |                     |                    |                                   |
| BROTHERS/SISTERS |                     |                    |                                   |
|                  |                     |                    |                                   |
|                  |                     |                    |                                   |
| SPOUSE           |                     |                    |                                   |
| CHILDREN         |                     |                    |                                   |
|                  |                     |                    |                                   |
|                  |                     |                    |                                   |
|                  |                     |                    |                                   |

**NUTRITION AND DIET** Please answer the following questions in the space provided:

1. How many meals do you eat each day?
2. Do you usually eat breakfast?
3. Do you diet frequently?
4. Do you smoke?  
If so, how much per day?
5. Do you exercise?
6. What type of exercise do you do?
7. Do you drink alcohol?  
If so, how much and how often?
8. What types of foods do you eat? List a typical day or two below:

**MY SIGNATURE BELOW CONSTITUTES CONSENT TO MEDICAL SERVICES:**

I consent to medical evaluation and treatment by THE INSTITUTE FOR PROGRESSIVE MEDICINE. I understand that THE INSTITUTE FOR PROGRESSIVE MEDICINE may recommend various methods to help me regain my health and those methods will be discussed with me.

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date

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## MEDICAL QUESTIONNAIRE

| <u>Name of RX</u> | <u>Strength and Dosage</u> | <u>Comments</u> |
|-------------------|----------------------------|-----------------|
| 1. _____          | _____                      | _____           |
| 2. _____          | _____                      | _____           |
| 3. _____          | _____                      | _____           |
| 4. _____          | _____                      | _____           |
| 5. _____          | _____                      | _____           |
| 6. _____          | _____                      | _____           |

### Nutritional Supplements and OTC Medications

|          |       |       |
|----------|-------|-------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |

### Allergies (Please list anything you are allergic to (medications, food, environmental, pets, etc.))

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

### Hospitalizations, Illnesses, Surgeries

| <u>Date</u> | <u>Reason</u> |
|-------------|---------------|
| 1. _____    | _____         |
| 2. _____    | _____         |
| 3. _____    | _____         |
| 4. _____    | _____         |
| 5. _____    | _____         |

Reviewed By: \_\_\_\_\_

MD Signature

Date

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### **CURRENT (OR RECENT PAST) SYMPTOMS**

**(Circle all that apply under each category)**

#### **GENERAL**

Weakness, Fatigue, Weight change, Night sweats, Fever, Sensitivity to heat or cold

#### **SKIN**

Rashes, Itching, Changes in hair or nails, Changes in color or pigmentation

#### **HEAD**

Headache, History of head trauma

#### **EYES**

Pain, Double Vision, Blurred Vision, Inflammation or Discharge, Glasses, Surgery

#### **EARS**

Loss of hearing, Ringing, Pain, Discharge, Dizziness

#### **NOSE**

Loss of Smell, Frequent Colds, Obstruction, Excess Discharge, Bleeding, Postnasal Drip

#### **MOUTH/THROAT**

Sores, Bleeding Gums, Hoarseness, Dentures, Change in Taste

#### **BREASTS**

Masses, Pain, Discharge, History of Carcinoma

#### **CARDIORESPIRATORY**

Chest Pain, Wheezing, Cough, Coughing Blood, Sputum Production, Trouble Breathing When Lying Down, Waking up suddenly due to cessation of breathing, Shortness of breath at rest or on exertion, Blueness of skin, Peripheral swelling, Hypertension, Leg pain on walking, Previous murmurs, History of rheumatic fever

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### **GASTROINTESTINAL**

Change in Appetite, Difficulty Swallowing, Heartburn, Abdominal Distress, Pain, Belching, Excess Gas, Abdominal Enlargement, Nausea, Vomiting, Vomiting of blood, Rectal bleeding, Black stools, Previous jaundice, Constipation, Diarrhea, Hemorrhoids, Need for laxatives

### **GENITOURINARY**

Dysuria, Frequency, Nighttime need to urinate, Urgency, Blood in urine, Incontinence, Impotence, Loss of libido, Pain with intercourse, Testicular pain or swelling, Gonorrhea, Syphilis, Contraception

### **ENDOCRINE**

Goiter, Thyroid trouble, Prednisone treatment, Diabetes

### **BLOOD/LYMPHATIC**

Anemia, Transfusions, Bleeding tendency, Clotting Problems, Lymph node enlargement or pain

### **JOINTS/MUSCLES**

Muscle cramps, Muscle weakness, Pain in joints, Swollen joints, Stiffness, Deformity of joints

### **NEUROLOGIC**

Fainting, Abnormal gait, Coordination seizures, Speech, Sensation, Paralysis, Memory loss, Depression

### **ALLERGIC HISTORY**

Sensitivity to allergens, drugs or vaccines, Eczema, Asthma, Hayfever, Hives

### **ADDITIONAL COMMENTS:**

## PHYSICIAN-PATIENT ARBITRATION AGREEMENT

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2: All Claims Must Be Arbitrated:** It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

**Article 4: Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

**Article 6: Severability Provision:** In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

By: \_\_\_\_\_  
Physician's or Duly (Date)  
Authorized Representative Signature

By: \_\_\_\_\_  
Patient's Signature (Date)

\_\_\_\_\_  
Print Patient's Name

By \_\_\_\_\_  
Print or Stamp Name of Physician,  
Medical Group or Association Name

By: \_\_\_\_\_  
Patient's Representative's Signature (if applicable)(Date)

By: \_\_\_\_\_  
Signature of Translator (if applicable) (Date)

\_\_\_\_\_  
Print Name and Relationship to Patient

\_\_\_\_\_  
Print Name of Translator