Ocean Wellness

New Patient History – Adult

Date of Initial Consultation: _____ Who is present at initial consult: _____
[The above is for office use only]

Patient Information:

Name of patient: _____ Male ____ Female ____
Date of birth: _____ Age: ____
SSN: _____
Address: _____
City: _____ State: _____ Zip: _____
Home phone: _____ Cell phone: _____
Work phone: _____
Email address: _____
Occupation: _____ Employer: _____
Marital status: Married __ Single __ Divorced __ Widowed __ Separated __
Spouse's Name: _____ Spouse's Employer_____
Names and Ages of Children: _____
Name and Telephone of an Emergency Contact: _____

Who may we thank for referring you? _____
What are your goals with us today? _____
_____

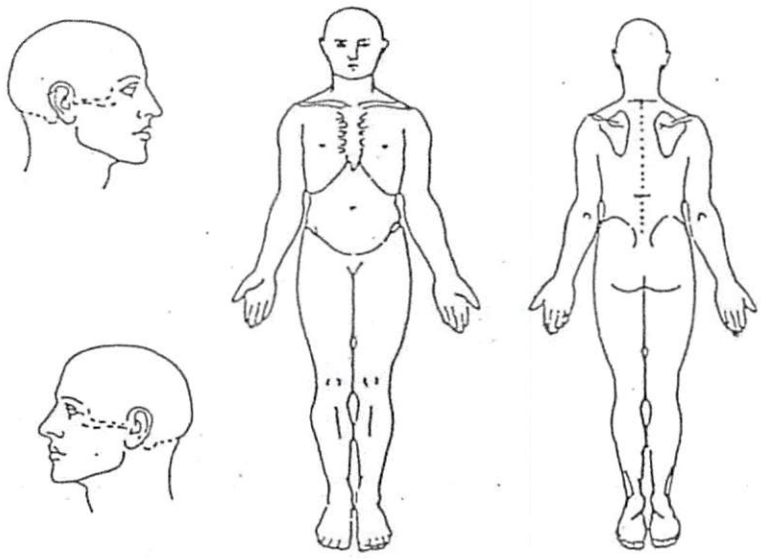
Current Health Condition

- Please list your chief complaints in order of severity:
  1. _____
  2. _____
  3. _____
  4. _____
  5. _____

- What do you feel are the main contributing factors to your health complaints?
  _____
  _____
  _____

- What other health care practitioners have you consulted for this/these complaints? (Please state doctor's name, diagnosis, therapy and results.)
  _____
  _____
  _____
  _____
  _____

Please mark all areas of discomfort on the diagram below.



Consent to Treat

I _____ hereby authorize this office and it's doctors to examine and administer care as the examining/treating doctor deems necessary. I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Patient signature: _____ Date: _____

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Bridgette Chelf, D.C. and Tara Wassel, D.C.
509 South Cedros Ave., Suite D. Solana Beach, CA 92075
(858) 792-7296 phone - (858) 792-8943 fax
drbwellness@gmail.com

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Notice of Privacy Practices – Acknowledgment of Receipt

Dear Patient,

Due to new Federal Law, HIPAA (Health Insurance Portability and Accountability Act), this clinic must inform you of how your personal and private health information will be protected and kept private.

Our office **will not release** any of your private and personal health information without your express, written consent. The information will only be released to the party that you have designated in writing and dated.

All of your information including but not limited to:

- 1) Personal information such as telephone and social security numbers, address of home, work or birthdays and any and all other personal information.
- 2) All doctor notes, examination forms, x-rays, and all treatment records, source of referral, diagnosis, progress notes and reports.
- 3) Any and all health information including membership and plan numbers, health plan and names and employers.

None of this information will be released via fax, mail, internet transfer, or in person without your express written consent. This form will be placed in your file.

_____ _____

Patient Signature Date

_____

Patient name (please print)

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Financial Agreement – Office Payment Policy

ALL CHARGES FOR SERVICES ARE PAYABLE AT THE TIME THE SERVICE IS RENDERED. SHOULD CHARGES EXCEED WHAT THE PATIENT CAN AFFORD, OTHER FINANCIAL ARRANGEMENTS MUST BE MADE IN ADVANCE. VISA AND MASTERCARD ACCEPTED.

INSURANCE

This office generally does not accept insurance for billing. We are happy to provide the patient with a statement that they can submit to their insurance for reimbursement. If, however, an exception is made and we agree to bill your insurance for you, please understand that this is done as a courtesy; it Is not our responsibility to pursue payment of your account. You hold the contract with your Insurance company and it is your responsibility to collect and/or negotiate settlement of your claims. We will be happy to furnish information and answer all inquiries directed to us from your insurance company.

CANCELLATION OR NO-SHOW

Twent- four hour notice is required to cancel an appointment. The full fee will be charged for no shows and all appointments not cancelled prior to 24 hours of the scheduled time.

COLLECTION OF ACCOUNT

Should it become necessary to use a discrete collection service to initiate assistance in collecting any account balance, the additional charges for this service will be assessed to the account and become the patient's responsibility.

TERMINATION OF PATIENT/PROVIDER RELATIONSHIP

This office and its providers reserve the right to terminate the patient-provider relationship and treatment at any time. Upon such termination, this office will supply the patient with a referral to a provider that has the facility and skills to continue the prescribed treatment. This office may not be held responsible for the quality or outcome of treatment given by another facility or provider.

I understand and accept the above information.

_____ _____

Patient or Guardian Signature Date

_____

Patient Name (please print)

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