New Patient Information

PHYSICIANS HolisticHealth Alliance

Name:	Home Phone #: _____ / _____ / _____ Cell Phone # : _____ / _____ / _____
DOB: ___ / ___ / _____ Gender: Male / Female	Would you like to receive appointment reminders? YES, email address: NO: ____
Address / Zip Code:	Would you like to receive PHA's periodic blog articles, updates, and offers? YES: ___ NO: ____
Social Security #:	**Primary Care Physician:** Address:
Emergency Contact Name : Phone #: _____ / _____ / _____	Phone # : _____ / _____ / _____

Insurance Information

PRIMARY INSURANCE: Yes No	**SECONDARY INSURANCE:** Yes No
Insurance Provider:	Insurance Provider:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:
Insurance ID Number:	Insurance ID Number:
Group Number:	Group Number:

Medical Information Release

I hereby authorize Physicians HolisticHealth Alliance, llc / Physicians HolisticHealth Alliance, llc / Uthman Cavallo, MD, llc to release any medical or appointment information to the following persons (i.e. spouse, parents, children or significant other):

Name	Relationship

53800 Generations Drive South Bend, In 46635 P 574.273.3880 F 574.271.0918
caringforthewholeyou.com

Name: _____ **DOB:** ___ / ___ / _____

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Surgical History

Surgery	Date	Reason
Hysterectomy		
Removal of Ovaries		
Endometrial Ablation		
Appendectomy		
Cesarean		
Laparoscopy		
Abdominal Surgery		
Bowel Surgery		
Other Surgeries		

Allergies

Drug Allergy- yes/no	Your Reaction
Drug name:	
Drug name:	
Drug name:	
Drug name:	
Drug name:	
Latex Allergy: Yes or No	
Environmental Allergy: Yes or No	

Past Medical History

mark any you have experienced

___High blood pressure	___ Gastrointestinal problems	___ Cholesterol problems
___ Polycystic Ovarian Syndrome (PCOS)	___ Heart problems	___ Diabetes
___ Infertility	___ Lung problems	___ Blood clots
___ High blood pressure in pregnancy	___ Stroke	___ Cancer
___ Diabetes in pregnancy	___ Bleeding tendency	___ Anemia
___ Thyroid problems	___ Muscle/joint/bone problems	___ Liver problems
___ Kidney problems	___ Depression/Anxiety	___ Other:

Name: _____ **DOB:** ___ / ___ / _____

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Family Medical History

Mother	
Father	
Maternal Grandmother	
Maternal Grandfather	
Paternal Grandmother	
Paternal Grandfather	
Siblings	
Children	

Preventative Health Maintenance Record

document the most recent date

Everyone	Date	Women	Date
Colonoscopy		Annual Exam/Physical	
Bone Density		Mammogram	
Tetanus Shot		Pap Smear	
Pneumonia Shot (Pneumothorax)			
Flu Vaccine		**Men**	
Shingles Vaccine		Annual Physical	
Childhood Vaccinations	Yes or No	Digital Rectal Exam	
Cardiac Stress Testing		PSA Test	
Electrocardiogram/Echocardiogram			

Social History / Lifestyle

Marital Status: S M W D	**Children (please list ages):**		
Current Occupation:	**Highest Level of Education:**		**Field of Study:**
Tobacco Use: Yes or No	Quantity:	How Long:	Concerns:
Alcohol Use: Yes or No	Quantity:	How Long:	Concerns:
Recreational Drug Use: Yes or No	Quantity:	How Long:	Concerns:

Name: _____ **DOB:** _____

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Social History / Lifestyle (continued)

Rate the following (1-10)

Level of Stress ___ Level of Energy ___ Health Rating ___

Describe your sleep patterns._____

Describe your physical activity._____

How do you see your health in the next 5 years, if you keep doing the same things?

_____

_____

Goals and Objectives for Care at PHA:

___ Symptom relief
___ Full correction of the problem
___ Optimal health: mind/body/spirit
___ Manage stress

Please tell us any problems or concerns you would like to address:

_____

_____

Diet

describe your average daily diet

Breakfast	
Snack	
Lunch	
Snack	
Dinner	
Snack	
Beverages	

Name: _____ **DOB:** _____

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Life Satisfaction

mark the following statements as they apply to you

___ In general I experience job satisfaction
___ I feel that I have a role in improving my community
___ I have a positive relationship with most family members
___ I enjoy spending time with friends
___ I know I have at least one person I can call no matter what
___ I look at mistakes as learning tools
___ I can express my anger without losing control
___ I want to sleep all the time
___ My sleep is restless & interrupted most nights
___ I feel depressed much of the time
___ I sometimes feel hopeless
___ My energy is low
___ I have frequent anxiety
___ I am concerned about a relationship problem
___ I often feel worthless
___ Other:

Medications / Supplements

Medication Name	# of tablets, capsules, drops	How Often	Reason
Supplement Name	**# of tablets, capsules, drops**	**How Often**	**Reason**

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Consent for Treatment

I hereby consent to and authorize Physicians HolisticHealth Alliance, llc / Uthman Cavallo, MD, llc, its associated physician's medical resident, nurse practitioners, students and other healthcare providers, to provide and perform such medical and surgical care, tests, procedures, drugs and other services and supplies as are considered advisable by such health care providers for my health and well-being.

If I should not comply with the medical program of care provided or recommended by physicians(s), or designated alternates(s), I understand that I then relieve my physician(s), designated alternate(s), associated medical staff, and the practice of all responsibility resulting from my action.

If the patient is a minor:
As parent/guardian, I give my permission for _____ to receive care.
Patient Name

Cancellations, No Shows and Tardiness

Physicians HolisticHealth Alliance, llc / Uthman Cavallo, MD, llc requires a 48 hour notice for new patient cancellations, 24 hour notice for established patient cancellations, and 10 days for surgery cancellations. If an appointment is not cancelled in advance, you will be charged a $50 fee ($75 for surgical cancellations) that is not covered by insurance and no future appointments will be scheduled until the no call/no show fees are paid in full. After three such missed appointments, you may be dismissed from the practice.

Arriving Late: We understand delays can happen, however we must try to keep the other patients and providers on time. If a patient arrives past their scheduled time, we will have to reschedule the appointment.

Patient Financial Responsibilities

It is important that you understand your financial responsibilities for the services you receive. Please check with your insurance plan to verify that your provider is in your insurance network. The changing healthcare environment puts more of this responsibility in your hands. We will be glad to discuss your account with you and set up a payment plan (however, please be advised that we outsource our billing and partner with a company called Kareo). ***Your responsibilities are outlined in this document. We ask you to read, agree to, and sign below prior to any treatment.***

In Network Insurance: Our office participates in some networks. You must bring your insurance card with you to every visit and make us aware of any changes in coverage. We also require a copy of your driver's license to confirm identity. Additionally, if your insurance company requires a physician referral, it is your responsibility to ensure that it has been obtained. If it has not, you will be asked to sign a waiver. You must notify us if you have and/or receive any Medicaid benefits.

Out of Network Insurance/Cash Accounts: We do not carry balances on accounts. You are expected to pay at the time of service for all services. For your convenience, we accept cash, personal checks, Visa, Master Card, and Discover.

Returned Checks: A $35 NSF will be applied to the patient's account. If you present two (2) checks that are returned to us, we will require cash for future services.

Co-payments and Deductibles: You are responsible for paying any co-payment or deductible at the time of service. For your convenience, we accept cash, personal checks, Visa, Master Card, and Discover.

Secondary Insurance: Initial filing to your secondary insurance will be billed as a courtesy. Patients will be responsible for their secondary insurance after it is initially filed.

Name: _____ **DOB:** ___ / ___ / _____

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Financial Responsibilities (continued)

Financial Arrangement for Surgery: We will obtain prior-authorizations if necessary. It is the patient's responsibility to call their insurance and find out their benefits.

Financial Arrangement for OB Care: It is the patient's responsibility to call their insurance and find out their benefits for prenatal care. Patients are expected to pay the co-insurance portion by the 30th week of pregnancy.

Non-Covered Services: Some service(s) provided are not covered by insurance or may be deemed medically unnecessary, experimental, non-covered and/or inclusive. The patient agrees to pay for these services. The patient accepts the responsibility to know their plan's provisions. And, the patient waives the right to be informed of plan exclusions or service that may be considered medically unnecessary (as defined by the patient's health plan), or non- covered services prior to receiving services.

Our charges are determined by what is usual and customary to our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

If you have any questions about your insurance, we are happy to assist you. Please contact our office at 574.273.3880. Specific coverage issues, however, should be directed to your insurance company's member service department (number found on back of card).

Cash Account Balances: Patients are required to pay their account balances to zero prior to receiving further services by our practice. Patients may call to speak with a business office representative to review accounts and discuss payment plans. Patients with balances over $100 must make payment arrangements prior to scheduling future appointments.

Special Circumstances: PHA is committed to promoting the health and well-being of the communities we serve. We understand that occasionally circumstances make it difficult for patients to pay their bills on time, so we offer payment plans. PHA reserves the right to determine a monthly payment schedule by discussing the account with you. If an increase in a patient's account balance occurs, we will need to adjust the payment agreement also.

Once a special payment plan is implemented, the patient may be required to pay for new services at the time they are provided to avoid an increase in the account balance.

Collections: We utilize the services of the law office, Diamond & Diamond. The PHA Business & Operations Team makes every effort to collect payment for balances before they reach the point of becoming delinquent. Should your balance become delinquent, it will be referred to Diamond & Diamond. At that point, you will no longer be able to receive services from PHA. We will transfer your records to a provider of your choice.

I acknowledge my understanding and agree that I am legally responsible for my account and all costs associated with the collection of my account. Account balances after insurance must be paid in full within 30 days of patient billing, unless other payment arrangements have been made, to avoid collection placement. A collection fee, attorney fee or other fees that may incur to collect payment will be added to any outstanding balance. I also authorize the practice, all associated physician and all associated agencies, to gather, maintain and release any and all of my information that may be required for the processing of any and all claims for third party payers.

I authorize Physicians HolisticHealth Alliance, llc / Uthman Cavallo, MD, llc to release information concerning illness or treatments to my insurance carrier, to submit fees for services rendered to my insurance for payment, and also direct payment to the Provider(s) who rendered medical services. I will accept responsibility for payment of fees submitted to my insurance carrier, and for any balance not covered by my insurance

Print: _____ Date: ___ / ___ / _____

Patient or Responsible Party

Signature: _____ Date: ___ / ___ / _____

Patient or Responsible Party

Signature: _____ Date: ___ / ___ / _____

Witness

Name: _____ **DOB:** ___ / ___ / _____

PHYSICIANS HolisticHealth Alliance

Acknowledgment of Receipt of Notice of Privacy Practice

direct any questions to our office at **574.273.3880.**

___ I have been presented with and received the Notice of Privacy Practices for Physicians HolisticHealth Alliance, llc. / Uthman Cavallo, MD, llc.

___ I have been presented with and choose not to receive the Notice of Privacy Practices for Physicians HolisticHealth Alliance, llc / Uthman Cavallo, MD, llc.

I understand that this Notice of Privacy Practice may change over time and that the obligations of Physicians HolisticHealth Alliance, llc / Uthman Cavallo, MD, llc and my rights under it may change.

___ Refusal: Patient or guardian of patient refused to acknowledge receipt of the Notice of Privacy Practices of Physicians HolisticHealth Alliance, llc / Uthman Cavallo, MD, llc.

___ Acknowledgment of receipt of the Notice of Privacy Practices was not obtained, despite Physicians HolisticHealth, llc. / Uthman Cavallo, MD, llc's good faith effort because:
_____.

Print: _____ Date: ___ / ___ / _____
Patient or Responsible Party

Signature: _____ Date: ___ / ___ / _____
Patient or Responsible Party

Signature: _____ Date: ___ / ___ / _____
Witness

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