



Absolute Integrated Medicine

333 17th Street Suite P
Vero Beach, FL 32960
772-770-6184

Please fill in the following information as completely as possible. In order for us to verify your insurance benefits, we must have the information listed below. This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

NAME _____ DATE _____

ADDRESS _____

CITY/STATE/ZIP _____

HOME PHONE _____ EMAIL _____

BIRTHDATE _____ AGE _____ MARITAL STATUS _____ Children _____

PLACE OF EMPLOYMENT _____

WORK PHONE _____ BEST # TO REACH YOU _____

Have you had an auto accident within the last two years? _____

If yes, please give the date of the accident _____

How did you learn about our office? _____

Major medical complaint: _____

Medications: _____

Surgical history: _____

PRIMARY INSURANCE:

MEDICARE _____ WORKCOMP _____ AUTO _____ HEALTH _____

Please supply us with a copy of your insurance card.

ABSOLUTE INTEGRATED MEDICINE

PATIENT QUESTIONNAIRE

- I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

- II. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

Name _____ Phone Number: _____
Name _____ Phone Number: _____

- III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent, if other than your home.

- IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked CONFIDENTIAL:

YES _____ NO _____

- V. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information, if other than your home phone number:

- VI. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?

YES _____ NO _____

PATIENT NAME _____ (guardian, if under 18 years)
(Please print)

Patient / Guardian Signature

Date

Absolute Integrated Medicine

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____
Printed Name - Patient or Representative

Signature

Relationship to Patient (if other than patient): _____

Date: ____ / ____ / ____

Witness _____
Printed name - Practice representative

Date: ____ / ____ / ____

Absolute Integrated Medicine

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our Patient Information sheet before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, MASTERCARD, AND VISA.

Regarding Insurance

We will verify coverage prior to treatment. If, for any reason, we are not able to verify coverage prior to your treatment, you will be charged for each treatment until verification is obtained. Our fees are determined by the complexity of the particular case and the different services used during treatment. Any balance due on your treatments is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you bring in all insurance information. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. In the event we do not accept assignment of benefits, we require that you provide a credit card number with authorization to bill that account for any balance your insurance company does not pay. If your insurance company has not paid your account in full within 45 days, the balance of your account will be automatically transferred to your credit card. In signing this document, you are assigning to this office the benefits to which you are eligible to receive for care rendered in this office. Additionally, in signing this document, you authorize the release of any information to any insurance company, adjustor or attorney that will assist in the payment of a claim.

Usual and Customary Rates (UCR)

Our practice is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. Please be aware that some, and at times, perhaps all of the services provided may be "non-covered" services and not considered reasonable and necessary under the Medicare program and/or by other medical insurance. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Your treatments will be more effective if you follow your doctor's guidelines and stick to your treatment schedule. Please help us to serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

A photocopy of this form shall be considered as effective as the original.

X _____ DATE _____
Signature of Patient or Responsible Party

Absolute Integrated Medicine

To: Patients Paying at the Time of Service

In an effort to minimize costs and create the best possible atmosphere for healing, we have made the following adjustments to our Usual and Customary Rates. We are able to do this because paying at time of service frees this office from time-consuming paper work and tracking of filed insurance claims.

At your initial visit, you will be responsible for the New Patient office visit. The bill will show the office visit and my fee. However, there are several procedures that may occur during your visit, which will be modified, any of these procedures used during your treatment will be reduced to \$0.00, and you will be responsible for the office visit fee only.

97810-52	Acupuncture 1 st 15 min	97813-52	Acupuncture w/Elec.stim1 st 15 min
97811-52	Acupuncture 2 nd 15 min	97814-52	Acupuncture w/Elec Stim 2 nd 15 min
97010-52	Heat therapy	97140-52	Manual Therapy
97014-52	Elec. Stim (Unattended)	97530-52	Kinetic Activities
97032-52	Elec. Stim. (Attended)	97110-52	Therapeutic Exercises
99070-52	Needles		

The fee for the New Patient office visit (code 99203) is \$ 95.00

The fee for each office visit after the initial visit (code 99213) is \$ 75.00

I have read and understand the information contained therein.

_____ Date _____

Patient's Signature

Yours in Health,

Jill Jaynes, AP
Acupuncture Physician