Health Medicine Center
PATIENT REGISTRATION INFORMATION

1620 Riviera Ave., Walnut Creek, CA 94596 Phone: 925-935-7500
Fax: 925-935-7770 www.healthmedicinecenter.net

Last Name: First Name: Initial: DOB: ☐ Male ☐ Female

Address: City: State: Zip:

Primary Phone: ☐ cell ☐ home Secondary Phone: ☐ cell ☐ home

E-mail: How do you want to contact you? ☐ Minor ☐ Single ☐ Married ☐ Other

Emergency Contact Name and Relation: Phone:

Employer: Occupation: Drivers License:

Primary Insurance: Subscriber ID#: Group#:

Card Holder/Responsible Party: (If other person than yourself, please continue below)

Soc SS#: Relationship: Birth Date:

Secondary Insurance: Subscriber ID#: Group#:

Card Holder/Responsible Party: (If other person than yourself, please continue below)

Soc SS#: Relationship: Birth Date:

WE WILL ASK TO MAKE A COPY OF YOUR DL AND INSURANCE CARDS AT THE TIME OF YOUR FIRST VISIT

CONSENT FOR CARE

I, _____ hereby grant permission to the practitioners of Health Medicine Center (HMC) to perform examinations and therapeutic services, and discuss modalities & options that are considered necessary or advised for my diagnosis and care. I understand that the nature of the recommended treatments for my care will be explained to me. I can choose to comply with or deny any treatment. Practitioners who may treat me include, but are not limited to: medical doctors, nutritionists, acupuncturists, body workers, psychologists, nurses, and chiropractors. I understand that the chart of my treatments will be kept confidential under strict HIPAA rules. I authorize the practitioners of HMC to keep a collective record, which may be discussed by practitioners who have provided or may provide care for me. I further understand that I may view my medical record at any time.

AUTHORIZATION TO RELEASE INFORMATION: Health Medicine Center will release all necessary information in order to process any claims to insurance companies when requested by me, or mandated by Medicare. I understand that no personal or medical information will be released without my prior authorization and signature, unless it is requested through a subpoena.

_____ _____

Print Name of Patient Signature of Patient Date:

_____ _____

Print Name of Parent / Guardian Signature of Parent / Guardian Date:

PRACTICE GUIDELINES AND PATIENT FINANCIAL POLICIES

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PLEASE INITIAL BELOW

_____ Emergencies: Our staff will make every effort to receive calls and respond promptly to any emergency during regular business hours. Dr. Saputo can also be reached via e-mail at drlen@doctorsaputo.com from 9 AM to 10 PM every day of the week. If you do not receive an immediate response, please call 911, or go to the nearest emergency room.

_____ Appointments: HMC requires a minimum of 24 hours notice to cancel or reschedule an appointment as a courtesy to other patients. Fees will be charged for missed or late appointment cancellation without 24 hours notice. This is calculated at 50 % of the regular fee of the time scheduled. A pattern of missed appointments may result in discharge from the practice.

_____ Telephone Consultations: Telephone consultations are available for most conditions, except for new illnesses and symptoms that require physical examinations. Phone consultations will be charged per time needed and require credit card payment via phone. There is no insurance billing for phone consultations.

_____ Financial Responsibility: The patient or responsible party will accept financial responsibility for all charges, whether or not paid by insurance. This includes all services rendered on my behalf or my dependants.

_____ Payment methods: HMC accepts cash, checks, Visa, and MasterCard.

_____ Medical records: The patient's medical record is the property of the practice. Copies of pertinent medical information are available upon 3-day prior request at a fee of $15.00. Records will be kept for the duration of time required by law.

_____ HMC has no contract with any insurance company. As such, HMC does not recognize a specific carrier's use of terms, co-payments, deductibles, or coinsurance. Patients are expected to pay full fees at the time of visit.

I acknowledge that the above information is true and correct. I have read and understand all the terms of this policy and by my initials above and my signature below, I attest that I fully understand each item and agree to the terms above.

_____ _____

Print Name of Patient Signature of Patient Date:

HIPAA Policy Acknowledgment

Health Medicine Center is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

You have the right to determine whether detailed messages may be left, including any protected health information, on the phone numbers of your choice. Please provide the following numbers where we can reach you and a decision as to whether or not a message may be left.

Primary Phone: _____☐ cell ☐ home Confirm Appointments OK? YES NO
Detailed Message OK? YES NO

Secondary Phone: _____☐ cell ☐ home Confirm Appointments OK? YES NO
Detailed Message OK? YES NO

E-mail: _____ Confidential Information OK? YES NO

Other person authorized to share your medical information: _____

Relationship to patient: _____ Phone: _____

I have read the Privacy Notice and understand my rights presented in the notice.

By way of my signature, I provide the Health Medicine Center with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____ _____ _____
Patient's Name (print) **Patient's Signature** **Date**

_____ _____
Authorized Facility Signature **Date**

OFFICE USE ONLY
I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: Initials: Reason:

6 year consent form / must be updated if not seen in a 2 year period

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Updated 1-10-19

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Integrative Health & Well Being
1620 Riviera Avenue
Walnut Creek, CA 94596
(925) 935-7500
www.HealthMedicineCenter.net

CONSENT FOR CARE

I authorize Health Medicine Center to perform a "thermal imaging risk assessment" of my breasts. I understand that thermal imaging is a risk assessment procedure that may signal the development of breast abnormalities. I understand that these services may not be considered "medically necessary" and may not be covered by Medicare or any other insurance company. Health Medicine Center is unable to provide you with a claim for your insurance, but we can generate a copy of the superbill after payment has been received.

I assume full responsibility for the timely payment of all costs, charges and expenses related to my treatment at Health Medicine Center. The amount of the bill shall be due and payable on presentation to the client, his/her agent, guardian, conservator, or third party responsible for payment.

_____

Date Signature of Patient or Legal Guardian

_____

Date Signature of Witness

May 2017

Breast Thermography Preparation

Best time to schedule your breast thermography:

For menstruating women: 28 days in menstrual cycle, day 1 being the start of your period, schedule your appointment approximately between day 15 and 28

For menopausal women: Try to schedule at or close to the same day of your prior breast thermography

Instructions: Please initial each box, indicating compliance with the protocol. If you have questions, please contact our office prior to your appointment to avoid late cancellation charges.

☐ I have waited 3 months after breast surgery, breast biopsy, completion of chemotherapy or radiation
☐ I have avoided any natural or artificial tanning of the chest for 7 days prior to the exam.
☐ I have not had a significant fever within 36 hours of the examination.
☐ I have waited 3 months after breastfeeding.

24 hours prior exam:

☐ I did not have any clinical or personal physical stimulation, examination or compression of the breast (For example: massages, chiropractic treatments, ultrasound, mammogram etc.)
☐ I have not applied any pain / nicotine patches to my chest.

On the day of the exam, at least 4 hours prior:

☐ I have not shaved underarms, used creams, lotions, makeup, deodorants, powders on breasts or underarms.
☐ I have refrained from sauna, steam room, hot tubs, hot or cold packs on any part of the body
☐ I have refrained from exercising

I certify that I have complied with the above preparation instructions. If I have not complied I will notify the office and I understand that a cancellation fee of $87.50 will be charged and the appointment has to be rescheduled.

Printed Name: _____ Signed Name: _____ Date: _____

Please present this checked and signed form to the technician at the time of your appointment

Please be prepared: The room will be 68 °F. You will have to sit for 15 min in a 68 degree °F room with your upper body undressed while you fill out a questionnaire and cool down until images of your breast can be taken. The total time in the room will be approximately 45 minutes.

Reporting: You will receive your report within 14-21 days. Please bring the full address and/or fax number for the health professional(s) to whom you want a copy of the report sent. If your result is a TH3 or higher, we will call you to set up a phone consultation with Dr. Saputo to go over the result at no additional charge.

Cost: The cost per breast thermography is $175.00. This includes a written report. The written report will also be mailed to your referring health care provider upon your request. If you wish to schedule an office visit with Dr. Saputo to go over the report or order any additional testing and you are not a Dr. Saputo patient, you will have to schedule a new patient appointment.