RECHARGE MEDICAL

Patient's first name _____ Patient's last name _____ Date _____

Medical history and consent form

1. Complete this form on a computer in Adobe Reader, then print it. Or, print it first, then complete it with a pen.
2. Bring the completed form to our office in person or fax it to 415-500-2417. Don't use email or internet fax—they aren't secure.

Birthdate		Biological gender	◯ male ◯ female
Address		Marital status	◯ single ◯ partnered ◯ widowed ◯ divorced
Primary language		Phone number	
E-mail address			
	Emergency contact		
Name		Phone number	
Relationship to you			
	History		
Major events, hospitalizations, or surgeries			
Allergies			
Ongoing or past medical issues			
Major events or conditions in family medical history			
Current medications, including over-the-counter drugs and herbals			
		If yes, what type? how much each day?	Tried quitting in the past? If yes, when?
Cigarettes	◯ yes ◯ no		
Other tobacco	◯ yes ◯ no		
Alcohol	◯ yes ◯ no		
Caffeine	◯ yes ◯ no		
Other drugs	◯ yes ◯ no		
	Previous doctor		
Name		Phone number	
Address		Date of last exam	

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Medical systems review form

1. Complete this form on a computer in Adobe Reader, then print it. Or, print it first, then complete it with a pen.
2. Bring the completed form to our office in person or fax it to 415-500-2417. Don't use email or internet fax—they aren't secure.
3. Mark items you have experienced recently or about which you have concerns with an X.
4. Mark items you don't understand with a question mark.

Fevers, chills, or sweat	
Recent loss of appetite	
Fatigue	
Recent unexpected weight loss	
Blurred or double vision	
Eye pain or irritation	
Eye discharge	
Failing vision	
Sensitivity to light	
Earache	
Ringing in ears	
Decreased hearing	
Difficulty swallowing	
Frequent nose bleeds	
Frequent sore throat	
Prolonged hoarseness	
Sinus trouble or congestion	
Chest pain	
Fainting spells	
Palpitations (fast, irregular heartbeat)	
Shortness of breath with exertion	
Swollen ankles	
Chronic cough	

Chronic shortness of breath	
Chronic wheezing	
Coughing up blood	
Excessive phlegm	
Persistent nausea, vomiting	
Diarrhea	
Constipation	
Change in appearance of stool	
Chronic abdominal pain	
Bloody or very black stool	
Jaundice (yellow skin)	
Back pain	
Joint pain	
Swelling in joints	
Muscle cramping	
Muscle weakness	
Muscle stiffness	
Arthritis	
Skin rashes	
Itching	
Chronic dry skin	
Suspicious moles, skin abnormalities	
Headache	

Unable to move parts of body at times	
Weakness	
Numbness, tingling sensations	
Seizures, convulsions	
Tremors, hands shaking	
Dizziness, vertigo	
Feeling depressed, sad	
Memory loss	
Difficulty concentrating	
Phobias, unexplained fears	
No pleasure in life anymore	
Cold or heat intolerance	
Excessive appetite	
Excessive thirst and urination	
Significant weight change	
Excessive bruising or bleeding	
Swollen glands in neck, armpits, or groin	
Hives	
Hay fever	
Getting lots of infections	

If you're a woman:	
Genital sores	
Painful urination	
Blood in urine	
Increased frequency of urination	
Loss of control of urine	
Unusual vaginal discharge	
Periods have stopped	
Life-disrupting menstrual symptoms	
Nipple discharge	
Breast mass or tenderness	
Want birth control	

If you're a man:	
Genital sores	
Painful urination	
Blood in urine	
Increased frequency of urination	
Loss of control of urine	
Urinating more than twice a night	
Difficulty getting or maintaining an erection	

RECHARGE MEDICAL

Notice of office policies

I understand and agree that:

Appointments

1. I must make an appointment in advance to receive services.
2. Appointments can be booked directly by calling 415-409-3456. Appointments made online are only requests. The requested time is not guaranteed until the staff has collected additional information from me and confirmed the appointment via email or phone call.
3. I must give notice at least 48 hours before the time of my appointment if I need to cancel or re-schedule.
4. If I fail to provide 48 hours notice or do not show up for my appointment, I will be charged a no-show or late cancellation fee.
5. If I arrive more than 10 minutes late I will not be seen, and no-show fees may apply.
6. Recharge Medical recommends that I arrive a few minutes before my scheduled appointment to attend to any needed paperwork.
7. Recharge Medical may refuse to schedule appointments or provide service for any reason.

Payment and billing

1. Payment for all services and fees are due at the time of service.
2. I am solely responsible for all charges in full, whether or not my care is covered by insurance.
3. Recharge Medical bills only the services and tests performed in their office; fees for outside services are billed separately.
4. Recharge Medical does not bill or accept payments from insurance companies.
5. Recharge Medical does not provide super bills or any insurance billing codes to patients or third parties.
6. I authorize Recharge Medical to charge the credit card I provided for all my services and fees.
7. Recharge Medical may release all relevant information about my services that is needed to secure payment.
8. Prices are subject to change at any time and are never guaranteed.
9. My account is considered delinquent if unpaid after 30 days, and will be referred to collections. Late fees will be applied to unpaid balances.
10. I will be subject to all service and legal costs related to collections.
11. No services or documents will be provided to me until my full balance is paid.
12. Recharge Medical accepts only the following payment forms: Visa, Mastercard, American Express, debit cards, and cash in United States currency.

Refunds

1. Charges for services, treatments, and fees are non-refundable and final.
2. When I buy a package of treatments, the package price is less than the total price of buying each treatment individually. If I do not complete a package, I am entitled to a refund of my original package, less the cost of the individually priced treatment(s) for the session(s) I received.

Communication

1. Recharge Medical and their partners (e.g., Practice Fusion) may contact me via the email I provide, via text message on the cell number I have provided, and/or via voicemail on the phone numbers I have provided. Recharge Medical may leave voice, text, or email messages regarding issues, such as: appointments, billing, and outstanding requirements.
2. Outside of office visits I may communicate with my physician by way of the medical assistants over the phone. If I want to communicate with my physician directly, I will make an appointment to do so and will be charged for the visit.

Prescriptions, orders, and paperwork

1. All prescriptions, refills, referrals, test orders, and paperwork are to be issued only during my appointments.
2. I will request any such needed documents only at my appointment.
3. I will request refills, completion of documents, and/or orders at least 7 business days before they are needed.
4. There may be additional charges for these services.

Controlled substances

1. I will not receive prescriptions for any controlled substance during my first visit.
2. If I need ongoing prescriptions for controlled substances, I will be referred to the appropriate specialist.

RECHARGE MEDICAL

Notice of office policies (cont'd)

I understand and agree that:

Pets

1. In compliance with local health codes and ADA, only certified animals (such as seeing eye dogs) are allowed inside the clinic.
2. Emotional support and other support animals are not allowed at any time.

I am responsible for

1. Providing my most current phone, email, and mailing addresses.
2. Providing my most current information concerning any and all changes related to my health, medications, allergies, or treatments.
3. Ensuring Recharge Medical receives all information (e.g., additional tests, vaccines, identification) in order to complete exams, treatments, and/or documents in a timely manner.
4. Informing Recharge Medical of any changes to my payment information.

Feedback and concerns

1. If I have concerns about services I received, Recharge Medical staff want to know about it. In most cases they are able to address any problems I encounter. Recharge Medical providers would much rather hear my concerns than have me go unsatisfied with the service I received.
2. If I have concerns about the conduct of any employee, HIPAA compliance, or other regulatory issues, I will contact the office and ask to speak with the chief operating officer.

Notice of privacy practices

This notice describes how health information about you may be used and disclosed and how you can get access to it. Please review this notice carefully.

This notice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.

What is PHI?

"Protected health information," or PHI, is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. This applies to all records containing your PHI that are created or retained by Recharge Medical.

Uses and disclosures of PHI

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other uses required by law.

1. **Treatment:** Your PHI will be used and disclosed to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be disclosed to a laboratory, home health agency, or pharmacy that provides care to you. Additionally, your PHI may also be disclosed to other health care providers for purposes related to your treatment, such as a specialist referral.
2. **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, your health insurer may be contacted to certify that you are eligible for benefits, and the details regarding your treatment may need to be disclosed to determine if your insurer will pay for your treatment. Your PHI may also be disclosed to obtain payment from you or third parties if they are responsible for your costs. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
3. **Health care operations:** Your PHI may be used or disclosed in order to support the business activities of your physician's practice. These activities included, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, your PHI may be disclosed to medical school students that see patients at our offices. Your PHI may be used to contact you as a reminder of your appointment. In addition, a sign-in sheet may be used at the registration desk where you will be asked to sign your name and indicate your physician. You may also be called by name in the waiting room when your physician is ready to see you.
4. **Other situations:** We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors, and Organ Donors; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.
5. **Other permitted and required uses and disclosures:** Any other uses or disclosures of your PHI will be made only with your consent, authorization or opportunity to object unless required by law.

RECHARGE MEDICAL

Your rights

You have the following rights regarding the PHI that we maintain about you:

1. **Confidential communications:** You have the right to request receipt of confidential communications from our office by alternative means or to an alternative location.
2. **Requesting restrictions:** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Health-care Professional.
3. **Inspection and copies:** You have the right to inspect and obtain a copy of your PHI. Under Federal Law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is now subject to law that prohibits access to protected health information. Our office may charge a fee for the costs of copying, mailing, labor and supplies associated with your request.
4. **Amendment:** You have the right to ask your physician to amend your health information if you believe it is incorrect or incomplete. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
5. **Accounting of disclosures:** You have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations.
6. **A paper copy of this notice:** You are entitled to receive a paper copy of our notice of privacy practices. To obtain a paper copy of this notice, contact us at (415) 409-3456.
7. **Complaints:** You have the right to complain if you believe your privacy rights have been violated. You may file a complaint, in writing, with our office or with the Secretary of the Department of Health and Human Services. You will not be penalized by us for the complaint.
8. **Revoke this authorization:** You have the right to revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Unless otherwise specified above, all requests must be submitted in writing.

AB1278 Required Notice

Pursuant to Assembly Bill (AB) 1278, physicians are required to provide a notice to patients regarding the Open Payments database, which is managed by the U.S. Centers for Medicare & Medicaid Services, or CMS. 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.

Exam and treatment authorization

1. I authorize Recharge Medical to render outpatient medical care to me.
2. I authorize their employees to render routine nursing care and to carry out the orders of doctors, or other health care providers, including consultants, associates, and assistants of their choosing.
3. I understand that there is no guarantee of a specific outcome for any exam or treatment I receive at Recharge Medical.

I have read the exam and treatment authorization above and by signing here give my consent to Recharge Medical to provide me with medical exam and treatment.

Signature of patient or patient's legal guardian	Printed name of signer	Date