BAY AREA WELLNESS CENTER

Frank Tortorice MD, IFMCP
1275 California Drive, Suite B
Burlingame, CA 94010
T: 650-692-7545
F: 650-692-7609

Thank you for choosing the Bay Area Wellness Center. Your doctor is fully committed to provide the highest quality of medical care for you.

In our effort to foster a professional and collaborative relationship between you and your doctor, and to avoid any possible misunderstandings, we ask you to be fully aware of your financial responsibilities relating to your treatment. Please read carefully our policies and acknowledge your acceptance of the same by signing below. If you have any questions regarding these policies, please feel free to ask our reception staff.

OFFICE POLICY

1. All new patients are required to fill out the registration forms thoroughly and completely. Copies of your ID and medical insurance card will be made as part of your medical file. Depending on the frequency of your visits, we will require you from time to time, to update your information and registration paperwork.

2. It is your responsibility to notify our office of the current address and telephone numbers of your insurance carrier(s) and any changes in your insurance coverage while undergoing medical care with our clinic.

3. It is your responsibility to understand your insurance coverage as it relates to the service you are about to receive. There is no guarantee that your insurance carrier will make actual payment or that payment will be as per the verification previously made by us. Some insurance companies require medical or administrative pre-authorization for treatment(s).

FINANCIAL POLICY

1. All copayments, deductibles, other fees (if applicable), or any pending unpaid balances with our clinic are due at the time of your visit and prior to receiving any services from the doctor. On a case-to-case basis, payment plans could be arranged.

   Payments may be made in cash, debit or credit card (Visa or Mastercard Only). We do not accept personal checks. A minimum bill of $15.00 is required for credit card use. If the required payment is not made at the time of your visit, you may not see the doctor.

2. Your medical insurance policy is a contract between you and your insurance provider. As a service to you, however, we will file your insurance claim provided you authorize and assign to us the payment of your medical benefits.

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3. Should your insurance provider fail to pay us after a reasonable period of time, we will seek payment from you. You are ultimately responsible for the payment of any medical services provided to you by our clinic. Any unpaid accounts will be forwarded to a collection agency after a certain period of time. The cost of collection will be added to your account.

4. Medicare patients who do not have supplemental insurance are required to pay the 20% co-insurance portion normally not paid by Medicare. If you have supplemental insurance, and your supplemental insurance provider, for any reason, will not pay the 20% co-insurance, then you are responsible to pay us the said 20% co-insurance.

5. If your insurance policy has a deductible larger than $500.00 and the insurance company says it has not been met, then you will need to pay the Bay Area Wellness Center $150.00 at your first visit and $100.00 on each succeeding visit until your deductible limit has been met. IF at the end of your treatments, you have made an overpayment, Bay Area Wellness Center will reimburse you as soon as your insurance provider has fully processed the claim.

6. Patients <u>without insurance</u> will be required to make cash payment (out-of-pocket) before they see the doctor. The amount due will depend on the type of service that will be rendered by the doctor.

7. Bay Area Wellness Center does not accept any attorney, third party or personal liens.

    A. If you are here as a result of an accident claim, you are required to pay 100% of the charges at time of visit.
    B. You can provide us with your health insurance information and we will bill them directly.

8. Our office will not enter into any dispute with our insurance company over any claim. This is ultimately your responsibility and obligation.

9. Administrative fees are charged for requests of copies of medical records. Fees are also charged for the completion of forms and letters and other documents including DMV, disability, or others. The amount of the fee is dependent on the length and the complexity of the form or letter. Please check with our reception staff.

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CANCELLATION AND NO-SHOW POLICY

IT IS IMPORTANT THAT PATIENTS FOLLOW THEIR APPOINTMENT SCHEDULES.

It is your responsibility to remember your appointment regardless of whether you received a courtesy reminder call from us or not.

If for any reason you would NOT be able to make it to your appointment schedule, please inform us as soon as possible. By letting us know ahead of time, we will be able to re-allocate your schedule to another patient who may be in serious need of treatment. In the event we are not able to take your call, please leave us a voicemail message.

Please note that any appointment missed, cancelled, or re-scheduled with less than 24-hour notice will be charged a $75.00 no show/rescheduling fee for regular office visits/nutrition visits as well as pre-operation visits or other procedural visits. These fees are not covered by your insurance and are to be paid by you prior to your next scheduled appointment.

Three missed appointments without prior notification to our office, or three cancellations of appointments with less than 24-hour notice will be considered a valid reason to discharge a patient from our clinic.

Knowing that I have a condition requiring diagnosis, treatment, or related medical care, I hereby grant my consent to such care by the Bay Area Wellness Center. I agree to receive medical examination(s), procedure(s), and/or treatment by my attending physician, and his assistant(s) as deemed necessary. I further acknowledge that no guarantees have been made to me as to the result of such care, medical examination(s), procedure(s), and/or treatment.

I have read, understood and accepted the terms of these policies. I am the patient, or the third party authorized by the patient, (as guardian or general agent), to execute this agreement.

_____ _____

Patients Printed Name Patients Date of Birth

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the Bay Area Wellness Center to finish medical information concerning patient _____. Name and address of person to receive records (e.g., spouse, care taker, children).

_____

Any and all information may be released including but not limited to mental health records protected by the Lanterman-Petris-Short Act, drug, and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below:

_____

_____

The information may be used only for the following purposes: *

_____

This authorization is effective now and will remain in effect until _____.

I understand that I have the right to receive a copy of this authorization.

_____ _____

Signature Date

_____

Print Name

If not signed by the patient, please indicate relationship:

[ ] Parent of guardian of minor patient (to the extent minor could not have consented to the care
[ ] Guardian or conservator of an incompetent patient
[ ] Beneficiary or personal representative of deceased patient ***
[ ] Spouse or person financially responsible (where information solely for purpose of processing application for dependent health care coverage(s).

*Signed _____ Date: _____

Treating Physician

**For the release of records (1) protected by the Lanterman-Petris-Short Act (LPS) or (2) containing HIV test results, a separate authorization is required for each separate disclosure. Further, the LPS act often requires that both patients treating physician and the patient sign the authorization for before information may be released. It is unclear whether the beneficiary or personal representative of a deceased patient can obtain and disclose certain records containing HIV test results.*

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PATIENT REGISTRATION

Today's Date: _____

_____
Last Name First Name Middle Initial

[ ] M [ ] F _____ _____ [ ] S [ ] M [ ] D [ ] W
Date of Birth Social Security Marital Status

ADDRESS: _____
Street City State Zip

BILLING ADDRESS (*If different from home address)*

_____
Street City State Zip

Home Phone: _____ Cell Phone: _____
Email: _____

EMERGENCY CONTACT

_____ _____ _____
Name Relationship Phone

_____ _____ _____
Name Relationship Phone

INSURANCE INFORMATION

_____ _____ _____
Primary Insurance Policy ID Number Group Number

_____ _____ _____
Secondary Insurance Policy ID Number Group Number

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly by the doctor.

_____ _____
Patient Signature Date

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Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability

Date: _____

Patient Name: _____ D,O,B _____

Chief Complaint: _____

History of present illness:

Location: _____ Quality: _____

Severity: _____ Duration: _____

Associated signs/Symptoms: _____ Modifying Factors: _____

_____ _____

Past Medical History

Have you ever had the following? Check the box if "Yes".

Measles	☐	Anemia	☐	Back Trouble	☐	Hepatitis	☐
Mumps	☐	Bladder Infections	☐	High Blood Pressure	☐	Ulcer	☐
Chickenpox	☐	Epilepsy	☐	Low Blood Pressure	☐	Kidney Disease	☐
Whooping Cough	☐	Migraine	☐	Hemorrhoids	☐	Thyroid Disease	☐
Scarlet Fever	☐	Tuberculosis	☐	Asthma	☐	Bleeding Tendency	☐
Diphtheria	☐	Diabetes	☐	Hives	☐	OTHER:	☐
Smallpox	☐	Cancer	☐	Eczema	☐		
Pneumonia	☐	Polio	☐	AIDS or HIV	☐		
Rheumatic Fever	☐	Glaucoma	☐	Infectious Mono	☐		
Heart Disease	☐	Hernia	☐	Bronchitis	☐		
Arthritis	☐	Blood/Plasma		Mitral Valve Prolapse	☐		
Venereal Disease	☐	Transfusions	☐	Stroke	☐		

Previous Hospitalizations/Surgeries/Serious Illnesses **When?**
Hospital, City, State

_____ _____ _____
_____ _____ _____

Medications: (Include over-the-counter):

_____
_____

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Patient Social History:

Marital Status Single ____ Married ____ Separated ____ Divorced ____ Widowed ____
Use of Alcohol Never ____ Rarely ____ Moderate ____ Daily ____
Use of Tobacco Never ____ previously, but quit: _____
Use of Drugs Never ____ Type/Frequency: _____

Family Medical History

	Age	Diseases	if deceased, cause of death.
Father	___	_____	_____
Mother	___	_____	_____
Sibling's	___	_____	_____
	___	_____	_____
	___	_____	_____
Spouse	___	_____	_____
Children	___	_____	_____
	___	_____	_____

Review of Systems: Please Check the box if the answer is "Yes"

Constitutional Symptoms	☐	Incontinence or dribbling	☐	Insomnia	☐
Good general health lately	☐	Kidney stones	☐	Suicidal Thoughts	☐
Recent weight change	☐	Sexual Difficulty	☐	Violent or Unusual Thoughts	☐
Fever	☐	Male-Testicle Pain	☐		☐
Fatigue	☐	Female – pain with periods	☐	**Endocrine**	☐
Headaches	☐	Female – irregular periods	☐	Glandular or hormone prob.	☐
		Female – vaginal discharge	☐	Excessive thirst or urination	☐
Eyes		Female - # of pregnancies	_	Heat or cold intolerance	☐
Eye disease or injury	☐	Female - # of miscarriages	___	Skin becoming drier	☐
Wear glasses/contacts	☐	date of last pap smear	_	Change in hate or glove size	☐
Blurred or double vision	☐				
		Musculoskeletal		**Hematologic/Lymphatic**	
Ears/Nose/Mouth/Throat		Joint pain	☐	Slow to heal after cuts	☐
Hearing loss or ringing	☐	Joint stiffness or swelling	☐	Bleeding or bruising	☐
Earaches or drainage	☐	Weakness of muscles or joints	☐	Anemia	☐
Chronic sinus problem	☐	Muscle pain or cramps	☐	Phlebitis	☐
Nose bleeds	☐	Back pain	☐	Past transfusion	☐
Mouth sores	☐	Cold Extremities	☐	Enlarged Glands	☐
Bleeding gums	☐	Difficulty in Walking	☐		☐
Bad breath or bad taste	☐			**Allergic/Immunologic**	☐
Sore throat or voice change	☐	**Integument (skin, breast)**	☐	History of skin reaction :	
Swollen glands in neck	☐	Rash or itching	☐	Antibiotics	☐
		Change in skin color	☐	Morphine	☐
Cardiovascular		Change in hair or nails	☐	Demerol	☐

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Heart Trouble	☐	Varicose veins	☐	Novocain or other aesthetics	☐
Chest pain or angina	☐	Breast pain	☐	Aspirin or other pain meds	☐
Palpitation	☐	Breast lump	☐	Tetanus, antitoxin	☐
Shortness of breath	☐	Breast discharge	☐	Iodine	
Swelling feet, ankles	☐		☐	OTHER:	
		Neurological			
Respiratory	☐	Frequent or recurring headaches	☐		
Chronic or frequent coughs	☐	Light headed or dizzy	☐	Known Food Allergies :	
Spitting up blood	☐	Convulsions or seizures	☐	_____	
Shortness of breath	☐	Numbness/tingling	☐	_____	
Wheezing	☐	Tremors	☐	_____	
	☐	Paralysis	☐		
Genitourinary		Head injury	☐		
Frequent urination	☐	**Psychiatric**		Environmental Allergies:	
Burning or painful urination	☐	Memory loss or confusion	☐	_____	
Blood in urine	☐	Nervousness	☐	_____	
Change in force of strain when urinating	☐	Depression	☐	_____	

Scribe Kick Consent Form

Consent Form for audio transcription during your visit at Bay Area Wellness Center to deliver a better quality of care.

We are innovating to allow our doctors to spend more time with you. By working with a professional remote scribe service, Scribe Kick, we are automating note-taking so our physicians can give you more of their undivided attention during your visits. This will mean more time for conversation, and more detailed records of our time spent together.

To enable the service, we request your consent to transmit an audio feed with your doctor for the purpose of providing more accurate notes and improving the scribing service. For us at BAWC and Scribe Kick, your privacy is extremely important to us, and the information discussed in your visit will never be shared or disclosed without your permission. Scribe Kick complies with all privacy laws, the Health Insurance Portability and Accountability Act (HIPAA), and have industry standard security, encryption and auditing measures to ensure your data is protected and private.

I, the undersigned, give consent to transmit and document my clinical visit for the purpose of fulfilling the electronic data entry of my medical record at Bay Area Wellness Center (BAWC). I understand if at any point I feel uncomfortable, and wish to speak to my physician privately, I can mute the service temporarily or permanently.

Print name	Signature	Date
_____	_____	_____