Barbara Newlon, D.O.

Osteopathic Medicine / Homeopathy
818 Fifth Avenue, Suite 202 San Rafael, CA 94901
415-459-2522 Fax: 415-454-1456

Welcome to our office. We are committed to the best, most comprehensive care possible.
We encourage you to ask questions. Let us know your concerns and communicate openly with us.
Please assist us by providing the following information. All information is confidential and is only released with your consent.

Today's Date: ____/____/_____

NEW PATIENT INFORMATION

Patient Name (Last, First Middle)	Date of Birth: ____/____/_____	Sex: ☐M ☐F
	Age: Height: ' "	Weight:
Parent if patient is a minor:		
Home address:	City State	Zip
Occupation:	Employer:	
Spouse's Name:	Employer:	
Primary Care Physician's Name:	PCP's Phone:	
Who referred you to our practice? ☐Family ☐Friend ☐Dr. ☐Other _____ (please give name)		

Complete all fields below. Tell us Best Contact method: Phone__ Email___ TXT___

Phone: Home:_____Cell:_____Work:_____

Email: _____ TXT:_____

Reason for Visit

_____

PERSON / INSURANCE RESPONSIBLE FOR FEES - (Attach Ins Card Copies)

FOR PRIVATE PAY –

Person to be billed _____ Soc Sec# _____-_____-_____**(Optional)**

Calif Driver's License # _____

Patient's relationship to Person to be billed? ____Self ____Spouse ____Child ____Other: _____

Billing Address City State Zip Phone

FOR INSURANCE RESPONSIBILITY –

Were you injured in a Motor Vehicle Accident? ☐Yes ☐No Date of Injury ____/____/_____ State, where occurred: ____

MVA Ins Name: _____ Claim#:_____

Claim Address: _____ MVA Ins Phone: _____

*Any charges not covered by your MVA insurance are your responsibility to pay.

Personal Ins #1:

Ins Name: _____ Subscriber: _____* DOB _____

Claim Address:_____ Subscriber ID#_____ Group#_____

Patient's relationship to Person to be billed? ____Self ____Spouse ____Child ____Other: _____

Personal Ins #2:

Ins Name: _____ Subscriber: _____ *DOB_____

Claim Address:_____ Subscriber ID#_____ Group#_____

Patient's relationship to Person to be billed? ____Self ____Spouse ____Child ____Other: _____

DATE: _____/_____/_____ PATIENT NAME:_____

NOTIFY IN CASE OF EMERGENCY

Name		Relationship	
Address	City	State	Zip
Home phone:	Work phone:	Cell phone:	
Nearest relative (not living with you)		Relationship	
Home phone:	Work phone:	Cell phone:	

OFFICE FINANCIAL POLICIES

- **PAYMENT POLICY:**

Non-insured patients

Payment for professional fees is due in full at the time of service.

Commercially Insured patients

We bill your private insurance company as a courtesy. You are responsible for calling your insurance carrier to find out what they cover of Dr. Newlon's fees and keeping your own records that are sent to you from the insurance company.

Medicare patients: *We are a Non-Participating Medicare provider.*

Payment for professional fees, based on the Medicare Limiting Charge, is due at the time of service. A copy of your Medicare card and other secondary ins, if any is required at time of visit. We will submit your claim to Medicare, who will then reimburse you 80% of their Allowed Amount. Medicare will then "automatically crossover" the claim to your secondary insurance, if you have arranged this with your secondary insurance.

- **MISSED APPOINTMENTS: There is a $100.00 charge for appointments missed/or cancelled without 48-hr notice. If the appointment is able to be filled, subsequent to your cancellation, there will be no charge.**
- **RETURNED CHECKS: All returned checks are subject to a $15.00 charge.**

AGREEMENT TO FINANCIAL POLICIES: ***(All patients to sign this section.)***

I have read, understand and agree to the above financial policies for professional fees for services rendered. I understand that I am ultimately responsible for all fees.

Patient or Authorized Person: Date / /

INSURANCE - AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

(Commercially insured patients to sign this section.)

I authorize the release of any medical or other information necessary to process my claims, in compliance with HIPPA and the privacy practices of this office, a copy of which has been provided to me. Further, I hereby authorize payment of medical benefits to be made directly to Dr. Barbara Newlon, D.O. I further understand that I am responsible for payment of all charges not covered by this assignment. This agreement will remain in effect until revoked by me in writing.

Patient or Authorized Person: Date / /

MEDICARE PATIENTS - SIGNATURE ON FILE: ***(Medicare patients to sign this section.)***

I authorize any holder of medical information about me to release to Medicare and its agents any information needed to determine payment of benefits for related services. I understand that Barbara Newlon, D.O. is a Non-Participating Medicare Provider; that I will pay for services at time of service; and, that my signature requests that Medicare reimbursement be made payable to me. Signature also authorizes release of medical information to other health

Patient's Name (Please Print)

Patient's Signature

Patient's Medicare # Date / /

Provider: Name, Address, & Telephone #
Barbara Newlon, D.O.
818 Fifth Avenue, Suite 202
San Rafael, CA 94901-3239
Appointments (415-459-2522)
Billing Dept (866)700-3998

Past Medical History

List *all* surgeries and dates:

_____

_____

_____

_____

Medications now used:

_____

_____

_____

_____

Describe dental work you have had:

Braces _____ Number of years _____

Crowns _____ How many? _____

Cavities _____ How many? _____

Root canals _____ How many? _____

Teeth pulled (describe) _____

If wisdom teeth have been taken, was general or local anesthetic used? _____

Dentures _____ Bridges _____
(permanent or removable)

Do you have, or have you ever had, any of the conditions listed below:

Asthma _____ Chronic ear infections _____

Heart disease _____ Chronic sore throat _____

High blood pressure _____ Constipation or tendency to _____

Sinus trouble _____ Diarrhea/colitis or tendency to _____

Hepatitis _____ Bladder infections or tendency to _____

Pneumonia _____ Vaginal infections _____

Bronchitis _____ Uterine fibroids _____

Diabetes _____ Cancer of _____

Learning disabilities _____ Treatment? _____

Allergies _____ HIV _____

Migraine headaches _____ Skin condition _____

Menstrual Cycle Information

Number of days between cycles _____ Cramping _____

Medication used? _____ Number of days of flow _____

How many pads/tampons per day? _____ Date of last PAP smear?

How many pregnancies? _____ _____ Normal? _____

Date of menopause _____

What kind of mattress do you sleep on and how old is it? _____

Family Medical History

	Current Age/Age at Death	**Health Issues**
Mother	_____/	_____
Father	_____ /	_____
Sibling	_____/	_____
Sibling	_____/	_____
Sibling	_____/	_____

Check the box next to any condition that has been suffered by a blood relative. Please indicate which relative.

____	Allergies	____	Multiple Sclerosis	____	Anemia
____	Arthritis	____	Cancer	____	Alcoholism
____	Asthma	____	Epilepsy	____	Glaucoma
____	Diabetes	____	Gout	____	Headaches
____	Genetic Disease	____	Ulcers	____	Tuberculosis
____	Stroke	____	Mental Illness	____	Heart Disease
____	Kidney/Bladder Problems	____	High Blood Pressure	____	Other

PRACTICE POLICIES

Cancellation Policy: Appointments must be cancelled at least 48 hours prior to arrival. Please understand that it can be difficult to fill your appointment with even 48 hours notice. I appreciate as much notice as possible. Please cancel Monday appointments by the prior Thursday.

Charges for Late Cancellations and No Shows: I understand that events happen that are not foreseeable. In order to manage a successful practice, I must charge any patient for appointments not cancelled 48 hours in advance. If I am able to fill the appointment, there will be no charge. As a courtesy to our patients, we will endeavor to call and remind patients of appointments. However, it is still the patient's responsibility to keep appointment times.

Late Arrival: I make every effort to stay on time and I ask that patients do also. Appointments are scheduled at 30-minute intervals. However, *your body* dictates what needs to be done for that day. Therefore, a treatment may take me 25 minutes and sometimes, 40 minutes. I take the time I need and occasionally you will have to wait 10-20 minutes for your appointment.

Emergency Treatments: Emergency treatments are scheduled the day you call. I leave one hour a day for urgent needs. Please call no later than 9:00 a.m.

Motor Vehicle Accidents If this is a motor vehicle accident and we are billing your automobile insurance, you are responsible for paying any amounts the insurance company does not pay.

Payment: Payment is expected at time of your visit. I will provide you with a super bill for insurance purposes, which includes diagnosis codes and fees. Our current fee schedule is $ _____ for initial consultation (approximately one hour) and $_____ for a regular office visit.

Medicare: Please advise us if you are a Medicare patient. We have opted out of this insurance which necessitates you sign a waiver stating you will not submit any claims for reimbursement to Medicare.

Returned Checks: All returned checks are subject to a $15.00 charge.

By signing this form, you agree not to bill Medicare for any treatments received by Dr. Newlon.

Signed: _____

Date: _____

PLEASE NOTE: In consideration of our patients and staff, we request that you refrain from wearing perfumes while in the office. Thank you.

Barbara Newlon, D.O.
818 5th Avenue, Suite 202
San Rafael, CA 94901
415-459-2522
Fax: 415-454-1456

INFORMED CONSENT TO OSTEOPATHIC MANIPULATIVE TREATMENT AND CARE

Print Patient's Name _____

I hereby request and consent to the performance of procedures which are within the scope of practice of osteopathic medicine including, but not limited to, osteopathic treatments on me (or on the patient named above, for whom I am legally responsible) by the osteopath named above. Dr. Newlon utilizes a technique called myofascial release and the cranial concept in osteopathy. The technique is direct, but not harsh or invasive.

I have had an opportunity to discuss with the osteopath named above and/or with other office or clinic personnel the nature and purpose of osteopathy. I understand that the results are not guaranteed.

I understand and am informed that in the practice of osteopathy there are some risks to treatment, including, but not limited to, temporary 3-10 day soreness in the musculo-skeletal system after treatment, including areas of initial non-complaint. Other reactions can be temporary fatigue or a sense of "spaceyness" or light-headedness after treatment. Sometimes a temporary headache occurs. In babies and small children, a temporary increase in fussiness or agitation can occur for up to five days after treatment (this is rare). There can be transient (30-60 second) soreness in the area being addressed during treatment.

I do not expect the osteopath to be able to anticipate and explain all risks and complications, and I wish to rely on the osteopath to exercise judgment during the course of the procedure which the osteopath feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____

Signature of patient or patient's representative Print Name of Patient's Representative

_____

Witness to Patient's Signature Relationship or Authority of Representative

Date:_____