New Patient Details

Name____

Preferred Name_________________

Address____

City_______________ **State**____________ **Zip**_________

Phone Number_______________________________________

DOB____

Gender ___**male.** ___**female** **Email**__________________

Language__________________________________

Race________________ **Ethnicity**_________________

Insurance Company___________________________________

Insurance Member ID__________________________________

Group Number_______________________

Guarantor____________________ **Guarantor DOB**__________

Relationship to Guarantor________________

Emergency Contact___________________**Phone**_____________

New Patient Intake

Name____

DOB____________________

Allergies____________________

Pharmacy

____

____

__________________________ ____________________

Do you do any of the following? If so, please indicate what and how often, or past use.

Alcohol:____________________Caffeine:_____________

Tobacco:___________________Recreational Drugs:______________

Cannabis:__________________Electronic Cigarettes:______________

Relationship Status:

___married ___single ___in a relationship

___divorced

___domestic partnership ___separated ___widowed

Do you live alone ___yes ___no

Do you exercise? ___yes ___no How often____________

Employer____________________

Medical History:

___high blood pressure ___high cholesterol
___diabetes ___cancer ___heart disease
other____
____
____
____

Surgeries:

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

Specialists ____________________ ____________________________

____________________________ ____________________________

Family History:

FATHER ___high blood pressure ___high cholesterol
___diabetes ___cancer ___heart disease

MOTHER ___high blood pressure ___high cholesterol
___diabetes ___cancer ___heart disease

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BROTHER ___high blood pressure ___high cholesterol
___diabetes ___cancer ___heart disease

SISTER ___high blood pressure ___high cholesterol
___diabetes ___cancer ___heart disease

MATERNAL GRANDMOTHER ___high blood pressure
___high cholesterol ___diabetes ___cancer ___heart disease

MATERNAL GRANDFATHER ___high blood pressure
___high cholesterol ___diabetes ___cancer. ___heart disease

PATERNAL GRANDMOTHER ___high blood pressure
___high cholesterol ___diabetes ___cancer ___heart disease

PATERNAL GRANDFATHER ___high blood pressure ___high cholesterol
___diabetes ___cancer ___heart disease

other____

____

____

____

____Adopted, does not know family history

Medications:

Name__________________Dosage______________Freqeuncy__________
Name__________________Dosage______________Freqeuncy__________
Name__________________Dosage______________Freqeuncy__________
Name__________________Dosage______________Freqeuncy__________
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Name__________________Dosage______________Freqeuncy__________

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Review Of Systems

Chest pain, tightness or discomfort
Yes
No
Change in appetite
Yes
No
Nausea/Vomiting
Yes
No
Change in bowel habits, constipation, or diarrhea
Yes
No
Urinary frequency, urgency, or burning
Yes
No
Blood in urine
Yes
No
Pain with intercourse
Yes
No
Calf pain with walking
Yes
No
Leg cramping
Yes
No
Muscle or joint pain/swelling
Yes
No
Dizziness/Fainting
Yes
No
Seizures
Yes
No

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Numbness/Tingling
Yes
No
Heat or cold intolerance
Yes
No
Excessive thirst
Yes
No
Weight loss or gain
Yes
No
Fatigue
Yes
No
Hair and nail changes
Yes
No
Ringing in ears
Yes
No
Vision changes
Yes
No
Eye pain/redness
Yes
No
Nasal congestion/discharge
Yes
No
Sinus pain
Yes
No
Sore throat
Yes
No
Neck pain/stiffness
Yes
No
Breast pain/discharge

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Yes
No

Breast-feeding

Yes
No

Cough

Yes
No
Wet
Dry

Shortness of breath/wheezing

Yes
No

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2023 HIPAA Agreement

Please review this notice carefully. It describes how medical information about you may be used and disclosed and how you can get access to this information. Please check each box appropriately.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of Quercus Natural Health and affiliate practitioners, and any other use required by law.
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. As another example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to

diagnose or treat you.

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Use required by law:

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when, required by the Secretary of the Department of Health and Human Services.

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YOUR RIGHTS:

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information.
You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information.
This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You may have the right to have your physician amend your protected health information.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

You may file a complaint with us by notifying our HIPAACompliance Officer of your complaint. We will not retaliate against you for filing a complaint.

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We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

By signing and submitting this form I acknowledge that I have been provided ample opportunity to read this document or that it has been read to me. I acknowledge that I have received the Notice of the Privacy Practices. Lastly, I understand all of the above and give my oral and written consent to the evaluation and treatment to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

I have read this and understand.

PATIENT SIGNATURE: * Today's Date: *

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INFORMED CONSENT

This informed consent ("Informed Consent") governs my care by Jim Ned Premier Health & Med Spa through Rebecca Garcia, FNP-C. I understand that I am seeking treatment from Rebecca Garcia, FNP-C . Accordingly, I hereby authorize and consent to the administration of all diagnostic procedures and/or any assessment measures that are part of Rebecca Garcia's evaluation of me/my child. I understand that after this evaluation and any possible diagnostic test results ordered by Rebecca Garcia, FNP that Rebecca Garcia, FNP may recommend certain therapeutic treatments, including, but not limited to, counseling, medication management, and/or higher levels of care. I understand that I have the right to be informed of the various steps and activities involved in the care that I receive from Rebecca Garcia, FNP. I understand that I have the right to make an informed decision whether to accept or refuse Rebecca Garcia's suggestions. I understand that I may revoke my consent to treatment at any time except to the extent that Rebecca Garcia, FNP has already rendered such treatment.

I understand that in certain situations only as mandated by state and local laws, without the consent of the patient or parent/legal guardian, Rebecca Garcia, FNP is required to report all cases of abuse or neglect of minors or certain vulnerable adults. I understand that state and local laws permit Rebecca Garcia, FNP to report to designated agency any case in which he believes in good faith that there is an imminent risk of danger to a patient or other person (e.g.potential for suicide or homicide). I also understand that if a patient communicates a threat to harm another person, Rebecca Garcia, FNP, is required to warn the potential victim and notify police. Additionally, if a judge orders release of medical records by a court order, Rebecca Garcia may be required to release confidential information.

By signing this form, I indicate my understanding of the principles and policies set forth here in this Informed Consent.

I have read and understand this document in its entirety and have had the opportunity to have my questions answered to my satisfaction.

PATIENT SIGNATURE*____

PATIENT NAME*____________________________________

DATE*________________