Barbara Newlon, D.O.

Osteopathic Medicine / Homeopathy

655 Redwood Highway Frontage Road West, Suite 285 Mill Valley, CA 94941

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 AND OR UPDATED 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

Complete all fields below: Tell Us Best Contact Method for You: Phone____Email___TXT___. Please indicate Best # to call or TXT

Phone: Home:________________ Cell:________________ Work:________________ Email:____________________________

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)

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 # (OPTIONAL)_____________

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: ________________

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Appointments (415-459-2522)

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

Your full charge for each service day's office visit will be collected at the time of your visit. We will bill your insurance company for you as a courtesy. If a copy of your or your child's insurance card is provided (including Name of Insurance, Claims mailing address, Member ID# and Group#); we will bill insurance carriers for you on an Un-Assigned basis, which means that insurance reimbursement will be requested to be made directly to you.

The patient is responsible to Dr. Newlon for any charges not covered by this assignment.

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 Medicare supplemental insurance, if any is required at your first visit. We will submit your claim to Medicare, which will then reimburse you their Allowed Amount. Medicare will "automatically crossover" the claim to your supplemental Medicare insurance.

- **MISSED APPOINTMENTS: There is a $100 to $150 charge for appointments missed/or canceled 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 $25.00 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. 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 insurance (including secondary or supplemental insurance).

This authorization will remain in effect until revoked by me in writing.

Provider: Name, Address, & Telephone #
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655 Redwood Highway, Suite 285
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Billing Dept (866)700-2008

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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? ______________________ Normal? ______________________

How many pregnancies? ______________________

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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.

Patient Mobility: Patients must be able to get in and out of chairs, on and off of the treatment table of their own volition; or have someone to assist them to do this. Dr. Newlon and her office staff are NOT able to assist immobile patients.

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 75 minutes to one hour) and $___________ for a regular office visit.

Returned Checks: All returned checks are subject to a $25.00 charge.

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.

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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 fo Patient's Representative

____ ____

Witness to Patient's Signature Date | Relationship or Authority of Representative

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices 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. "Protected health information" is information about you, including demographic information, which may identify you and that relates to your past, present or future physical or mental health or condition and related health car services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who 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 use required by law.

Treatment: 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. For 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.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Your Rights: 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. 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.

You 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 obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

Complaints

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 privacy contact of your complaint.

Signature below is only acknowledgment that you have received this Notice of Privacy Practices.

Print Name: ______________________________ Signed: ________________________________

Date: ___________________________