

PATIENT INFORMATION

Thank you for choosing **RICHICHI FAMILY HEALTH**. In order to properly serve you, we need the following information.

PATIENT INFORMATION

Name: _____ (Last, First, MI) Email: _____

Address: _____ (Street) _____ (City, St, Zip)

Phone: _____ (Home) _____ (Work) _____ (Cell)

Social Sec#: _____ Date of Birth: _____ Sex: Male Female

Place of Employment: _____ Occupation: _____

Employer's Address: _____

Extended Information: (Choose One) Minor Single Married Separated Divorced Widowed

Spouse/Parent's Name: _____ Relationship: _____

Spouse/Parent's Employer: _____ Work Phone: _____

Person to Contact in Case of Emergency: _____ Phone: _____

IF SEASONAL RESIDENT: 2nd Address _____

DATES AT 2ND ADDRESS: From _____ To _____

Guarantor/Responsible Party: (Person Responsible for Payment of Your Service if different from Patient)

Name: _____ Relationship to Patient: _____

Address (if different from Patient): _____

INSURANCE INFORMATION

Name of Insured: _____ Date of Birth: _____ SS# _____

Insurance Co: _____ Policy #: _____ Group #: _____

Choose One: Self Spouse Parent Other: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? No Yes If Yes, please complete the following:

Insurance Co: _____ Policy #: _____ Group #: _____

Policy Holder: _____ Date of Birth: _____ Self Spouse Parent Other:

PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

I authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts incurred by myself for services.

I give my permission to leave phone messages regarding my medical care/appointment confirmation: Yes No

Check here if you prefer to be contacted by email.

Signed (Patient or Guardian) _____ **Date** _____

All bills are ultimately the responsibility of the patient. We will file insurance claims as noted, however, if your insurance has not paid in 60 days, the bill is due and payment by you is expected immediately.

COMPREHENSIVE PATIENT HISTORY

Please complete the following two pages.

Patient Name: _____ Date of Birth: _____ Soc. Sec. #: _____
 Occupation _____ List all previous occupations: _____
 Birth place: _____ List all States/Countries visited: _____
 What is the reason for today's visit? _____ Today's Date: _____

Describe the following (if applicable):

Location of problem: _____ How long have you had this problem? _____
 How severe is this problem? Mild Moderate Very How often are you having the problem? _____
 What caused the problem? _____
 Do you know of anything else that may have contributed to this problem? _____
 Does anything else occur with this problem? _____
 When was your last complete physical examination? _____ Where? _____

PERSONAL HISTORY:

ILLNESSES: Have you ever had:

Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chicken pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Meningitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Whooping cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia/jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Scarlet fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes or cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Asthma/emphysem	<input type="checkbox"/> Yes <input type="checkbox"/> No

INJURIES: Have you ever had:

Broken bones	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sprains/dislocations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lacerations (extensive)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Concussion/head injury	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ever been knocked out	<input type="checkbox"/> Yes <input type="checkbox"/> No

SURGERY: List previous hospitalizations/serious injuries: _____ **When?** _____

1. _____

2. _____

3. _____

4. _____

5. _____

ALLERGIES: List any (food, drug, other):

1. _____

2. _____

3. _____

4. _____

5. _____

SOCIAL HISTORY:

Occupation: _____

Marital Status: Single Married Separated Divorced Widowed

Use of alcohol: Never Rarely Moderate Daily: _____

Use of tobacco: Never Previously but quit Current packs per day: _____

Drug use: Never Type/Frequency: _____

Excessive exposure at home/work Fumes Dust Solvents Noise

Caffeine use: How many cups coffee/tea/soda per day? _____

Regular exercise: How often? _____

MEDICATIONS: List all regularly taken:

1. _____

2. _____

3. _____

4. _____

5. _____

Do you get regular flu shots? Yes No

Last Tetanus _____

Last Pneumonia _____

FAMILY HISTORY

Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Acute Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding Tendency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hereditary Defects	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma/emphysem	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Mental Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital Deformities	<input type="checkbox"/> Yes <input type="checkbox"/> No

Patient History Continued:

FAMILY HISTORY:	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brother or Sister	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

PLEASE ANSWER ALL QUESTIONS *Have you recently experienced any of the following?*

GENERAL HEALTH & WELL-BEING Good general health lately <input type="checkbox"/> Yes <input type="checkbox"/> No Recent weight change <input type="checkbox"/> Yes <input type="checkbox"/> No Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	GENITOURINARY Frequent urination (voiding) <input type="checkbox"/> Yes <input type="checkbox"/> No Burning or painful urination <input type="checkbox"/> Yes <input type="checkbox"/> No Blood in urine or discoloration <input type="checkbox"/> Yes <input type="checkbox"/> No Change in force or strain when urinating <input type="checkbox"/> Yes <input type="checkbox"/> No Inability to control bladder or dribbling <input type="checkbox"/> Yes <input type="checkbox"/> No Getting up at night to pass urine <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney stones <input type="checkbox"/> Yes <input type="checkbox"/> No Male – testicle pain <input type="checkbox"/> Yes <input type="checkbox"/> No	BRAIN & NERVOUS SYSTEM Frequent or recurring headaches <input type="checkbox"/> Yes <input type="checkbox"/> No Light headed or dizzy <input type="checkbox"/> Yes <input type="checkbox"/> No Convulsions or seizures <input type="checkbox"/> Yes <input type="checkbox"/> No Numbness or tingling sensations <input type="checkbox"/> Yes <input type="checkbox"/> No Tremors <input type="checkbox"/> Yes <input type="checkbox"/> No Paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No Temporary blindness <input type="checkbox"/> Yes <input type="checkbox"/> No Loss of consciousness <input type="checkbox"/> Yes <input type="checkbox"/> No Weakness of any extremity (leg or arm) <input type="checkbox"/> Yes <input type="checkbox"/> No
EYES Eye disease or injury <input type="checkbox"/> Yes <input type="checkbox"/> No Wearing glasses/contact lens <input type="checkbox"/> Yes <input type="checkbox"/> No Blurred or double vision <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	GASTROINTESTINAL Loss of appetite <input type="checkbox"/> Yes <input type="checkbox"/> No Change in bowel movements <input type="checkbox"/> Yes <input type="checkbox"/> No Nausea or vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No Heartburn or chronic indigestion <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No Painful bowel movements or constipation <input type="checkbox"/> Yes <input type="checkbox"/> No Red blood cells in stool or tarry, black stools <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach pain <input type="checkbox"/> Yes <input type="checkbox"/> No Hemorrhoids or rectal itching <input type="checkbox"/> Yes <input type="checkbox"/> No	MENTAL HEALTH Memory loss or confusion <input type="checkbox"/> Yes <input type="checkbox"/> No Nervousness <input type="checkbox"/> Yes <input type="checkbox"/> No Depression <input type="checkbox"/> Yes <input type="checkbox"/> No Sleep problems <input type="checkbox"/> Yes <input type="checkbox"/> No
EARS, NOSE, THROAT, SINUS Hearing loss <input type="checkbox"/> Yes <input type="checkbox"/> No Ringing in the ears <input type="checkbox"/> Yes <input type="checkbox"/> No Perforated (hole in) ear drums <input type="checkbox"/> Yes <input type="checkbox"/> No Earaches or drainage <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus problems <input type="checkbox"/> Yes <input type="checkbox"/> No Seasonal nasal discharge (allergies) <input type="checkbox"/> Yes <input type="checkbox"/> No Loss of smell <input type="checkbox"/> Yes <input type="checkbox"/> No Nose bleed <input type="checkbox"/> Yes <input type="checkbox"/> No Mouth sores <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No Bad breath or bad taste <input type="checkbox"/> Yes <input type="checkbox"/> No Sore throat or voice change <input type="checkbox"/> Yes <input type="checkbox"/> No Swollen glands in neck <input type="checkbox"/> Yes <input type="checkbox"/> No	BONES, JOINTS, MUSCLES Joint pain, stiffness, or swelling <input type="checkbox"/> Yes <input type="checkbox"/> No Weakness of muscles or joints <input type="checkbox"/> Yes <input type="checkbox"/> No Muscle pain or cramps <input type="checkbox"/> Yes <input type="checkbox"/> No Back pain <input type="checkbox"/> Yes <input type="checkbox"/> No Cold extremities (legs) <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty in walking <input type="checkbox"/> Yes <input type="checkbox"/> No	ENDOCRINE Glandular or hormone problem <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid disease <input type="checkbox"/> Yes <input type="checkbox"/> No Excessive thirst or urination <input type="checkbox"/> Yes <input type="checkbox"/> No Heat or cold intolerance <input type="checkbox"/> Yes <input type="checkbox"/> No Dry skin <input type="checkbox"/> Yes <input type="checkbox"/> No Change in hat or glove size <input type="checkbox"/> Yes <input type="checkbox"/> No
HEART & CIRCULATORY SYSTEM Heart trouble <input type="checkbox"/> Yes <input type="checkbox"/> No Chest pains <input type="checkbox"/> Yes <input type="checkbox"/> No Palpitations or flutter of heart <input type="checkbox"/> Yes <input type="checkbox"/> No Swelling of feet, ankles or hands <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath that awakens you at night <input type="checkbox"/> Yes <input type="checkbox"/> No Cramping in legs <input type="checkbox"/> Yes <input type="checkbox"/> No High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	SKIN Rash or itching <input type="checkbox"/> Yes <input type="checkbox"/> No Change in skin color <input type="checkbox"/> Yes <input type="checkbox"/> No Change in hair or nails <input type="checkbox"/> Yes <input type="checkbox"/> No Varicose veins <input type="checkbox"/> Yes <input type="checkbox"/> No Breast pain <input type="checkbox"/> Yes <input type="checkbox"/> No Breast lump <input type="checkbox"/> Yes <input type="checkbox"/> No Breast discharge <input type="checkbox"/> Yes <input type="checkbox"/> No	BLOOD & LYMPH Slow to heal after cuts <input type="checkbox"/> Yes <input type="checkbox"/> No Easily bruise or bleed <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No Past transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No Enlarge glands <input type="checkbox"/> Yes <input type="checkbox"/> No
LUNGS Frequent coughing <input type="checkbox"/> Yes <input type="checkbox"/> No Spitting up blood <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma or wheezing <input type="checkbox"/> Yes <input type="checkbox"/> No	WOMEN ONLY: Pain with periods <input type="checkbox"/> Yes <input type="checkbox"/> No Irregular periods <input type="checkbox"/> Yes <input type="checkbox"/> No Vaginal discharge <input type="checkbox"/> Yes <input type="checkbox"/> No # pregnancies: _____ # miscarriages: _____ Date of last PAP smear? _____ Finding of last PAP: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Date of last period? _____ Date of last Mammogram? _____ Do you practice birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what type: _____	

Patient's Signature: _____ **Date:** _____

I have reviewed and confirmed this information with the patient. **Provider Signature:** _____
 Today's Date _____

MEDICAL RECORDS RELEASE AUTHORIZATION

PATIENT INFORMATION:

Name: _____ (Last, First, MI)

Address: _____

Phone: _____ Date of Birth: _____ SS#: _____

AUTHORIZATION:

I hereby authorize (Physician, Clinic, Hospital or other Health Care Provider) to release medical records:

From (Name of Party Releasing Records):

Name: _____

Address: _____

Phone #: _____

Date of Services: _____ to _____

To (Name of Requesting Party):

Name: **RICHICHI FAMILY HEALTH**

Address: **1217 PIPER BLVD, SUITE 101, NAPLES, FL 34110**

Fax #: **(239) 593-0067** Phone #: **(239) 514-2005** Email: **info@richichihealth.com**

PURPOSE OF RELEASE OF MEDICAL RECORDS:

- | | |
|---|---|
| <input type="checkbox"/> Change in family doctor | <input type="checkbox"/> Specialty appointment |
| <input type="checkbox"/> Insurance claim processing | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Legal claim processing | |

The Undersigned Hereby Releases RICHICHI FAMILY HEALTH from Any and All Legal Responsibility or Liability that could occur from this Action.

Patient Signature: _____ Date: _____

PAYMENT POLICY

Thank you for choosing RICHICHI FAMILY HEALTH as your primary care provider. We are committed to providing you with the best possible health care. In order to better serve you, we have adopted the following payment policy:

1. INSURANCE. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. CO-PAYMENTS & DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

3. MEDICARE & SECONDARY INSURANCE. Whether or not your secondary payer is a crossover, you are expected to pay the 20% co-payment at the time of service. Upon receiving payment from your secondary insurance company, we will refund you the payment.

4. NON-COVERED SERVICES. Please be aware that some, & perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

5. PROOF OF INSURANCE. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

6. CLAIMS SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. COVERAGE CHANGES. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you and payment will be expected immediately.

8. NON-PAYMENT. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. A monthly interest rate will accrue to your patient balance for non-paid services. Partial payments will not be accepted unless otherwise agreed upon. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

9. MISSED APPOINTMENTS. If you fail to show up or cancel your appointment with less than a 24 hour advance notice, you will be charged a fee of **\$25, (\$50 for a physical).** As a courtesy, a reminder call is made by our staff a day prior to your appointment, but in no way does this relieve the patient of the responsibility to fulfill their scheduled appointment.

10. PAYMENTS ACCEPTED. Cash, Check, American Express, Discover, Master Card, Visa. If your check is returned for insufficient funds, we reserve the right to add a penalty charge of **\$35.00** to your account.

11. CHARGEABLE SERVICES. You will be charged for additional services you request including: medical form completion, phone and email consultations, and prescription refills (requested outside a scheduled visit).

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of Patient (or Responsible Party)

Date

**PRIVACY PRACTICES
ACKNOWLEDGEMENT & CONSENT**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly or indirectly.**
- **Obtain payment from third-party payers (your insurance company).**
- **Conduct normal healthcare operations, such as quality assessments and physician certifications.**

I have received and reviewed a copy of the Notice of Privacy Practices (in office or printed out from website) containing a more complete description of the uses and disclosure of my health information. I understand that RICHICHI FAMILY HEALTH has the right to change its privacy notice and that I may contact RICHICHI FAMILY HEALTH any time to obtain a current copy of the Notice of Privacy Practices. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the RFH Privacy Officer, 1217 Piper Blvd, Suite 101, Naples, FL 34110.

I hereby give my consent for RICHICHI FAMILY HEALTH to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). With this consent, RICHICHI FAMILY HEALTH may call, mail, or email my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

I prefer to be contacted regarding my appointment, billing, or medical care in the following manner:

- Home Phone: _____ Check here if you ONLY want us to leave a call back phone #
- Work Phone: _____ Check here if you ONLY want us to leave a call back phone #
- Cell Phone: _____ Check here if you ONLY want us to leave a call back phone #
- Written Communication ONLY (We will send all information to your home address, unless requested differently)
- Other (Please specify): _____

I authorize the following persons to be contacted regarding my appointments, billing, or medical care.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

By signing this form, I am consenting to allow RICHICHI FAMILY HEALTH to use and disclose my PHI to carry out TPO.

Signature of Patient (or Legal Guardian)

Date

Print Patient's Name

Print Legal Guardian's Name (if applicable)