PINNACLE
HEALTHCARE SERVICES

PATIENT INTAKE FORM

Welcome to Pinnacle Healthcare Services!

We are glad to have you join our family. To speed up the check-in process and ensure that you are highly satisfied with your experience in our office, we kindly request that you complete the following new patient paperwork prior to your first visit. If you have previously completed this, please review the information below and make the necessary updates.

A. PATIENT PROFILE

1. Patient Name: _____
2. Date Of Birth: _____
3. Gender: Select Gender _____
4. Address: _____
5. City: _____ State: _____ Zip code:_____
6. Mobile: _____
7. Home: _____
8. Preferred Phone # Mobile ◯ Home ◯
9. Appointment Reminders: Email ☐ Text ☐ Voice ☐

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B. EMERGENCY CONTACT INFORMATION

1. Contact Name: _____
2. Contact Phone #: _____
3. Relationship to Patient: _____

4. Contact Name: _____
5. Contact Phone #: _____
6. Relationship to Patient: _____

7. Contact Name: _____
8. Contact Phone #: _____
9. Relationship to Patient: _____

C. PHARMACY INFORMATION

1. Pharmacy Name: _____
2. Address: _____
3. City: _____ State: _____ Zip code:_____
4. Pharmacy Phone #: _____

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D. HEALTH INSURANCE INFORMATION

1. Provider Name: _____
2. Insurance ID#: _____
3. Group Number: _____
4. Coverage is Under: Me ◯ Spouse ◯ Parent or Other ◯
5. If Parent or Other, Name of Insured: _____

Eligibility Guarantee:

I hereby certify that I am eligible with the health insurance company under the subscriber indicated on my registration sheet. I understand that if the above is not true or I am not eligible under the terms of my medical and hospital subscriber agreement, I am liable for any or all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services rendered within thirty days of receiving a bill.

Signature of Patient or Authorized Person:_____

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E. PERSONAL AND MEDICAL HISTORY

1. Occupation: _____

2. Marital Status:
   a. ◯ Single
   b. ◯ Married
   c. ◯ Domestic Partner
   d. ◯ Divorced
   e. ◯ Separated
   f. ◯ Widow(er)

3. Have you completed: (check all that apply)
   a. ☐ Living Will
   b. ☐ Durable Power of Attorney
   c. ☐ POLST (Physician Orders for Life-Sustaining Treatment)
   d. ☐ Advanced Healthcare Directive
   e. ☐ Do Not Resuscitate Order

4. Tobacco use:
   a. ◯ Never Smoked
   b. ◯ Former Smoker
   c. ◯ Current Smoker

5. Usage method:
   a. ☐ Pipe
   b. ☐ Cigar
   c. ☐ Snuff
   d. ☐ Chew

6. Alcohol use: Yes ◯ No ◯

7. If yes, how many drinks/week: _____

8. Is alcohol use a concern for you? Yes ◯ No ◯

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9. Allergies to Medications or Food: (please specify)

   a. Medications: _____

   b. Foods: _____

   c. Allergies: _____

Medications/Immunizations:

_____

_____

_____

10. Family History: (check all that apply)

Mental Health Disorder ☐ Alcohol Issues ☐ Breast Cancer ☐

Colon Cancer ☐ Prostate/Uterine Cancer ☐ Lung Cancer ☐

Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐

Heart Disease/Kidney Disease ☐

11. Do you have any of the following symptoms (circle all that apply):

Fever ☐ Chills ☐ Sweats ☐ Double vision ☐ Blurry vision ☐

Eye pain ☐ Hearing loss ☐ Ringing in Ear ☐ Nose Bleeds ☐

Pain with Swallowing/Hoarseness ☐ Neck Pain ☐ Chest Pain ☐

Palpitations ☐ Fast/Difficulty Breathing ☐ Change in Bowels ☐

Change in Urinary Pattern ☐ Pain with Intercourse ☐

Severe Menstrual Cramps ☐ Easy Bruising ☐ Loss of Sensitive to Hot/Cold ☐

Increased Thirst ☐ Joint Pain ☐ Rash or Skin Changes ☐

Hair or Nail Changes ☐ Headache ☐ Seizures ☐ Vertigo ☐

Weight Gain ☐ Weight Loss ☐

Other___: _____

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F. HIPPA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a “friendly” version. A more complete text is available in the office.

What is this all about? Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available at the Department of Health and Human Services.

www.hhs.gov

G. CONSENT TO OBTAIN PATIENT MEDICATION HISTORY

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance. Also, over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included. I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Signature of Patient or Authorized Person: _____

H. CONSENT TO TREATMENT

I hereby give my permission for Pinnacle Healthcare Services to give me medical treatment. I allow Pinnacle Healthcare Services to file for insurance benefits to pay for the care I receive. I understand that Pinnacle Healthcare Services will have to send my medical record information to my insurance company and

- I must pay my share of the costs
- I may be financial liable for the cost of these services

I understand:

- I have the right to refuse any procedure or treatment
- I have the right to discuss all medical treatments with my provider

Signature of Patient or Authorized Person: _____

I. RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize and request the insurance company(s), or agent thereof, to pay directly to Pinnacle Healthcare Services or services provided to me by Dr. Kurwa Nyigu. I am aware that I am financially responsible for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverages are subject to coordination of benefits. This signature will also serve as an authorization to release medical information necessary to satisfy payment.

Signature of Patient or Authorized Person: _____

J. ADOPTED CLINIC POLICIES

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with

other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative
3. The practice utilizes several vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services
7. We agree to provide patients with access to their records in accordance with state and federal laws
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request

Signature of Patient or Authorized Person: _____

K. CONSENT TO TREATMENT VIA TELEMEDICINE

I consent to treatment involving the use of electronic communications to enable health care providers at different locations to share my individual patient medical information

for diagnosis, therapy, follow-up, and/or education purposes.

I consent to forwarding my information to a third party as needed to receive telemedicine services, and I understand that existing confidentiality protections apply.

I acknowledge that while telemedicine can be used to provide improved access to medical care, as with any medical procedure, there are potential risks, and no results can be guaranteed or assured. These risks include but are not limited to technical problems with the information transmission; equipment failures that could result in lost information or delays in treatment.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time, without affecting my right to future treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

Signature of Patient or Authorized Person: _____

L. CONSENT TO TEXT & EMAIL COMMUNICATION

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I am authorized to receive text messages for appointment reminders, feedback, and general health reminders/information.

Signature of Patient or Authorized Person: _____