Patient's first name | Patient's last name | Date

Medical care consent form

1. Complete this form on a computer in Adobe Reader, then print it. Or, print it first, then complete it with a pen.
2. Bring the completed form to our office in person or fax it to 415-500-2417. Don't use email or internet fax—they aren't secure.

Birthdate		Social Security #	
Address		Biological gender	male female
		Marital status	single partnered widowed divorced
Driver's license #	state	Phone number	
Race		Primary language	
E-mail address			
	Emergency contact		
Name		Phone number	
Relationship to you			
	Employment		
Employer's name		Employer's phone number	
Your title			

Consent to treatment

I authorize Recharge Medical to render inpatient or outpatient medical care to me. I authorize their employees to render routine nursing care and to carry out the orders of my doctor, or other healthcare provider, including consultants, associates, and assistants of their choosing.

Signature of patient or patient's legal guardian | Printed name of signer | Date

Patient's first name	Patient's last name	Date

Insurance and payment form

1. Complete this form on a computer in Adobe Reader, then print it. Or, print it first, then complete it with a pen.
2. Bring the completed form to our office in person or fax it to 415-500-2417. Don't use email or internet fax—they aren't secure.

Name of insured person		I am the insured person	yes (self) no (dependent)
Financially responsible person (guarantor)			
Name			
Address		Phone number	
E-mail address			
Primary insurance		Name	
Type	hmo ppo	Phone number	
	medicare medicaid	Policy number	
	other	Group number	
Secondary insurance		Name	
Type	hmo ppo	Phone number	
	medicare medicaid	Policy number	
	other	Group number	
Credit card			
Name on card		Billing address	
Card number			
Expiration date			
Security code			

Assignment of benefits

I authorize all of the following:

1. Payment of insurance benefits to be made directly to Recharge Medical.
2. Recharge Medical to release information needed to secure payment of benefits.
3. The use of this signature on all insurance submissions.
4. A photocopy of this authorization shall be as valid as the original.

Financial responsibility

I understand that the filing of insurance claims on my behalf is a courtesy and that I'm financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections and attorney's fees. I agree that Recharge Medical may charge the credit card I provided for any fees that are not covered by my insurance.

Signature of patient or patient's legal guardian	Printed name of signer	Date

RECHARGE MEDICAL

Patient's first name | Patient's last name | Date

Medical history form

1. Complete this form on a computer in Adobe Reader, then print it. Or, print it first, then complete it with a pen.
2. Bring the completed form to our office in person or fax it to 415-500-2417. Don't use email or internet fax—they aren't secure.

Major events, hospitalizations, or surgeries	
Allergies	
Ongoing or past medical issues	
Major events or conditions in family medical history	
Current medica-tions, including over-the-counter drugs and herbals	

			If yes, what type? how much each day?	Tried quitting in the past? If yes, when?
Cigarettes	yes	no		
Other tobacco	yes	no		
Alcohol	yes	no		
Caffeine	yes	no		
Other drugs	yes	no		

	Previous doctor		
Name		Phone number	
Address		Date of last exam	

RECHARGE MEDICAL

Patient's first name ______ Patient's last name ______ Date ______

Medical systems review form

1. Complete this form on a computer in Adobe Reader, then print it. Or, print it first, then complete it with a pen.
2. Bring the completed form to our office in person or fax it to 415-500-2417. Don't use email or internet fax—they aren't secure.
3. Mark items you have experienced recently or about which you have concerns with an X.
4. Mark items you don't understand with a question mark.

Symptom	Mark
Fevers, chills, or sweat	
Recent loss of appetite	
Fatigue	
Recent unexpected weight loss	
Blurred or double vision	
Eye pain or irritation	
Eye discharge	
Failing vision	
Sensitivity to light	
Earache	
Ringing in ears	
Decreased hearing	
Difficulty swallowing	
Frequent nose bleeds	
Frequent sore throat	
Prolonged hoarseness	
Sinus trouble or congestion	
Chest pain	
Fainting spells	
Palpitations (fast, irregular heartbeat)	
Shortness of breath with exertion	
Swollen ankles	

Symptom	Mark
Chronic cough	
Chronic shortness of breath	
Chronic wheezing	
Coughing up blood	
Excessive phlegm	
Persistent nausea, vomiting	
Diarrhea	
Constipation	
Change in appearance of stool	
Chronic abdominal pain	
Bloody or very black stool	
Jaundice (yellow skin)	
Back pain	
Joint pain	
Swelling in joints	
Muscle cramping	
Muscle weakness	
Muscle stiffness	
Arthritis	
Skin rashes	
Itching	
Chronic dry skin	
Suspicious moles, skin abnormalities	

Symptom	Mark
Headache	
Unable to move parts of body at times	
Weakness	
Numbness, tingling sensations	
Seizures, convulsions	
Tremors, hands shaking	
Dizziness, vertigo	
Feeling depressed, sad	
Memory loss	
Difficulty concentrating	
Phobias, unexplained fears	
No pleasure in life anymore	
Cold or heat intolerance	
Excessive appetite	
Excessive thirst and urination	
Significant weight change	
Excessive bruising or bleeding	
Swollen glands in neck, armpits, or groin	
Hives	
Hay fever	
Getting lots of infections	

If you're a woman:	
Genital sores	
Painful urination	
Blood in urine	
Increased frequency of urination	
Loss of control of urine	
Unusual vaginal discharge	
Periods have stopped	
Life-disrupting menstrual symptoms	
Nipple discharge	
Breast mass or tenderness	
Want birth control	

If you're a man:	
Genital sores	
Painful urination	
Blood in urine	
Increased frequency of urination	
Loss of control of urine	
Urinating more than twice a night	
Difficulty getting or maintaining an erection	

Patient's first name | Patient's last name | Date

Notice of office policies

I understand and agree that:

Appointments

1. If I'm more than 10 minutes late for an appointment, my appointment might be rescheduled.
2. If I fail to provide notice of change or cancelation within 24 hours of my appointment, I may be billed a fee of $50.00.
3. Recharge Medical may refuse to schedule appointments with me for any reason, including missing or being late for previous appointments.

Billing

1. Recharge Medical bills for only the medical services and tests performed in its office; fees for outside services are billed separately.
2. If my insurance company doesn't pay within 30 days, I am billed directly.
3. My account is considered delinquent if unpaid after 30 days. A private collection agency resolves delinquent accounts. My account will be subject to all reasonable collection and court costs.

Insurance and payments

1. All payments, including co-payments, co-insurance, deductibles, and deposits, are due before services are rendered.
2. I shall present my insurance card at every visit.
3. If my insurance plan changes or is terminated, I will notify the office immediately. If I fail to do this, I am financially responsible for any and all services that are rendered. If my account becomes delinquent, I am responsible for any fees incurred to collect the outstanding balance.
4. My insurance policy is a contract between me and my insurance company. Not all services are covered by my insurance company. I'm responsible for knowing what is and isn't covered by my insurance. I'm ultimately responsible for payment of services provided, regardless of whether my insurance covers it. I'm responsible for communicating with my insurance company regarding their coverage.

Narcotics and controlled substances

1. I will not receive prescriptions for any controlled substance on my first visit.
2. If I need ongoing narcotic prescriptions, I'll be referred to a pain specialist for those prescriptions and further pain management.
3. Controlled substances will not be continually refilled.

Communication

1. Outside of office visits I may communicate with my physician by way of the medical assistant.
2. If I want to communicate with my physician directly, I will make an in-office appointment to do so.

Prescriptions and orders

1. All prescriptions, refills, referrals, lab orders, test orders, and paperwork (such as disability reports and medical releases) are to be issued only during my appointment.
2. I will request any such needed services at my appointment.
3. I understand that there might be additional charges to complete paperwork that I request.

Notice of privacy practices

This notice describes how health information about you may be used and disclosed and how you can get access to it. Please review this notice carefully.

This notice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.

What is PHI?

"Protected health information," or PHI, is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. This applies to all records containing your PHI that are created or retained by Recharge Medical.

Uses and disclosures of PHI

Your protected health information may be used and disclosed by your physician, 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 the physician's practice, and any other uses required by law.

1. **Treatment:** Your PHI will be used and disclosed 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, your PHI may be disclosed to a laboratory, home health agency, or pharmacy that provides care to you. Additionally, your PHI may also be disclosed to other health care providers for purposes related to your treatment, such as a specialist referral.

Signature of patient or patient's legal guardian | Printed name of signer | Date

Patient's first name | Patient's last name | Date

2. **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, your health insurer may be contacted to certify that you are eligible for benefits, and the details regarding your treatment may need to be disclosed to determine if your insurer will pay for your treatment. Your PHI may also be disclosed to obtain payment from you or third parties if they are responsible for your costs. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
3. **Health care operations:** Your PHI may be used or disclosed in order to support the business activities of your physician's practice. These activities included, 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, your PHI may be disclosed to medical school students that see patients at our offices. Your PHI may be used to contact you as a reminder of your appointment. In addition, a sign-in sheet may be used at the registration desk where you will be asked to sign your name and indicate your physician. You may also be called by name in the waiting room when your physician is ready to see you.
4. **Other situations:** 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 Donors; 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 to investigate or determine our compliance with the requirements of Section 164.500.
5. **Other permitted and required uses and disclosures:** Any other uses or disclosures of your PHI will be made only with your consent, authorization or opportunity to object unless required by law.

Your rights

You have the following rights regarding the PHI that we maintain about you:

1. **Confidential communications:** You have the right to request receipt of confidential communications from our office by alternative means or to an alternative location.
2. **Requesting restrictions:** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. You may also request that any part of your PHI 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 the 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 Health-care Professional.
3. **Inspection and copies:** You have the right to inspect and obtain a copy of your PHI. 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 now subject to law that prohibits access to protected health information. Our office may charge a fee for the costs of copying, mailing, labor and supplies associated with your request.
4. **Amendment:** You have the right to ask your physician to amend your health information if you believe it is incorrect or incomplete. 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.
5. **Accounting of disclosures:** You have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations.
6. **A paper copy of this notice:** You are entitled to receive a paper copy of our notice of privacy practices. To obtain a paper copy of this notice, contact us at (415) 409-3456.
7. **Complaints:** You have the right to complain if you believe your privacy rights have been violated. You may file a complaint, in writing, with our office or with the Secretary of the Department of Health and Human Services. You will not be penalized by us for the complaint.
8. **Revoke this authorization:** You have the right to revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Unless otherwise specified above, all requests must be submitted in writing.

Signature of patient or patient's legal guardian | Printed name of signer | Date