DelVal Integrative Health Partners, LLC
Rebecca Nice, DO

205 Telford Pike
Telford, PA 18969

Phone: 215.383.1305
Fax: 215.383.1306

Health History Intake Form

Patient Name	**Date of Birth**	**Gender**	**Today's Date**

Medical History – Please check if you currently have or have ever been diagnosed with any of the following:

Yes	No		Yes	No	
		High Blood Pressure			Cancer (specify type below)
		Diabetes			Hepatitis
		Heart Attack			Gallstones
		Stroke			Fibromyalgia
		Mini-Stroke (TIA)			Osteoarthritis
		High Cholesterol			Rheumatoid Arthritis
		Heart Murmur			Blood Clots (DVT/PE)
		Atrial Fibrillation			Hernia
		Mitral Valve Prolapse			Bladder Infections (UTI)
		Asthma			Kidney Infections
		COPD/Emphysema			Kidney stones
		Tuberculosis			Sexually Transmitted Disease
		Seasonal Allergies			Seizures
		Eczema			Multiple Sclerosis
		Lyme disease			Lupus (SLE)
		Irritable Bowel Syndrome			Hyperthyroid (overactive)
		Diverticulosis/Diverticulitis			Hypothyroid (underactive)
		Colitis			Anemia
		Crohn's Disease			Blood Transfusion
		Reflux/GERD/Ulcers			Depression/Anxiety

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Please list any additional illnesses or further explain answers.

Surgical History – Please check if you have had any of the following procedures and note the approximate date.

Date	Procedure		Date	Procedure
	Appendectomy			Oral surgery/wisdom teeth
	Caesarian Section			Tonsillectomy
	Gall Bladder			Vasectomy
	Hernia repair			

Please list any additional surgeries and the approximate date.

Medications/Supplements - Please list any prescribed and over-the-counter medications along with dosages and reason for taking (use back if additional space required).

Medication/Supplement	Dose	Frequency	Reason/Diagnosis

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Allergies- Please list any allergies to medical-related substances (medicines, dyes, iodine, latex, etc.)

Substance	**Reaction**

Social History – Please answer the following questions.

	Yes	**No**		
Do you currently smoke?			If yes – daily amount	
			If yes – number of years	
If no, did you ever smoke?			If yes – quit date	
Do you currently drink alcohol?			If yes – amount and type	
			If yes – how frequently	
If no, did you ever drink alcohol?			If yes – quit date	
Do you currently use illicit drugs?			If yes – what?	
Do you have a history of illicit drug use?			If yes – quit date	
Are you sexually active?			If yes – men, women, both	
Have you ever been physically abused?				
Have you ever been verbally abused?				
Do you exercise?			If yes – what type, frequency?	

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Family History – Please include parents, grandparents, sibling, and children (if applicable).

Relationship	**Alive/Deceased? Age?**	**Illnesses/Conditions; Cause of Death**
Father		
Mother		
Paternal Grandfather		
Paternal grandmother		
Maternal Grandfather		
Maternal Grandmother		

Review of Systems – Do you now have or have you ever had any of the following?

Now	Past		Now	Past	
		Fatigue			Easy Bruising
		Fevers			Easy Bleeding
		Weight Loss - Unexplained			Prolonged Bleeding
		Weight Gain – Unexplained			Indigestion
		Heat Intolerance			Nausea
		Cold Intolerance			Vomiting
		Blurry Vision			Diarrhea
		Eye Pain			Constipation
		Spots/Floaters in Eyes			Abdominal Pain
		Watery Eyes			Hemorrhoids
		Vision Change			Bloody or Dark Stool

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		Earaches			Blood in Urine
		Hearing Loss			Painful urination
		Tinnitus (Ringing in Ears)			Urinary urgency
		Runny Nose			Muscle Weakness
		Snoring			Joint Stiffness
		Post Nasal Drip			Muscle Spasms
		Congestion - Nasal			Joint Pains
		Frequent Sore Throats			Rashes
		Gum Problems			Acne
		Hoarseness			Changing Moles
		Chest Pain/Discomfort			Headaches
		Palpitations			Memory Problems
		Leg Pain with Walking			Sleep Problems
		Swelling of Legs/Feet			Numbness
		Varicose Veins			Weakness
		Shortness of Breath			Dizziness
		Cough			Anxiousness
		Wheezing			Sadness
					Hallucinations
Now	Past		Now	Past	
		Females Only:			**Males Only:**
		Nipple Discharge			Penile Discharge
		Breast Pain			Genital Lesions/Rash
		Vaginal Discharge			Testicular Pain
		Genital Lesions/Rash			

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Females Only:

Are you currently pregnant?	
Are you actively trying to become pregnant?	
Are you using birth control? If so, what type?	
First day of Last Menstrual Period	

Health Maintenance – Please list the date of the most recent test.

Test	**Date**	**Result**
Mammogram		
Pelvic Exam/Pap Smear		
Testicle/Prostate Exam		
PSA Test		
Rectal Exam, Stool for Blood		
Colonoscopy		
DEXA scan		
Vision exam		
Dental Exam		
Last Physical examination		
Last bloodwork		
Tetanus (Td, Tdap/Adacel)		
Shingles/Zostavax		
Pneumonia/Pneumovax		

Have you ever had an abnormal screening test? If yes, when and what was done about it?

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PATIENT INFORMATION

(Please Print) **(Circle one)**

Name_____ D.O.B._____ Sex M F Age_____

Address_____ SS#_____

(Circle one)

City_____ State ____ Zip_____ Marital Status S M W D

Home Phone (_____) _____Cell Phone (_____) _____

Email _____

Employer_____Work Phone (_____)_____

Spouse's Name_____ D.O.B_____

Spouse's Employer_____

Emergency Contact_____ Phone (_____) _____

(Name of Individual NOT Group Name)

***Referring Doctor_____**

Pharmacy_____Phone(_____)_____

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INSURANCE INFORMATION

(Please present insurance cards to receptionist) ID Checked_____

Primary Ins._____ Address_____

ID#_____ Group#_____ Subscribers Name_____

Subscribers Relationship to Patient _____Subscribers D.O.B._____

Secondary Ins._____ Address_____

ID#_____ Group#_____ Subscribers Name_____

Subscribers Relationship to Patient _____Subscribers D.O.B._____

Is patient a student? _____ Full time ___ Part time___

Race American Indian__ Asian__ African American __Caucasian __Other __

Ethnicity Non-Hispanic__ Hispanic __ Language English__ Spanish __ Other __

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ASSIGNMENT of BENEFITS/AUTHORIZATION to RELEASE INFORMATION

I request that payment of authorized private insurance benefits be made on my behalf to DelVal Integrative Health Partners, LLC, Rebecca Nice, DO, for any service furnished to me by my physician. This also applies to all secondary insurance. I authorize any holder of medical information about me be released to the private insurance company/ies which need any information in determining these benefits payable for related services.

Authorized Signature _____Date_____

Parent/Guardian_____Date_____

OFFICE POLICIES

I understand that patient co-pays are due at time of visit. An additional $10 service fee will be billed if co-pay is not paid at time of visit.

Authorized Signature _____Date_____

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WORKMANS COMPENSATION OR AUTO ACCIDENT

(If patient's condition is work related or auto accident, please fill in the following information)

Claim number for filing claim_____

Insurance Company _____

Insurance Address_____

Workplace Name (if W. Comp) _____

Work Address_____

Date of injury/accident_____

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HIPPA Permission for Medical Information Release

Patient Name	Date
Personal Representative Name	Relationship to Patient

It is our office policy that we will not release confidential and/or unauthorized information by home or cell phone, work phone, voicemail or answering machine unless instructed by you to do so. When we call to speak with you or return your phone call, we will only leave a message if the name and telephone number is provided on the recorded message to identify the residence and you have authorized us to leave a message. We will not leave information with any unauthorized person who may answer the telephone.

By signing this form, I hereby give this medical office and its staff permission to leave medical information pertaining to my care in the manner(s) set forth below. I assume responsibility to notify this office of any changes in this information and shall not hold the office liable for failure to do so.

Please answer the following questions.

	Yes	No
Can we leave a message on your answering machine or voicemail?		
Can we leave a message with a household member?		
Can we give medical information to a household member?		

Name of household member(s) authorized to receive your medical information	Relationship

Signature of Patient /Guardian	Date

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Payment Policy

We know that payment for medical treatment and insurance policy coverage can be a confusing process. We have established the following guidelines in order to help navigate the many aspects of health care. Please read it and ask any questions you may have. A copy will be provided to you upon request.

Insurance- We participate with most insurances. If you are not insured by a plan we participate with, payment is expected in full at each visit. If you are insured by a plan we participate with but your insurance card is not up-to-date, payment is expected in full at for each visit until we can verify your coverage. Insurances vary in their coverage and knowing your insurance benefits is your responsibility. There may be limitations and exclusions to your coverage. Our offices cannot guarantee that your carrier will pay your claim. If your claim with your insurance carrier is denied, you will be responsible for payment for the services rendered.

Co-payments and deductibles- All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance provider. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

Non-covered services- Please be aware that some (and perhaps all) of the services you receive may be non-covered or not considered reasonable or necessary by your insurance. You must pay for these services in full at the time of the visit. If an Advanced Beneficiary Notice (ABN) form must be signed in order to allow you to receive services not covered by your insurance carrier, no services will be provided until the form is signed. You will be responsible for payment in full for all services covered on the ABN.

Proof of insurance- All patients must complete our patient information form prior to seeing the doctor. We must obtain a copy of your driver's license/legal photo identification and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be held responsible for the balance of the claim.

Claims submission- We will submit your claims and assist you in any way we reasonable can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company. We are not party to that contract.

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Coverage changes- Prior to each visit, we will ask you to verify your demographic information and insurance coverage and provide proof of insurance and identity. If your insurance changes, please notify us prior to your next visit so that we can make the appropriate changes to help you receive your maximum benefits. It is your responsibility to inform us of all such insurance changes, please notify us prior to your next visit so that we can make the appropriate changes to help you receive your maximum benefits. It is your responsibility to inform us of all such demographic (i.e., name, address, etc.) changes and all coverage changes to enable us to properly submit claims. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Nonpayment- if your account is 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please beware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis.

Missed appointments- Our policy is to charge $ 50.00 for appointments not cancelled within 24 hours prior to the schedule appointment time. These charges are you responsibility and will be directly charged to you.

We are committed to providing the best treatment for our patients. Thank you for understanding our payment policy. Feel free to ask if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by each and every provision contained herein

Patients Name
Date
Patient/Guardian Signature

- ❑ I understand a charge of $50 will apply If I miss or cancel an appointment without 24 hours notice.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name (please print) Date

_____
Patient or Authorized Representative (if applicable)

_____
Signature

AUTHORIZATION FOR VOICE MAIL USE

I authorize the staff of DelVal Integrative Health Partners, LLC, to leave appointment changes, appointment reminders or any other protected health information on an answering machine or voice mail at the following numbers:_____or_____(void if blank).

_____ _____
Signature of Patient or Authorized Representative (if applicable) Date

NOTE: It is the patient's responsibility to keep this information current.

AUTHORIZATION TO SEND MAIL

I authorize DelVal Integrative Health Partners, LLC to send me the statement of my account or any other correspondence or protected information in envelope(s) displaying full name and address of sender.

_____ _____
Signature of Patient or Authorized Representative (if applicable) Date

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices, but was unable to do as documented. _____Office Staff _____Date
Reason: