The Healing Sanctuary

PATIENT INTAKE FORM

PATIENT INFORMATION

Today'sDate:_____/ / Name: _____
Last Name First Name Middle Initial

DOB:_____/_____/_____ Age:_____ Gender: ☐ M ☐ F Height:_____Weight: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Social Security Number:_____Driver's License Number: _____

Address: _____ _____ _____ _____
Street City State Zip Code

Home: (_____)_____Cell: (_____) _____

Work: (_____)_____Preferred Contact Number: ☐ Home ☐ Work ☐ Cell

Email: _____

☐ Yes, you would like to receive clinic updates and informational material. It will solely be used within The Healing Sanctuary for clinic purposes only.

How did you hear about us? ☐ Friend ☐ Family ☐ Radio ☐ Search Engine ☐ Newspaper ☐ Social Media ☐ Other

Preferred Method of Communication: _____

Emergency Contact:_____Emergency Phone: (_____) _____

Address: _____ _____ _____ _____
Street City State Zip Code

Relationship to Patient: _____

EMPLOYMENT INFORMATION

Patient Employer Name:_____Occupation: _____

Contact Number: (_____) _____

INSURANCE INFORMATION

Primary Insurance Carrier

Insurance Carrier:_____

Carrier Phone: (_____)_____

Co-Pay Amount:_____

Policy Number:_____

Group Number:_____

Policy Holder's Name:_____

Policy Holder's DOB:_____/_____/_____

Policy Holder's SSN:_____

Effective Date:_____/_____/_____

Secondary Insurance Carrier (if applicable)

Insurance Carrier: _____

Carrier Phone: (_____) _____

Co-Pay Amount: _____

Policy Number: _____

Group Number: _____

Policy Holder's Name: _____

Policy Holder's DOB:_____/_____/ _____

Policy Holder's SSN: _____

Effective Date:_____/_____/ _____

Please list names of anyone you would like us to treat as your Personal Representative on your behalf. This person would have all the same rights to your medical record access that you do.

_____ _____

Name Relationship

_____ _____

Name Relationship

I acknowledge that I have had the opportunity to review The Healing Sanctuary's Notice of Privacy Practices.

X _____

Patient Signature

CONSENT FORTREATMENT

I consent to examination, diagnosis and medical care including office lab services (blood draws), injections and imaging (ultrasound, AFI) to be performed by providers and employees of The Healing Sanctuary.

X _____ _____

(Signature of Patient or Parent/Guardian of Minor) (Date)

HEALTH QUESTIONNAIRE

DOB: _____ Age: _____ Gender: _____ Height_____ Weight_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Preferred Pharmacy: _____

YOUR HEALTH

What are your goals for your wellness consultation today? Please list in priority from 1 to 4.

1. _____
2. _____
3. _____
4. _____

CURRENT MEDICATIONS AND SUPPLEMENTS (That you're taking)	

ALLERGIES	
Medications/Supplements/Food/Environment:	**Reaction: (rash, nausea, shortness of breath, anaphylactic shock)**

ALCOHOL CONSUMPTION	TOBACCO CONSUMPTION
How many drinks currently per week? *1 drink = 5 ounces wine, 12 oz beer, 1.5 ounces spirits* ☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ > 10	How many years? _____ Packs per day: _____

YOUR HEALTH (CONT.)

REPRODUCTIVE HISTORY

Age of 1st Menses:_____

Date of Last Period:_____/_____/ _____

Date of Last Pap Smear:_____/_____/_____

Date of Last Mammogram:_____/_____/ _____

Date of Last Colonoscopy:_____/_____/_____

Date of Last Bone Density Scan:_____/_____/ _____

REPRODUCTIVE HISTORY

Are you using any method to prevent pregnancy? ☐ Yes ☐ No

If yes, which type? ☐ Pill ☐ Tubal ☐ Vasectomy ☐ Condoms ☐ Depo-Provera ☐ IUD ☐ Diaphragm

Do you have pain with intercourse? ☐ Yes ☐ No

MEDICAL AND SURGICAL HISTORY

DIAGNOSIS	DATE OF ONSET OR RESOLUTION

SURGERIES	DATE

* Use additional sheet if needed.

PREGNANCY HISTORY

DATE	# WEEKS AT DELIVERY	HOURS IN LABOR	BIRTH WEIGHT	SEX	DELIVERY TYPE (VAGINAL, C-SECTION, FORCEPS)	COMPLICATIONS

FAMILY MEDICAL HISTORY

Please list any conditions or illnesses (i.e., cancers, high blood pressure, diabetes, autoimmune diseases, heart disease, blood disease, asthma, depression, substance abuse, celiac disease, IBS).

Family Member	Diagnosis	Age at Onset	If Deceased, Age of Death
Mother			
Father			
Brother			
Sister			
Paternal Grandmother			
Paternal Grandfather			
Maternal Grandmother			
Maternal Grandfather			

Medical Doctors or Providers Whom You See

The Healing Sanctuary
Discover. Heal. Teach. Live.

FINANCIAL POLICY

Thank you for choosing The Healing Sanctuary as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Please understand that payment for services and a clear understanding of our Patient Financial Policy is a part of that relationship. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, marital status, personal representatives, etc.)

Insurance

It is the patient's responsibility to know if our office is participating with their insurance plan. If we are not a participating provider in your insurance plan, you will be responsible for payment in full at time of service. If there is a discrepancy with our information, the patient will be considered self-pay until coverage is determined. However, as a courtesy, we will file your initial insurance claim.

To bill your insurance, we must receive a copy of your insurance card and a valid government photo ID.

Co-pays and Co-Insurance

- All co-payments and past due balances are due **at time of check-in** unless previous arrangements have been made
- Co-pays are a requirement of your insurance plan, but it does not effect your obligation to pay our bill.
- We accept cash, check or credit cards; Absolutely no post-dated checks will be accepted

Deductibles

Most insurance plans require that patients pay a predetermined dollar amount each year prior to services being covered. If you have not met your deductible, you will be asked to pay in full at the time of your office visit.

Claims

Once a claim has been submitted to your insurance, we allow up to 45 days for them to respond. After those 45 days, the outstanding balance becomes your responsibility. It is your responsibility to ensure your insurance responds to claims.

Additional Testing

For preventative care exams the physician may request you to undergo certain additional screening tests. Please contact your insurance company to determine if these are covered benefits to avoid incurring charges for which you will be held responsible.

Referrals and Prior Authorization

Certain health insurances require that you obtain a referral or prior authorization from your Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from your insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if the necessary referral or preauthorization is not obtained.

Medicaid Patients

The Healing Sanctuary is both a Primary Care clinic and a specialty clinic. Therefore, if you are to be seen for primary care, we require you to have your PCP switched with Medicaid before we provide medical services to you. The Healing Sanctuary is a specialist for OB/GYN services, you can be referred to us through another PCP for these services. These are required and checked for every office visit you will have with us. You agree that your appointment will be canceled if you have not established us as your PCP or received the proper referral prior to your visit.

Medicare Patients
Please have a full understanding of your Medicare benefits, and what may be ***your*** responsibility. For some diagnoses, you may have to evaluate how well your treatment is working. To do that, the doctor requires certain diagnostic tests be performed. The doctor will tell you what those tests are and why they are necessary. Before your tests are performed, you may be asked to sign an Advanced Beneficiary Notice or "ABN." ***Why do we ask you to sign the ABN?*** We ask patients to sign an ABN whenever Medicare appears likely to deny payment for a specific service. Medicare requires we provide you a written notification when it is likely you will be responsible for the bill.

Self-Pay
Self-pay accounts ***must*** be paid in full at time of service unless prior arrangements have been made. You are self-pay if you are:

- A patient without insurance coverage
- A patient covered by insurance plans in which The Healing Sanctuary does not participate
- A patient without an insurance card on file with us

Fees

Phone Appointments
If you wish to speak to a provider by phone, it must be scheduled, and the phone consultation fee paid prior to speaking with the provider. We cannot bill your insurance for a phone consultation. Currently, insurance companies do not cover phone consultations.

Phone Visit Fee Scale

	MD/DO	NP/PA
5-10 Minutes	$75	$50
11-20 Minutes	$150	$100
21-30 Minutes	$225	$150

Zoom Visit Fee Scale

	All Physicians
CASHRX	$75
CASH15 (level 2)	$90
CASH 30 (level 3)	$180
CASH 45 (level 4)	$270
CASH 60 (level 5)	$360

Email Conversations

MD/DO	NP/PA
$100	$50

Missed Appointments
We require a 24 hour notice of appointment cancellation prior to your appointment.

- Your first office visit missed and not previously canceled will be charged a $25 fee, 2nd appointment is $50, and 3rd is $75
- Your first IV therapy or hyperbaric appointment not previously cancelled will be charged a $50 fee, 2nd appointment is $75, and 3rd is $100.
- If the IV bag is made before the cancellation, the charge will be full cost

The Healing Sanctuary sends appointment reminders via email and text messaging. If you wish to receive either of those, please let the front desk know. After your 2nd no show, a letter will be sent to you. After 3 No-Show's, we will send a Notice of Termination letter and dismiss you as a patient.

Returned Checks
Returned check fee is $25, payable by cash or credit card. This will be applied to your account in addition to the insufficient funds amount. Following a returned check, we may choose to place you on a cash only basis.

Estimated Costs
Estimated costs are not guaranteed since the services used to compute the quote can vary from services you actually receive due to treatment decisions, unforeseen complications, additional tests or services ordered by your physician, and variation in the clinical needs of each patient. Costs also will vary depending on your insurance coverage and deductible.

New Patient Office Visit:	275.00 to 450.00
Follow-Up Office Visit:	175.00 to 275.00
Prescription Refill:	100.00 to 175.00
Infusion Therapy:	75.00 to 375.00

Collections
If your account gets turned over to collections, there could be a collection fee added to your balance, billed through the collection agency.

Patient agrees to be responsible for any interest charges, court costs, and/or attorney fees if balance goes to collections.

Payment

Prior to providing additional services to you, payment in full of total outstanding balances is required. All balances after 90 days will be charged an 18% finance charge.

Patient Payment Responsibility
We cannot offer services without expectation of payment. The patient or their legal representative is ultimately responsible for all charges and agrees to pay for all services received, whether covered or non-covered. "Non-covered" means that a service is not allowed for payment under your insurance contract. If you are unsure whether a service is covered by your plan, it is your responsibility to call your insurance company to determine what your schedule of benefits allows, if a deductible applies and your potential financial responsibility.

If your insurance company offers appeal procedures, we will not under any circumstances falsify or change a diagnosis or symptom to convince an insurer to "pay" for care that is not covered, nor do we delete or change the content in the record that may prevent services from being considered covered. This is insurance fraud.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

Payment is expected at the time of your visit. We accept cash, debit or credit card. Payment will include any unmet deductible, coinsurance, co-payment amount, prior balance, or non-covered charges.

Payment Plan
Extended payment arrangements are available if needed. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress. A payment plan is not active until a Payment Plan Consent form has been signed.

Membership Agreement/Package Consent:
All memberships, packages, and/or single treatments are non-transferrable, non-refundable, and all services not used will not roll over after a year of purchase.

Past Due Balances
Due to the high cost of rendering care and the low reimbursements by many insurers, we simply cannot afford to carry large account balances.

- Balances not paid within 90 days will be considered past due and will begin to incur 18% interest
- For past due accounts, a single phone call will be made to try to make payment arrangements
- Patients with accounts sent to collection face termination from the practice and will need to find another provider

Accounts sent to collection incur additional fees including but not limited to late fees, collection agency fees, interest and attorney fees. The person financially responsible for the account will be responsible for all outstanding balances and collection costs. Patient agrees to be responsible for any interest charges, court costs, and/or attorney fees if balance goes to collections.

Please direct questions regarding payment to:
The Healing Sanctuary Billing Department
(208) 497-0500

It has become increasingly expensive to collect fees rightfully due to the provider for services rendered in good faith to patients. Therefore, we have found it necessary to be very explicit in the financial policies of this practice. Non-payment by some affects the cost of healthcare to all of our patients. If you do not present a form of payment to meet your obligations to your insurance provider and to your healthcare provider, we cannot accept you as a patient or continue to schedule you for office visits.
Thank you for taking time to review our Financial Policy. This policy helps our office provide quality care to our valued patients. If you have any questions or need clarification of any of the above, please feel free to ask.

This financial policy is effective immediately as of the date signed below, and will replace any prior policies.

By signing The Healing Sanctuary's Financial Policy, I acknowledge that I have read, understand and agree to the above terms and conditions, and agree to ultimately accept sole responsibility for payment of my account in full.

Printed Name: _____

Signature: _____ Date: _____

Notice of Privacy Practices and Financial Policy

By signing this document, I acknowledge that I have received a copy of the Notice of Privacy Practices and a copy of the Financial Policy for The Healing Sanctuary. I acknowledge that I have read, understand, and agree to the terms and conditions, and agree to ultimately accept sole responsibility for payment of my account in full.

X _____ _____

Printed Name Date

_____

Signature