Aaron Johnson,
ARNP

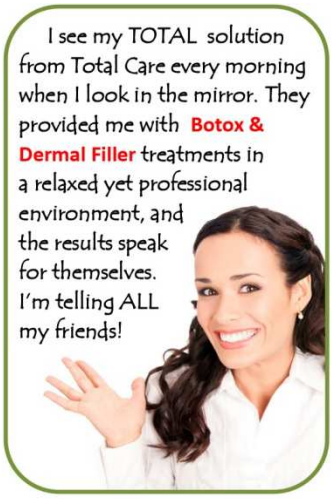
TOTAL CARE CLINICS

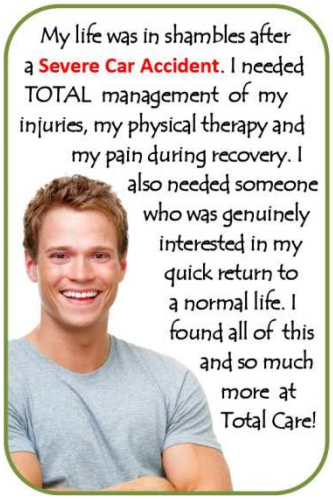
509-735-WELL

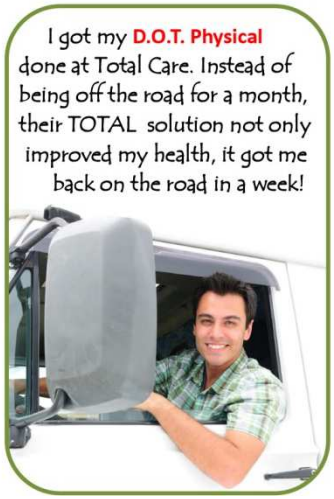
Tyler Christensen, ARNP | Christopher Benner, ARNP | Gabriel Sims, ARNP | Madeline Rannow, LMP

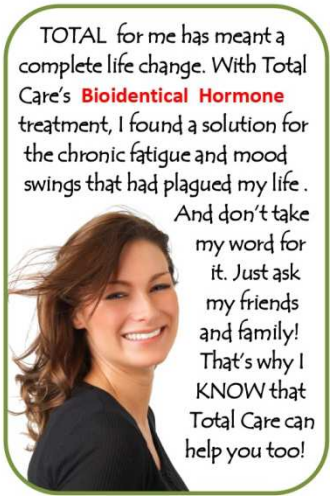
Thank you for choosing Total Care Clinics and for trusting our team with your health. We look forward to serving your family and being a part of your ongoing healthcare.

As is the case with you, each new patient who chooses Total Care has a specific need when they first contact us. What we have discovered is that many people do not realize how many other kinds of care they can take advantage of as a Total Care patient. And so, right at the beginning, we want to make sure you are aware of each service that our team can provide for your family.









Be sure to visit with your provider at your first appointment about the services that best fit the healthcare needs of your family. We are in the business of meeting needs…and in living up to our name as we work to provide TOTAL care to the Tri-Cities Community and across the Columbia Basin.

Welcome!

The Total Care Team

NEW PATIENT INFORMATION

TOTAL CARE CLINICS

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Gabriel Sims, ARNP - Madeline Rannow, LMP

Please insure that all additional paperwork is thoroughly filled out and signed so we have the opportunity to provide you with the best possible care.

Last Name:

First Name: Middle Initial:

Date of Birth: / / Gender: **M F**

Social Security #:

Address:

City: State: Zip:

Home Phone: ( ) -

Work Phone: ( ) -

Cell Phone: ( ) -

E-mail :

Current Employer?

Marital Status: **Married / Single / Widowed / Divorced**

Parent or Guardian (if under 18):

Date of Birth: / /

Relationship to Patient:

Emergency Contact:

Home Phone: ( ) -

Work Phone: ( ) -

Cell Phone: ( ) -

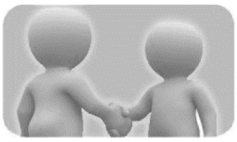
Current Primary Physician?

COMMUNICATION FORMAT AUTHORIZATION

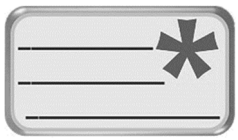
Our mission is to serve our patients and make every visit as easy as possible. To continue in this effort, we will be switching from phone-call appointment reminders to either TEXT or EMAIL reminders. You will continue to receive phone-call reminder until we complete the data transition, but we also need to update your chart to reflect WHICH type of reminder you prefer in the future.

I prefer ☐ **TEXT REMINDERS** ☐ **EMAIL REMINDERS**

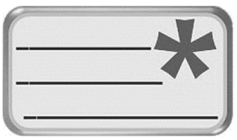
HOW DID YOU HEAR ABOUT TOTAL CARE CLINICS? (please CHECK off as many as apply)



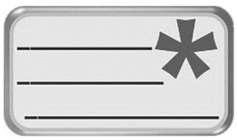
☐ **My Friend _____ Referred me to Total Care**



☐ **I found Total Care online** ***(Where online did you find us?)***



☐ **I was referred by a physician OR an ER** ***(Please tell us who)***



☐ **I heard about Total Care another way** ***(How?)***

INSURANCE INFORMATION

Primary Insurance: **Group#:** **ID#:**

Name of Insured: Date of Birth: / / SS#:

Relation to Patient:

Address (if different):

Insured Employer: Work Phone: ( ) -

Secondary Insurance: **Group#:** **ID#:**

Name of Insured: Date of Birth: / / SS#:

Relation to Patient:

Address (if different):

Insured Employer: Work Phone: ( ) -

PRINT PATIENT NAME: _____

PRINT GUARDIAN NAME: _____

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NO SHOW & CANCELLATION POLICY

We make every effort to provide you with an appointment that accommodates your schedule. Once the appointment is made, that time is reserved especially for you. If an appointment is cancelled without advanced notice, it not only means that you do not get the service you need, it also prevents other patients the opportunity to schedule that appointment time.

As of January 1st, 2014, we reserve the right to charge a **$30 fee per-occurrence** for NO SHOW appointments that takes place without a minimum of **24** hours advance notice.

Outstanding fees will be collected prior to your next scheduled appointment. Please note that your insurance carrier is NOT responsible for these charges.

We appreciate your understanding and cooperation.

Signature of Patient/Guardian:_____ Date:_____
(Signature indicates Patient has read and understood the afore-stated policy)

FINANCIAL POLICY

The following is a statement of our financial policy which we require you to read and sign prior to your treatment. As a courtesy to our patients, we accept assignment of insurance benefits in most cases. Please be aware that your insurance policy is a contract between you and your insurance company. Also, be aware that some and perhaps all of the medical services we provide may not be covered or considered reasonable and necessary under your specific medical plan.

Please note the following: All co-payments or patient responsibility portions are due at the time that services are provided. Any amounts not covered by your insurance company are your responsibility. This includes, but is not limited to, charges for office visits, supplies and labs. All medical bills incurred in this office are the sole responsibility of the patient or the patient's legal guardian regardless of insurance status. Should your account not be paid within sixty (60) days of the date treatment was provided, or within thirty (30) days of insurance settlement, your account may be sent to collections. In the event that legal action becomes necessary related to your collections, you will be responsible for all attorney's fees and court costs.

Signature of Patient/Guardian:_____ Date:_____
(Signature indicates Patient has read and understood the afore-stated policy)

PATIENT AUTHORIZATION

I hereby give consent to Total Care Clinics and its employees and/or contract personnel to render treatment to myself and/or my child (or child under my guardianship). Although rare, complications from treatment are a possibility and I will discuss any concerns I may have with the doctor prior to the initiation of treatment. I authorize payments of all medical benefits directly to Total Care Clinics for services provided.

Signature of Patient/Guardian:_____ Date:_____
(Signature indicates Patient has read and understood the afore-stated policy)

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

I consent to the use of disclosure of my protected health insurance by Total Care Clinics for the purposes of analyzing, diagnosing and providing treatment to me, obtaining payment for my healthcare bills or to conduct health operations for TCC. I understand that analysis, diagnosis or treatment of me by TCC may be conditioned upon my consent as evidenced by my signature below.

I understand that I have the right to request a restriction as to how may protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. TCC is not required to agree to the restrictions that I request. However, if TCC agrees to a restriction I request, the restriction is binding. I have the right to revoke this consent in writing at any time, except to the extent that TCC has taken action in reliance of this consent.

My "protected health information" means health information, including my demographics, collected by me or my physician, health provider, health plan, employee plan, or clearinghouse. This information relates to my past, present, or future physical or mental health or condition.

TCC reserves the right to change the privacy practices described in the Notice of Privacy Practice. I may obtain a revised notice by calling TCC and requesting a copy to be mailed to me or asking for one at the time of my next appointment.

Signature of Patient/Guardian:_____ Date:_____
(Signature indicates Patient has read and understood the afore-stated policy)

I AUTHORIZED TOTAL CARE CLINICS TO COMMUNICATE INFORMATION TO THE FOLLOWING INDIVIDUALS:

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

PRINT PATIENT NAME: _____

PRINT GUARDIAN NAME: _____

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FAMILY HEALTH HISTORY – PLEAES INDICATE IF ANY OF YOUR BLOOD RELATIVES CURRENTLY HAVE OR HAVE HAD ANY OF THESE CONDITIONS

ILLNESS	RELATION	ILLNESS	RELATION
AIDS or HIV		Kidney Disease	
Arthritis		Lung Disease	
Asthma		Psychiatric Care	
Bleeding Disorder		Stroke	
Bowel Disorder		Thyroid Problems	
Cancer		Tuberculosis	
Chemical Dependency		Other: Please List	
Depression		Thyroid Problems	
Diabetes		Tuberculosis	
Epilepsy / Convulsions		Other: Please List	
Glaucoma / Eye Disease			
Heart Disease			
High Blood Pressure			

SOCIAL HABITS - PLEASE INDICATE IF YOU HAVE USED ANY OF THE FOLLOWING SUBSTANCES AND, IF SO, WHEN & HOW OFTEN

SUBSTANCE	FREQUENCY	DURATION	CONCLUSION
Alcohol: YES NO	Drinks per week?	For how many years?	Discontinued when?
Caffeine: YES NO	Ounces per day?	For how many years?	Discontinued when?
Tobacco: YES NO	Packs per day?	For how many years?	Discontinued when?
Street Drugs: YES NO	Frequency:	For how many years?	Discontinued when?
Type of Drug:	1)	2)	3)

PREVENTATIVE CARE – PLEASE INDICATE THE LAST TIME YOU HAD THE FOLLOWED (LIST MM/DD/YYYY)

EXAM / VACCINE	DATE	EXAM / VACCINE	DATE
Cholesterol Screening		Flu Shot	
Lipid Profile		Pneumonia Shot	
Eye Exam		Colonoscopy	
Hearing Test		Tuberculosis Test	
Hepatitis Vaccine		Tetanus / Diphtheria	
Please list any abnormal results related to any of these exams and vaccine administrations:			

CURRENT MEDICATIONS – PLEASE LIST ANY MEDICATIONS YOUR ARE CURRENTLY TAKING INCLUDING OVER-THE-COUNTER MEDICATIONS

MEDICATION	DOSAGE	FREQUENCY	REASON

DRUG ALLERGIES – PLEASE LIST ANY MEDICATIONS TO WHICH YOU ARE ALLERGIC

PRINT PATIENT NAME: _____

PRINT GUARDIAN NAME: _____

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PATIENT HEALTH HISTORY – INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS AND LIST THE APPROXIMATE DATE OF DIAGNOSIS BY MONTH & YEAR. IF THE DATE IS UNKNOWN, PLEASE INDICATE THE APPROXIMATE AGE OF ONSET.

ILLNESS	DATE	ILLNESS	DATE
AIDS or HIV		High Blood Pressure	
Anemia		High Cholesterol	
Alcoholism		Kidney Disease	
Allergies (not meds)		Liver Disease	
Anorexia / Bulimia		Lung Disease	
Appendicitis		Migraine Headaches	
Arthritis		Mononucleosis	
Asthma		Mumps. Measles	
Cancer		Pneumonia	
Chemical Dependency		Psychiatric Care	
Chicken Pox		Rheumatic Fever	
Depression		Rubella	
Diabetes		STD's	
Emphysema		Stomach Ulcers	
Epilepsy / Convulsions		Stroke	
Kidney / Bladder Infections		Thyroid Problems	
Fibromyalgia		Tonsillitis	
Frequent Lung Infections		Tuberculosis	
Gall Bladder Disease		Whooping Cough	
Gout		Other: Please List	
Glaucoma			
Heart Disease			
Hepatitis (list type)			

HOSPITALIZATION & SURGERY HISTORY

HOSPITALIZATION	DATE	OPERATION / SURGERY	DATE

FEMALE PATIENTS ONLY

EXAM / PROCEDURE	DATE	RESULTS	DOCTOR
Pap Smear			
Clinical Breast Exam			
Mammogram			

Age of menstrual onset:	Do you perform MONTHLY self-breast exams: YES NO	
Regular?	Current methods of Birth Control:	
Irregular?	# of Pregnancies:	# of Live Births:
Pain or cramping with menstrual flow:	Pregnancy Complications?	
Date of last menstrual cycle:		

MALE PATIENTS ONLY

EXAM / PROCEDURE	DATE	RESULTS	DOCTOR
Prostate Exam			
PSA (Prostate Specific Antigen)			

PRINT PATIENT NAME: _____

PRINT GUARDIAN NAME: _____

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HORMONE QUESTIONNAIRE

This form is used to evaluate your current symptoms that may be related to common hormone imbalances. If you are interested in hormone therapy please read through each category and check ALL that apply, then answer the questions on the bottom.

SYMPTOMS I HAVE EXPERIENCED IN THE LAST 3 MONTHS (PLEASE CHECK AS MANY AS APPLY)		
___ Agitated	___ Erectile Dysfunction	___ Mood Swings
___ Anxiety	___ Fatigue	___ Night Sweats
___ Bloating	___ Foggy Thinking	___ Palpitations
___ Changes in Menstrual Cycle	___ Forgetful	___ Poor Concentration
___ Decreased Energy	___ Irregular Bleeding	___ Poor Sleep
___ Decreased Libido	___ Hair Loss	___ Tender Breasts
___ Decreased Muscle Mass	___ Hot Flashes	___ Vaginal Dryness
___ Decreased Testicular Size	___ Increased Body Fat	
___ Depression	___ Joint Aches	
Please list below the 3 symptoms that are most concerning to you?		
1.	**2.**	**3.**

ADDITIONAL QUESTIONS (PLEASE CIRLCE ALL THAT APPLY)	
Do you work any of the following?	***SWING Shift / NIGHT Shift***
Have you ever had any type of cancer?	***YES / NO***
If YES, in what part of the body was your cancer?	_____
Have one of your parents or siblings had breast cancer?	***YES / NO***
Have you had a hysterectomy?	***YES / NO (If YES, in what Year? _____)***
Are you currently OR have you previously taken hormones?	***YES / NO***
Are you currently OR have you previously taken supplements?	***YES / NO***
Have you had prior testing for MTHFR (YES / NO) or Vitamin D levels (YES / NO)	

Is there anything else you would like to discuss?

_____

_____

_____

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

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Patient Last Name: **Date:_____/_____/_____**

First Name: Middle Initial:

Date of Birth: / / Gender: **M F**

Home Phone: ( ) - Ok to leave detailed voice mail message **[ ] YES [ ] NO**

Mobile Phone : ( ) - Ok to leave detailed voice mail message **[ ] YES [ ] NO**

Disclosures may be made by/to the following party:

1. Name: Relation to patient:

[ ] Lab Reports **[ ]** Radiology Reports **[ ]** Appointment Information **[ ]** Billing **[ ]** All

*Limitations on Disclosure

2. Name: Relation to patient:

[ ] Lab Reports **[ ]** Radiology Reports **[ ]** Appointment Information **[ ]** Billing **[ ]** All

*Limitations on Disclosure

3. Name: Relation to patient:

[ ] Lab Reports **[ ]** Radiology Reports **[ ]** Appointment Information **[ ]** Billing **[ ]** All

*Limitations on Disclosure

Period of Care covered by this Authorization: From _____/_____/_____ to _____/_____/_____

1. I understand that this authorization will expire one year after I have signed the form, or other time frame as specified here: _____/_____/_____
2. I understand that I may revoke this authorization at any time by notifying Total Care Clinics in person, and it will be effective on the date notified except to the extent any action has already been taken in reliance upon it.

** ** **

Patient signature (or authorized rep) Print Name Date

Patient unable to sign due to: _____ Relationship to patient: _____

I.D. Provided: **[ ]** Copy Provided: **[ ] YES [ ] NO** **Accepted by:**_____