Richichi Family Health

PELICANPRIMARYCARE

Thank you for choosing our Practice. In order to properly serve you, we need the following information:

PATIENT INFORMATION

Name: (Last, First, MI)	Social Sec#:	Birth Date:	Gender: ☐M ☐F	Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed
Race/Ethnicity: ☐American Indian ☐Asian ☐Black/African Amer. ☐White ☐Native Hawaiian/Other Pacific Islander ☐Hispanic/Latino ☐Other			Preferred Language: ☐English ☐Spanish ☐Other:______________	
Address: (Street)			(City, St, Zip)	
Northern Address: (Street) (City, St, Zip)			Dates at Northern Address:	
Home Phone:	Cell Phone:	Work Phone:	Email:	
I prefer to be contacted by: ☐Phone ☐Text ☐Mail ☐Email	*I prefer to be reminded of my appointments by (check all that apply)*: ☐Cell ☐Home ☐Office ☐Mail ☐Email ☐Cell only ☐Home only ☐Office only ☐Mail only ☐Email only			
I give my permission to leave phone messages regarding my medical care/appointment confirmation: ☐*Yes* ☐*No*				

PHARMACY

(Name):	(Phone)	(Address)

EMPLOYMENT/SCHOOL INFORMATION

Employer/School:	Occupation:	Phone:	Address:

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:	Relationship:	Phone:

BILLING AND INSURANCE

Name of Insured (as it appears on ins card):	Chose one: ☐Self ☐Spouse ☐Parent ☐Other:________________	Date of Birth:	Social Sec#:
Primary Insurance Co:	Plan Name:	Secondary Ins. Co (if applicable):	Plan Name:

Responsible Party (Person responsible for payment of your service if different from patient)

Name:	Date of Birth:	Relationship to Patient:	Phone:
Address (if different from patient): (Street)		(City, St, Zip)	

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.

SIGN HERE (Patient or Legal 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.

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PELICANPRIMARY**CARE**

Please complete the following:

Patient Name:	Birth Date:	Birth Place:

Visit Reason: What brings you to the office today? ____

Allergies (*Food, drug, other*)

☐Adhesive tape	☐Antibiotics	☐Latex
☐Barbiturates (sleeping pills)	☐Aspirin	☐Iodine
☐Codeine	☐Sulfa	☐Local Anesthetics
Other allergy	Reaction	
Other allergy	Reaction	

Current Medications (*Bring bottles and/or medication list*)

Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency

Past Medical History (*Check all that apply*)

☐Alcoholism	☐Fractures	☐Kidney disease
☐Allergies	☐GERD	☐Liver disease
☐Anemia	☐Glaucoma	☐Lung disease
☐Arthritis	☐Gout	☐Osteoporosis
☐Asthma	☐Migraines	☐Pneumonia
☐Cancer	☐Heart disease	☐Skin disease
☐Concussions	☐Hepatitis (A,B,C)	☐Substance abuse
☐COPD	☐High blood pressure	☐Thyroid disorder
☐Diabetes	☐High cholesterol	☐UTI's
☐Epilepsy	☐HIV/AIDS	

Current Problems (*Check all that apply*)

☐Good general health lately

☐Weight change	☐Leg cramping	☐Nausea or vomiting	☐Atypical moles/warts	☐Easy bruising
☐Fever	☐Heart trouble	☐Heartburn/indigestion	☐Breast mass	☐Excessive bleeding
☐Fatigue	☐Palpitations	☐Hemorrhoids/rectal itch	☐Change in hair/nails	☐Hair loss
☐Eye problems	☐Swelling extremities	☐Changes in urination	☐Rash or itching	☐Hormone problems
☐Ear problems	☐Shortness of breath	☐Burn/painful urination	☐Dizziness	☐Hot/cold intolerance
☐Sinus issues	☐Coughing	☐Male-testicle pain	☐Fainting	☐Sweating
☐Nasal issues	☐Wheezing	☐Back pain	☐Headaches	☐Anxiety
☐Sore throat	☐Abdominal pain	☐Difficulty walking	☐Memory loss	☐Depression
☐Swollen glands	☐Constipation	☐Joint stiffness/pain	☐Tremor	☐Sleep disturbance
☐Chest pains	☐Diarrhea	☐Muscle pain	☐Weakness	

Surgical History & Hospitalizations

Reason	Date
Reason	Date
Reason	Date

Other Medical Providers

Name	Specialty
Name	Specialty
Name	Specialty

Preventive Health History (*Approximate if necessary – i.e. month/year or year only*)

When last physical?	____________	Bone density?	____________	Flu vaccine?	____________
Colonoscopy?	____________	Chest X-ray?	____________	Pneumonia vaccine?	____________
Echocardiogram?	____________	Eye exam?	____________	Tetanus vaccine?	____________
EKG?	____________	Hearing exam?	____________	Shingles vaccine?	____________

Women Only

Last Pap? __________	Normal ☐Yes ☐No
Last Mammo? __________	Normal ☐Yes ☐No
# Children __________	# Miscarriages _____
# Pregnancies __________	# Abortions _____
☐Irregular menstral cycle	☐Vaginal discharge

Family History

	Heath Condition	If deceased, cause of death
Father		
Mother		
Sibling		
Sibling		
Other		
Other		

Social History

Occupation:	Exposure: ☐Fumes ☐Dust ☐Solvents ☐Noise	
Hobbies/Rec:		
Exercise: (Type)	(Frequency)	
Sexually active: ☐Yes ☐No	Birth control/protection: ☐Yes ☐No Type:	
Tobacco: ☐Never ☐Past ☐Current	☐Cigarettes Packs/day:__________	☐Smokeless Times/day:__________
Alcohol: ☐Never ☐Rare ☐Moderate ☐Daily	(Frequency)	(Type)
Caffeine: ☐Never	(Type)	(Frequency)
Supplements: ☐Never	(Type)	(Frequency)
Drug use: ☐Never	(Type)	(Frequency)

SIGN HERE **Patient's Signature:**____ Date:__________

Provider Signature:__________________________________ Date__________ ☐ *I have reviewed & confirmed this info with the patient.*

Richichi Family Health

PELICANPRIMARY**CARE**

PAYMENT POLICY

1. INSURANCE. We are in network with most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you 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 forms before the visit. We must obtain a copy of your driver's license and current valid insurance. If you fail to provide us with the correct insurance info 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 to get your claims paid. Your insurance company may need you to supply certain info directly. It is your responsibility to comply with their request. Please know the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your benefits are a contract between you and your insurance company; we are not party to that contract.
7. COVERAGE CHANGES. Please notify us of insurance changes 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 be billed and payment expected.
8. NON-PAYMENT. Accounts over 90 days past due will receive a letter stating that you have 20 days to pay your account in full and a monthly interest rate will accrue for non-paid services. Partial payments will not be accepted unless otherwise agreed upon. We will refer delinquent accounts to a collection agency and you and your immediate family members may be discharged from this practice. You will be notified by regular and certified mail that you have 30 days to find alternative medical care. Our providers will then 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, and our prices are representative of the usual and customary charges for our area.

SIGN HERE

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

(Signature)____**(Date)**________________

NOTICE OF PRIVACY PRACTICES

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 & direct my treatment & follow-up among multiple health 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 ("RFH") & PELICAN PRIMARY CARE ("PPC")** have the right to change its privacy notice and that I may contact RFH/PPC 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/PPC Privacy Officer, 1217 Piper Blvd, Suite 104, Naples, FL 34110.

I hereby give my consent for RFH/PPC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). With this consent, RFH/PPC 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 authorize the following persons to be contacted regarding my appointments, billing, or medical care.

Name:	Relationship:	Phone#:
Name:____________________	Relationship:____________________	Phone#:____________________
Name:____________________	Relationship:____________________	Phone#:____________________
Name:____________________	Relationship:____________________	Phone#:____________________

SIGN HERE

By signing this form, I am consenting to allow RFH/PPC to use and disclose my PHI to carry out TPO.

(Signature Patient or Legal Guardian)____**(Date)**________________

(Print Patient's Name)____________________________________**(Print Legal Guardian's Name-If Applicable)**____________________________

Richichi Family Health PELICANPRIMARYCARE

MEDICAL RECORDS RELEASE AUTHORIZATION

PATIENT INFORMATION:

Name: (Last, First, MI) ______________________________

Address: ______________________________

Phone: ____________________ Date of Birth: ______________

AUTHORIZATION:

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

» **FROM** (Name of Health Care Provider Office Releasing Records):

Name: ______________________________

Address: ______________________________

Phone #: ____________________ Fax #: ____________________

Approximate dates of service: ____________________ to ____________________

******OFFICE USE ONLY******

☐ Abstract Summary (2 yrs. office visits/labs/imaging/hospitalizations)

☐ Office Visits: ______________ ☐ Diagnostic Tests: __________ ☐ Medication List

☐ Lab Results: ______________ ☐ History & Physical ☐ Immunization Record

☐ Hospital Records: ______________________________

» **TO** (Name of Requesting Party):

☐ *Richichi Family Health*
1217 Piper Blvd Ste 101
Naples, FL 34110
PH: (239) 514-2005
Fax: (239) 593-0067
info@richichihealth.com

☐ **PELICAN** PRIMARY **CARE**
23421 Walden Center Dr Ste 100
Bonita Springs, FL 34134
PH: (239) 514-2008
Fax: (239) 593-0067
info@pelicanprimarycare.com

PURPOSE OF RELEASE OF MEDICAL RECORDS:

☐ Change in family doctor ☐ Other (specify): ____________________

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

Patient Signature: ______________________________ **Date:** ______________