Rogue Functional Wellness LLC

Patient Information:

Patient Name: _____Phone #: _____

Address : _____, City_____, State_____, Zip_____

Email: _____ Age: _____

Date of Birth: _____ Sex: _____Marital Status: _____ Spouse/Partner: _____

Social Security #: _____ Insurance Company: _____

ID #: _____ Group #: _____

Reason for visit: _____

How did you learn about our office? _____

Patient Employment:

Occupation: _____ Employer: _____

Employer Address: _____ Phone #: _____

Emergency Contact:

Name: _____ Phone #: _____

Relationship: _____

Allergies: (Medications, Food, Plants, Animals, Metals, etc.)

_____

Medications, Vitamins, Supplements: (Name, Dose, Route, Frequency. Example: Aspirin 81 mg by mouth daily)

_____

_____

Medical History: (Example: Hypertension, Diabetes, Colon Cancer, etc.)

_____

_____

Psychiatric History: (Example: Depression, Anxiety, Bipolar, Schizophrenia, etc.)

_____

Surgical History: (Example: Tonsillectomy, Appendectomy, Cholecystectomy, Right ACL repair, etc.)

_____

761 Golf View Dr. Ste C, Medford OR. 97504
Ph. 541.326.4294 Fax. 541.359.4018
www.roguefunctionalwellness.com

Rogue Functional Wellness LLC

Family Medical History:

_____

Immunization History: (Year given, Leave blank if you haven't received it.)

MMR: _____ Polio: _____ Pneumonia: _____ Influenza: _____ Shingles: _____ Hepatitis A: _____
Hepatitis B: _____ Meningococcal: _____ HPV: _____ Varicella: _____ Rotovirus: _____
Haemophilus B: _____ Tetanus Diptheria: _____ Pertussis: _____ Meningococcal B: _____
Typhoid: _____ Yellow Fever: _____ Rabies: _____ Immune Globulin: _____

Caffeine Use: (Daily amount. Example: Coffee 2-4 cups daily.)

_____

Tobacco Use: (Type, Amount, Duration? Example: Cigarettes, 1 pack for 20 years.)

_____

Alcohol Use: (Type, Amount, How Often? Example: Beer, 4 cans a week.)

_____

Drug Use: (Type, How Often, Duration? Example: Cocaine, 2 times of month for 10 years.)

_____

Hazardous Exposures: (Heavy Metals, Chemicals, Radiation, Noise, etc.)

_____

Infectious Exposures: (STD's, MRSA, TB, Hepatitis, HIV/AIDs, Tick bites, Travel to Africa, etc.)

_____

Diet & Exercise:

Describe your diet (Mediterranean, Paleo, Low Carb, etc): _____
How often do you eat fast food? _____
How often do you consume sugary food and/or drinks? _____
How often do you eat red meat or processed foods? _____
How much water do you drink daily? _____
Describe your exercise regimen: _____

761 Golf View Dr. Ste C, Medford OR. 97504
Ph. 541.326.4294 Fax. 541.359.4018
www.roguefunctionalwellness.com

Rogue Functional Wellness LLC

Safety Screening:

Do you own firearms? Are they secure? _____ Smoke and CO2 detectors in your home? _____

Do you wear seatbelts? _____ Do you wear sunscreen? _____Wear sunglasses? _____

Do you wear a helmet when riding bicycles, motorcycles and recreational vehicles?_____

Do you feel safe at home? _____ Abuse or Domestic Violence? _____

Do you fall frequently? _____ Have you had any problems with memory? _____

Are you feeling hopeless or depressed? _____ Thoughts of death and suicide? _____

Preventative Screenings: (Date, Provider, Clinic, and Result of last screening)

Colonoscopy: _____

Blood Pressure: _____

Skin Cancer: _____

Cholesterol: _____

Dental Exam: _____

Do you wear dentures? (Upper, lower, full) _____Do they fit well?_____

Eye Exam: _____

Do you wear glasses or contacts? _____

Hearing Exam: _____

Do you use hearing aids? _____Do they fit well? _____

Females:

Mammogram: _____

Cervical Cancer/Pap: _____

Do you perform your monthly self-breast exams? _____

Males:

Prostate Exam/PSA: _____

Do you perform your monthly self-testicular exams? _____

I hereby affirm that all information is correct to the best of my knowledge.

Signature: _____ **Date:** _____

761 Golf View Dr. Ste C, Medford OR. 97504
Ph. 541.326.4294 Fax. 541.359.4018
www.roguefunctionalwellness.com

Rogue Functional Wellness LLC

Financial Agreement:

Fees for office visits are determined by the complexity of the medical problem, the time spent with the patient, and when indicated, the use of lab, medications, imaging, diagnostics, procedures and supplies. The responsibility for payment of services ultimately rests with the person signing this agreement. Time-of-service discount charges are due at the time of service, otherwise you will be billed at full fees. Patients with outstanding balances may be required to make a payment or pay off their balance before any other services are rendered. Rogue Functional Wellness, LLC accepts cash, checks, and most major credit cards. Rogue Functional Wellness, LLC will bill selected insurance carriers for covered services. The patient is responsible for providing all necessary insurance information prior to service. Co-pays are due at the time of service. Balances as a result of unpaid copays and unmet deductibles will be billed to the responsible party. Rogue Functional Wellness, LLC will make every attempt to verify your insurance eligibility. However, if service coverage cannot be verified you will be responsible for all charges incurred for services rendered. If you desire to file your own insurance claim, Rogue Functional Wellness, LLC with provide you with the forms necessary to do so. This includes CMS 1500 Claim Form and a copy of your visit information. It is your responsibility to make payments for any balances owed. If you are having difficulties paying your bill, contact our billing office and make arrangements for timely payments. Unpaid balances may be referred to a collection agency for legal action. This could adversely affect your credit rating and availability of services.

No Show / Late Cancellation Policy:

In order to accommodate patient needs to be seen promptly, we require more than 24 hours to cancel or change an appointment. We reserve the right to charge a $100.00 no show/cancellation fee for last minute cancellations or no shows. This charge is not billed to any insurance company (if you have one), it is your responsibility to pay.

Lab, Imaging, and Diagnostics Charge Policy

Some labs, imaging, and diagnostics will be performed by an outside healthcare entity. The outside healthcare entities performing these tests will bill health insurance and/or the patient for their services. Rogue Functional Wellness, LLC does not bill for these outside services.

By signing you understand and agree to all of the above stated.

Signature: _____ Date: _____

761 Golf View Dr. Ste C, Medford OR. 97504
Ph. 541.326.4294 Fax. 541.359.4018
www.roguefunctionalwellness.com

Rogue Functional Wellness LLC

Acknowledgement of Notice of Privacy Practice

I understand that Rogue Functional Wellness, LLC will use and disclose my health information only in the course of providing medical care. I understand that my health information both created and received by Rogue Functional Wellness, LLC may be in the form of written document, electronic records and/or spoken word. Health information may include my health history, allergies, medications, review of systems, substance use, family history, social history, immunizations, physical examinations, test results, diagnosis, treatment and other pertinent health-related information. I understand that Rogue Functional Wellness, LLC is permitted to use and disclose my health information in order to:

- Make decisions to plan and carry out my treatment.
- Refer to/or consult and coordinate with other health care providers in the course of my treatment.
- Determine my eligibility for health plan and insurance coverage, submit bills, claims, and other related information to insurance companies and/or others who may be responsible for paying for some or all of my healthcare.
- Perform various office, administrative and business functions that support the ability to provide me with appropriate care, including provision of medical supplies and equipment and arrange for payment.

Under the Notice of Privacy Practice, I understand that I can exercise my right to exclude some or all of my health information from being used or disclosed. A copy of the Notice of Privacy Practice is available upon request.

By signing you understand and agree to all of the above stated.

Signature: _____ Date: _____

Information Release:

In order to share any of your medical information with another person, please write their information below. Without this authorization, Rogue Functional Wellness, LLC will not release any of your health information. You may revoke this authorization for release of medical information at any time.

Name: _____ Relationship: _____

Address: _____Phone: _____

761 Golf View Dr. Ste C, Medford OR. 97504
Ph. 541.326.4294 Fax. 541.359.4018
www.roguefunctionalwellness.com

Rogue Functional Wellness LLC

Patient Consent for Treatment

I hereby authorize treatment that may be considered necessary and/or advisable by the health care provider and certify that no guarantee or assurance has been made as to the result which may be obtained.

By signing I understand and agree to all of the above stated and give consent for treatment.

Signature: _____ Date: _____

761 Golf View Dr. Ste C, Medford OR. 97504
Ph. 541.326.4294 Fax. 541.359.4018
www.roguefunctionalwellness.com

Rogue Functional Wellness LLC

Controlled Substance Policy

Prescriptions and refills for controlled substances require an appointment for a written prescription. Prescriptions of controlled substances must be taken as directed. There will be no early refills. We are not responsible for lost or stolen controlled substance prescriptions and we will not replace them. Chronic conditions requiring more than 6 months of treatment with controlled substances may be referred to a specialist for further management. Controlled substances and medications from other healthcare providers must be disclosed to Rogue Functional Wellness, LLC to ensure your safety. Illicit drugs cannot be used if you are prescribed controlled substances from this office. Patients receiving controlled substances may be subjected to random drug testing and pill counts upon the request of the provider. Drug testing will be at the patient's expense. Refusal or failure of drug testing and pill counts will result in discontinuation of controlled substances and dismissal from the practice. If diversion of controlled substance or illegal activity is suspected or brought to our attention local law enforcement will be notified.

I understand and agree to this policy. Any deviation or violation of this policy could result in; discontinuation of controlled substance prescriptions and/or refills, dismissal from the practice, and involvement of law enforcement.

Signature: _____ Date: _____

761 Golf View Dr. Ste C, Medford OR. 97504
Ph. 541.326.4294 Fax. 541.359.4018
www.roguefunctionalwellness.com