### WELCOME TO OUR OFFICE

Please complete this form legibly. If you need assistance, please feel free to ask. We are happy to help you.

Date:

Patient First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address:

City: State: Zip:

Please check box for which phone number will be your best contact:

##### 🞏Home: 🞏Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏Work: \_\_\_\_\_\_\_

Sex: [ ]  M [ ]  F Date of Birth: Social Security # (Not Required): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status (check box): [ ]  Single [ ]  Married [ ]  Widowed [ ]  Separated [ ]  Divorced

Race (check box): [ ]  Asian [ ]  African American or Black [ ]  White [ ]  Native American or Native Alaskan [ ]  Native Hawaiian or Pacific Islander [ ]  White [ ]  Other

Ethnic Group (check box): [ ]  Hispanic / Latino [ ]  Not Hispanic / Latino

Pharmacy phone and address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Responsible Party (insurance): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or [ ]  Self

If not self, Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Language Spoken:

Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please give your insurance card and Photo ID card(s) to the receptionist so we may make a copy. Thank You!**

#### CONSENT FOR TREATMENT

I, hereby authorize **Institute for Rheumatology & Integrative Medicine (IRIM),** DBA: as: Alex M. Lam, M.D., P.A., to examine and treat me as a patient. I also authorize such treatment and procedures, as deemed necessary by the physician, including but not limited to, medications, blood samples, urine samples and other therapies. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee or assurance has been made or implied to me as to the results that may be obtained by examination and treatment. I hereby certify that I understand the above authorization.

Patient/Guardian Signature Date

Print Patient / Guardian Name Relation to Patient

OFFICE PHILOSOPHY/ FINANCIAL POLICIES / MISSED APPOINTMENTS / REFERRAL POLICIES

OFFICE PHILOSOPHY

We would like to take this opportunity to inform you that we will spend as much time as necessary with you to fully address your medical problems. This enables us to explain our suggestions and recommendations in depth and answer any questions you may have during your visit. Our staff schedules patients accordingly and we try to be as efficient as possible in order to expedite your entrance and departure from this office. Please be reassured that we value your time. However, given the unpredictable nature of our work, it is not uncommon to have a prolonged waiting period. On many occasions, we are delayed for such matters as patients’ medical problems that require immediate attention, hospital calls, physician calls, and/or emergencies. These issues are unforeseen and need to be addressed appropriately. We do not leave this office until all patients are seen and all their medical problems are addressed.

Initials Date

We encourage your comments and suggestions. Thank you.

## FINANCIAL POLICIES

## We will be sure to discuss our fees prior to the beginning of your treatment. Payment of fees for services rendered is expected at the time services are provided. We file insurance as a courtesy to our patients. However, we do require co-payments to be paid at the time of service. We accept cash, checks, and most major credit cards (Visa, MasterCard, Discover, and AMEX). Returned checks are subject to a $35 fee.

Initials Date

I acknowledge and understand the above-stated Policy

**MISSED/CANCELED APPOINTMENTS**

Since our profession is based on an appointment schedule, we ask that you show consideration by calling well in advance if you are unable to keep an appointment. We would like to offer that appointment to another patient in need of seeing the physician. This notice is to inform you that if you fail to give our office a 24-hour notice of cancellation, there will be a **cancellation fee of $25.00 for each missed appointment** billed to your account that cannot be filled by your insurance. This fee will be asked for payment at the following appointment.

## Please be advised repeated checks of your health are required due to the possibility of an adverse outcome. Failure to keep appointments poses risks to our ability to properly treat you and may jeopardize your health.

I acknowledge and understand the above-stated Policy

Initials Date

## REFERRAL POLICIES

## Unfortunately, our office is unable to actively monitor each patient’s referral status. Patients are responsible for obtaining their referrals from their Primary / Family physician prior to each visit. Please keep in mind that most offices require a 7 day notice prior to your appointment. If you do not have a referral for your visit, your appointment will be rescheduled. Please make sure to contact our office prior to your appointment to ensure a correctly coded and dated referral has been received. Most plans will require a new referral for each visit.

Initials Date

I acknowledge and understand the above-stated Policy

*If your insurance does not require a referral for office visit, please initial*

*to verify that you are informed of policy in the event your insurance changes. Thank you.*

ASSIGNMENT OF BENEFITS / MEDICARE AUTHORIZATION

## INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage and assign directly to **Institute for Rheumatology & Integrative Medicine (IRIM),** DBA: as: Alex M. Lam, M.D., P.A, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I am responsible for any fees or legal fees that Institute for Rheumatology & Integrative Medicine (IRIM), DBA: as: Alex M. Lam, M.D., P.A.,incur for the full collection of payments.

Patient/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Printed Name

## MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to **Institute for Rheumatology & Integrative Medicine (IRIM)**,DBA: as: Alex M. Lam, M.D., P.A.**,** for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in Item 9 of the CMS 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based on the charge determination of the Medicare carrier.

*If you do not currently have a Medicare insurance or Medicare plan, please initial to verify that you are informed of policy in the event your insurance changes. Thank you.*

Patient/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Printed Name

**H.I.P.A.A. Disclosure of Patients Protected Health Information**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If you would like us to waive your protected rights and provide messages, information, or results to a spouse, significant other, or family member, please indicate below. We will be unable to assist any person(s) who are not listed on this form. \*\*A valid photo ID will be required when picking up in items in office.

Please be sure to update this information as needed, for phone number changes or changes in preferences.

My protected health information may be shared with the following persons:

1. **Name: Relationship:**

|  |  |
| --- | --- |
| We are able to discuss: | We are able to release for pick up: |
| Appointment Information: [ ] Yes [ ] No | Medical Records [ ] Yes [ ] No |
| Billing Information: [ ] Yes [ ] No | Prescriptions / Sample Medications: [ ] Yes [ ] No |
| Medical Information: [ ] Yes [ ] No | Prescribed Orders: [ ] Yes [ ] No |

1. **Name: Relationship:**

|  |  |
| --- | --- |
| We are able to discuss: | We are able to release for pick up: |
| Appointment Information: [ ] Yes [ ] No | Medical Records [ ] Yes [ ] No |
| Billing Information: [ ] Yes [ ] No | Prescriptions / Sample Medications: [ ] Yes [ ] No |
| Medical Information: [ ] Yes [ ] No | Prescribed Orders: [ ] Yes [ ] No |

1. **Name: Relationship:**

|  |  |
| --- | --- |
| We are able to discuss: | We are able to release for pick up: |
| Appointment Information: [ ] Yes [ ] No | Medical Records [ ] Yes [ ] No |
| Billing Information: [ ] Yes [ ] No | Prescriptions / Sample Medications: [ ] Yes [ ] No |
| Medical Information: [ ] Yes [ ] No | Prescribed Orders: [ ] Yes [ ] No |

1. **Name: Relationship:**

|  |  |
| --- | --- |
| We are able to discuss: | We are able to release for pick up: |
| Appointment Information: [ ] Yes [ ] No | Medical Records [ ] Yes [ ] No |
| Billing Information: [ ] Yes [ ] No | Prescriptions / Sample Medications: [ ] Yes [ ] No |
| Medical Information: [ ] Yes [ ] No | Prescribed Orders: [ ] Yes [ ] No |

1. **Name: Relationship:**

|  |  |
| --- | --- |
| We are able to discuss: | We are able to release for pick up: |
| Appointment Information: [ ] Yes [ ] No | Medical Records [ ] Yes [ ] No |
| Billing Information: [ ] Yes [ ] No | Prescriptions / Sample Medications: [ ] Yes [ ] No |
| Medical Information: [ ] Yes [ ] No | Prescribed Orders: [ ] Yes [ ] No |

1. **Name: Relationship:**

|  |  |
| --- | --- |
| We are able to discuss: | We are able to release for pick up: |
| Appointment Information: [ ] Yes [ ] No | Medical Records [ ] Yes [ ] No |
| Billing Information: [ ] Yes [ ] No | Prescriptions / Sample Medications: [ ] Yes [ ] No |
| Medical Information: [ ] Yes [ ] No | Prescribed Orders: [ ] Yes [ ] No |

I verify that I am giving consent to the following individuals to have access to my protected health based on my checked preferences. I am aware that if an individual is not listed on this form then no information will be provided.

Patient/Guardian Signature Date

Health Insurance Portability and Accountability (H.I.P.A.A.)

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, , understand that as part of my health care, **Institute for Rheumatology & Integrative Medicine (IRIM),** DBA: as: Alex M. Lam, M.D., P.A.**,** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

• A basis for planning my care and treatment,

• A means of communication among the many health professionals who contribute to my care,

• A source of information for applying my diagnosis and surgical information to my bill

• A means by which a third-party payer can verify that services billed were actually provided, and

• A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and will be provided with a *Notice of Information Practices****,*** (please ask for copy at reception) that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

• The right to review the notice prior to signing this consent,

• The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Institute for Rheumatology & Integrative Medicine (IRIM), DBA: as: Alex M. Lam, M.D., P.A.**,** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Institute for Rheumatology & Integrative Medicine (IRIM), DBA: as: Alex M. Lam, M.D., P.A., reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Institute for Rheumatology & Integrative Medicine (IRIM), DBA: as: Alex M. Lam, M.D., P.A.**,** change their notice, they will send a copy of any revised notice to the address I’ve provided.

**Please explain here any wishes to have the following restrictions to the use or disclosure of your health information (for example, not to share information with referring provider or family physician):**

**I fully understand and accept / decline the terms of this consent.**

Patient Name Date

Signature of Patient/Guardian

If Guardian, Guardian Name (Please Print) Relation to Patient

**Patient Health Summary**

**In order to treat you properly, it is important to answer completely to each question listed below. If a question does not apply, please respond with N/A (not applicable).**

**PRINT PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ALLERGIES**  [ ]  No known allergies

Please list any allergies that you have. This includes medications, foods, and environmental items. Please also list the reaction to these allergies.

|  |  |
| --- | --- |
| ALLERGIES | REACTION |
|  |  |
|  |  |
|  |  |

**CURRENT MEDICATIONS/ VITAMINS/ SUPPLEMENTS** [ ]  Not currently taking anything

|  |  |  |
| --- | --- | --- |
| Name of medication | Dosage | How often do you take? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**PAST MEDICAL HISTORY**

**SURGICAL HISTORY**

|  |  |  |
| --- | --- | --- |
| When? | Why? What was the problem? Part of the body? | What hospital / clinic was the surgery performed at? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**FAMILY HISTORY**

Please list all Relevant History, Include Grandparents, Parents, Siblings and Children.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Maternal Grandparents | Paternal Grandparents | Mother | Father | Siblings | Children |
|  |  |  |  |  |  |

**Patient Health Summary**

**In order to treat you properly, it is important to answer completely to each question listed below. If a question does not apply, please respond with N/A (not applicable).**

**PRINT PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SOCIAL HISTORY**

 Marital Status: [ ]  Married [ ] Single [ ] Separated [ ] Divorced [ ] Widowed

 Do you have any children? If yes, how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you currently exercise? If so, how many times per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you currently drink coffee, energy drinks, caffeinated beverages?

 If so how many / how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TOBACCO HISTORY**

 [ ] Non-smoker

|  |  |  |
| --- | --- | --- |
| Smoking Status (please check)  | How many times a day?How often per week? | Cigar / Cigarettes / Vaporizer / Recreational |
| [ ]  Current Smoker  |  |  |
| [ ]  Past Smoker |  |  |
| [ ]  Social Smoker  |  |  |

 If past smoker, what year or how long has it been since quitting? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any additional street / recreational drugs you are currently using? If so, name of drug and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALCOHOL HISTORY**

 [ ] Non-drinker

|  |  |  |
| --- | --- | --- |
| Consummation of alcohol (please check)  | How many times a day?How often per week? | Wine / Beer / Liquor |
| [ ]  Current drinker  |  |  |
| [ ]  Past drinker |  |  |
| [ ]  Social drinker  |  |  |

If past history of consuming alcohol, what year or how long has it been since quitting? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHARMACY INFORMATION**

Please provide us with your pharmacy information so that we may be able to electronically prescribe to your pharmacy.

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT PORTAL**

Please provide us with your e-mail address so that we may grant you access to your health information through our Patient Portal. Access to our Patient portal provides you with access to your records, direct messaging services, cancel/confirm appointments, and sending refill requests.

E-Mail address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ @ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fall Prevention Balance and Dizziness Survey**

***Please fill out if you are 55 years of age or older***

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

To help determine if you may be headed for a fall or have a balance disorder, take the Balance Self-Test Below. If you answer yes to two or more of the questions, you could be at risk. The best way to determine if you have a problem is to share with the doctor any fears or concern you have regarding falling, dizziness or vertigo, so that he or she may help determine the cause of your symptoms.

|  |  |  |  |
| --- | --- | --- | --- |
| **Please read each question and check the box that most describes your answer.** | **Yes or Often** | **Some-times** | **No or Never** |
| 1. Do you ever lose your balance or feel dizzy or unsteady?
 |  |  |  |
| 1. Have you continue to experience dizziness after an injury or accident?
 |  |  |  |
| 1. Do you feel unsteady when you are walking or climbing stairs?
 |  |  |  |
| 1. Do you feel dizzy while sitting down or rising from a seated or lying position?
 |  |  |  |
| 1. Does walking down the aisle of a super market or stopping next to moving traffic make you dizzy
 |  |  |  |
| 1. Does moving your head quickly make you dizzy or cause you to feel nauseous?
 |  |  |  |
| 1. Are you dizzy or unsteady when you first get up in the morning?
 |  |  |  |
| 1. Do you ever fall or feel like you are about to fall for no apparent reason?
 |  |  |  |
| 1. Do you use a Walker, cane or any other form of assistance for your mobility?
 |  |  |  |
| 1. Have you had a recent loss of, or decrease in your vision or hearing?
 |  |  |  |
| 1. Do you fear falling?
 |  |  |  |
| 1. Have you experienced dizziness, vertigo, or serious imbalance in the past six months?
 |  |  |  |
| 1. Has your balance problem caused problems in your social life?
 |  |  |  |
| 1. Have you fallen more than once in the past year without an obvious cause?
 |  |  |  |
| 1. Does dizziness or imbalance interfere with your job or your household responsibilities?
 |  |  |  |

Please fill out the the top with your name and date, sign the survey at the bottom and provide this to your physician during your visit.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Patient Signature Phone**