Sienna Wellness Institute
Phone: (760) 379-8630
Fax: (760) 379-7658

6425 Lynch Canyon Drive
Lake Isabella, CA. 93240

1661 Triangle Drive
Ridgecrest, CA. 93555

PATIENT INFORMATION

First Name: _____ Middle: _____ Last: _____

Date of Birth: _____ Age: _____ Sex: _____ SSN: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

CONTACT INFORMATION

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Email Address: _____
(for electronic access to medical records)

ADDRESS/MAILING INFORMATION

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

PHARMACY INFORMATION

Preferred Pharmacy: Name _____

Address _____

EMERGENCY CONTACT/NEXT OF KIN

First & Last Name: _____ Phone Number: _____

GRANT ACCESS TO YOUR MEDICAL INFORMATION

We may discuss Your health information with the following people (Caregivers, Family Members, etc.)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID: _____ Policy Holder: _____

Secondary Insurance: _____ ID: _____ Policy Holder: _____

SIGNATURE

By signing below, I agree that all information provided is accurate and up to date to the best of my knowledge. By signing I consent to allow prescription history to be gathered electronically through my preferred pharmacy and to receive appointment reminders and messaging via email, voice, and text messaging. By signing I consent to have digital photos of my likeness and/or medically necessary digital photos uploaded to my electronic medical record. By signing I consent to allow immunization registry to be documented online.

_____/_____

Patient/Guardian Signature Date

We will need a copy of your insurance card and form of picture ID.
All payments, co-payments, and deductibles will be due at time of visit.

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Patient's Name: _____DOB: _____

MEDICATIONS: List all prescription and over-the-counter drugs, their strength (mg) and # of tablets/day you are currently taking. Attach a list if needed.

☐ **No Medications** ☐ **Have list, see attached**

Drug	**Strength (mg, mcg)**	**Directions** (How do you take it? When? How often?)	**How long have you been taking medication**

ALLERGIES: List all known allergies to medications, and reactions.

□ **No Known Allergies**

Allergy:	**Reaction:**

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Patient's Name: _____DOB: _____

Name of Previous Primary Care Physician: _____

MEDICAL HISTORY: Indicate if **you** have ever had any of the following:

	Yes	No
High Blood Pressure		
Stroke		
TB		
Heart Problems		
Cancer		
Mental Illness		
Hepatitis		
STD Infections		
Shortness of Breath		
Obesity		

	Yes	No
Arthritis		
Ulcers/Wounds		
Diabetes		
Bleeding Disorders		
Gout		
MRSA		
Vascular Disease		
HIV		
Broken Bones		
Other (list)		

CURRENT MEDICAL PROBLEMS: Please list any current medical problems you are currently being treated for.

Current Medical Problem	Name of Treating Doctor

SURGICAL HISTORY: Please list any surgeries and hospitalizations you have had and when.

Surgery/Hospitalization	When

FAMILY HISTORY: Please list any illnesses that run in your family.

Father: _____

Mother: _____

Brother: _____

Sister: _____

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Patient's Name: _____DOB: _____

SOCIAL HISTORY:

Current tobacco use? _____ Previous tobacco user? _____Type of tobacco? _____ #packs/cans/bowls per day: _____

Do you drink alcohol? _____ Did you previously drink alcohol? _____When was your last drink? _____

How active are you? (circle) vigorous moderate sedentary What type of exercising do you do? _____

How frequently do you exercise? Number of times per week _____ or Number of hours per week _____

How do you describe your diet? (circle) healthy standard junk food other _____

Confidential: Do you use any recreational drugs? (circle) yes no formally

Type of drug(s) _____Use(d) needles? _____

PREVENTATIVE CARE: Date of most recent health maintenance:

Mammogram	Date: _____
Colonoscopy	Date: _____
Prostate	Date: _____
Eye Exam	Date: _____
Physical	Date: _____
Dexa Scan (bone scan)	Date: _____

IMMUNIZATIONS: (Please present immunization records)

COVID Vaccine	Date: _____	Flu Vaccine	Date: _____
Pneumonia Vaccine:	Date: _____	Shingles Vaccine	Date: _____
TB Test:	Date: _____	Tetanus	Date: _____

Questions or concerns:

_____

_____

_____

_____

This is a confidential record and will be kept within this facility. Information contained here will not be released to anyone without your written authorization to do so.

_____/_____

Patient/Guardian Signature Date

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On the next 5 pages, you are required to only fill in the yellow highlighted areas.

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AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I authorize_____
(Name and address of physician or health care provider authorized to use or disclose information)

To furnish to _____
(Name and address of person/organization to which disclosure is made)

Health information described below on: _____
(*Patient name)*

For the purpose of: _____

This information is limited to the following type and amount of information. (Use dates where appropriate).

- □ Progress Notes
- □ Consultation Reports
- □ Laboratory, Pathology Reports
- □ Radiology Reports/Imaging Reports
- □ Medical Records relating to injury
- □ Other: _____
- □ Immunization Records
- □ Any and all records for the last 2 years
- □ All medical records

DISCLOSURES REQUIRING SPECIAL CONSENT:
My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for: (initial appropriate area)

HIV/AIDS virus_____ Mental Health/Psychiatric Disorders_____

Sexually Transmitted Diseases_____ Drug, Alcohol Abuse/Treatment_____

I understand that I have a right to revoke this authorization at any time. I understand that my revocation must be in writing and presented to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date event or condition:

_____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Health Information Management. I understand I have a right to receive a copy of this authorization.

_____/_____
Signature of Patient, Parent or Legal Guardian — Patient Date of Birth

_____
Patient Address

_____/_____
If signed by other than patient, indicate relationship — Patient telephone number

_____/_____
Witness signature — Date

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OFFICE FINANCIAL POLICY

Patient Name: _____ Date of Birth: _____

Basic Policy: Payment for services is due in full at the time of service. There will be a $30.00 service charge for returned checks.

For Patients with Insurance: **Co-payments and deductibles are due at the time of service.** As a convenience to our patients, we will bill most primary and/or secondary insurance carriers for you. If the insurance carrier(s) deny the claim for any reason, I understand that I am responsible for any and all applicable fees, less any co-payment and/or deductible payments made to date.

Surgery Fees: All co-pays, deductibles and payments for non-covered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier.

Worker's Compensation: If your injury is work-related, we will need the case number and carrier name prior to your visit in order to bill the worker's compensation insurance company.

Yearly Health Checks: Periodic preventive health checks may or may not be covered under your health insurance policy; however, they may be required by your physician.

Missed Appointments: In fairness to other patients and the physicians, we require at least 24 hours notice to cancel or reschedule appointments. **We will directly charge the patient $50.00 for appointments cancelled with less than 24 hours notice. We will also directly charge the patient $50.00 for every "no show" (missed) appointment.**

PATIENTS SIGNATURE ON FILE: I request payment of authorized medical benefits be made on my behalf to **Sienna Wellness Institute** for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claims. If "other health insurance" is indicated on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to **SIENNA WELLNESS INSTITUTE/SIENNA PODIATRY, PC**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that I am financially responsible for all charges if I provide incorrect insurance information at the time of service. I hereby authorize said assignee to release all information necessary to secure the payment.

I have read, understood, and agree to the above financial policy for payment of professional fees. I understand that the patient is ultimately responsible for all professional fees.

_____/_____
Patient's Signature Date

_____/_____
Facility Representative Signature Date

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ADVANCE BENEFICIARY NOTICE (ABN)

Patient Name: _____ Date of Birth: _____

The purpose of this form is to help you make an informed choice about whether or not you want to receive services and/or items.

In the event your insurance company fails to pay for services rendered or the insurance you supplied is inactive or inaccurate on the date the Provider provides services, the patient is responsible for all payments.

It is your responsibility to know your insurance policy and what it does and does not cover, such as:

1. **DEDUCTIBLE (In or out of network)**
2. **COPAY**
3. **CO-INSURANCE**
4. **ALL NON-COVERED BENEFITS**
5. **DURABLE MEDICAL EQUIPMENT (DME)**
6. **TELEMEDICINE VISITS**

Our facility and its Providers participate with many different insurance policies and plans.

It is also your responsibility to know if our facility and its Providers participate with your individual insurance plan.

By signing below, I am aware I may be billed for services and/or items not covered by the insurance company and plan I provided and agree to pay any such charges.

_____/_____

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Open Payments Database

Patient Name: _____ Date of Birth: _____

The federal Centers for Medicare and Medicaid Services (CMS) requires your signature as proof of receiving the following information:

The Open Payments Database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from the manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

Please indicate if you would like a copy of this notice at time of initial appointment.

☐ I Would Like a Copy of This Notice.

_____ _____

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

I certify that I have been offered a copy of Sienna Medical Corporation/Sienna Podiatry Notice of Privacy Practices.

The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of Sienna Medical Corporation/Sienna Podiatry's health care operations.

The Notice of Privacy Practices also describes my rights and Sienna Medical Corporation/Sienna Podiatry's duties with respect to my protected health information.

The Notice of Privacy Practices is posted in the lobby and on Sienna Medical Corporation/Sienna Podiatry's website at www.siennawellness.com.

Sienna Medical Corporation/Sienna Podiatry reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may request a revised copy from the facility at any time.

☐ I Would Like a Copy of Sienna Medical Corporation/ Sienna Podiatry's Notice of Privacy Practices

_____ _____

Patient/Guardian Signature Date