WELCOME!

We respect your time and we would like to make your visit to our office as efficient as possible.

We are pleased to tell you that our office is located in an area easily accessible by car or bus. We also have ample parking space. Should you need directions, please call us ahead of time.

REMINDERS:

1) **CANCELLATIONS / NO SHOW**: please call us at least 24 hours before your appointment to avoid a $50 no show fee.
2) **FOR YOUR VISIT:**
   1. Please plan to arrive at least 15 minutes prior to your scheduled appointment.
   2. In order for us to expedite your registration process, **please complete the following items and send it to us electronically via IQ Health or mail/fax 3 days before your scheduled appointment**:
      - ***Patient Registration*** *Form, completely filled-out and signed*
      - ***Financial Policy Form,*** *completely reviewed and signed*
      - ***Medical History Form****, completely filled-out and signed*
      - ***Consent Form****, completely filled-out and signed*
      - *List of* ***all your current medications***
3) ***To bring at the time of your visit:***
   - *Valid* ***insurance card****(s)*
   - ***Photo ID****, preferably state issued/ student ID for minor*
   - ***Co-pay****, if it applies to your insurance*

******PLEASE BE AWARE THAT FAILURE TO COMPLETE AND BRING THE ABOVE ITEMS WITH YOU MAY RESULT TO RESCHEDULING YOUR APPOINTMENT* *****

4) ***Registration through our IQ Health Patient Portal***
   - Access to our online patient portal is a must in order to efficiently communicate with our office.
   - Your email address will be required for the set up.
   - This portal allows you to be able to do the following:
     - View Your Visit Summary/Test Results
     - Request an appointment
     - Request medication refills
     - Update demographic information
     - Send and receive non-urgent messages
     - Keep track of your health

Enclosed you will find important documents about our practice.
To better serve you, please review and complete the documents carefully.

Please do not hesitate to call us if you have any questions.

5201 Pennell Road
Media, Pa 19063
877-346-4543

Today's Date:	Last Name:	First Name:	MI:	Gender:

Street Address:	City:	State:	Zip Code:

Marital Status:	Social Security #:	Date of Birth:	Age:	Occupation:

Home Phone:	Cell Phone:	Work Phone:	Email Address:

Responsible Party:	Date of Birth:	Social Security #:
		- -

Home #	Work #	Cell #	Relationship to Patient:

Address:		**Employer:**
City/State/Zip:		

Emergency Contact:	Relationship to Patient:

Phone: Home #	Work #	Cell #

Insurance Carrier	Primary Holder Name	Date of Birth:

Effective Date	ID #	Group #

AUTHORIZATION AND ACKNOWLEDGEMENT

Please initial and sign at the bottom:

________ **Authorization and Assignment of Benefits:** I hereby give permission to United Medical Clinic of Pa,LLC/Fini Health and Wellness Group, PLLC and its employees, agents, and medical providers to release medical information to health plans, health organizations, governmental agencies, and other entities charged with fiscal responsibility for the payment of medical services rendered to me. I hereby authorize payment of the medical benefits otherwise payable to me to be directed to United Medical Clinic!of PA, LLC/Fini Health and Wellness Group,PLLC. I consent to have any monies received by the provider of services on my behalf to be applied to my outstanding accounts. I assume full responsibility for payment of any charges for the medical services provided. I understand that any or all of my medical information may be electronically submitted to any or all treating providers, hospitals, and/ or health care entities. I permit a copy of this authorization to be used in place of the original.

_________ **Financial Policy Acknowledgement:** I hereby acknowledge that I have received and reviewed the FINANCIAL POLICY of United Medical Clinic! of PA, LLC/Fini Health and Wellness Group, PLLC. I understand that it is my responsibility to provide United Medical Clinic! of PA, LLC/Fini Health and Wellness Group, PLLC with my current demographic, insurance, and medical information.

________ **HIPAA Privacy Acknowledgement:** I hereby acknowledge that I have received and reviewed the NOTICE OF THE PRIVACY PRACTICES from United Medical Clinic!of PA, LLC/Fini Health and Wellness Group, PLLC.

Patient or Guardian Signature:_________________________________ **Relationship:** ________________ **Date:** _______________

Our Financial Policy

Thank you for choosing us as your medical provider. We are committed to provide you with a consistently high standard of care and pleased to discuss our services at any time. Your clear understanding of our Financial Policy is an important part of our professional relationship. We request that you take time to **review, understand, and sign below** prior to receiving treatment from us.

You are expected to present your current insurance card(s) at each visit. Any minor patient must be accompanied by an adult representative who has assumed financial responsibility for the minor patient. To protect patients from identity theft, we also ask that you present a photo identification card at time of visit.

It is your responsibility to advise us of any change in your address, telephone number, or employer information.

Your insurance is a contract between you and your insurance company. We are not a party to the contract. It is very important that you understand the provisions of your policy. We will file an insurance claim as a courtesy to our patients however this does not release you of your financial responsibility.

If you have more than one insurance plan, it is your responsibility to inform us regarding the order of how we should file your claim and coordinate with your insurances as well.

We will collect your co-payment, deductible, balances, or charge for non-covered services at the time of your visit. We will not be responsible for any disputes between you and your insurance company regarding copays, deductible, covered charges, etc. other than to supply factual information.

We cannot guarantee payment of all claims. If your insurance pays only a portion of the bill or rejects your claim, you will be responsible for the timely payment of your account. For those who request it, we provide an estimate of the cost of the service to be performed, if such information is available to us.

If you do not have insurance, or we do not participate with your insurance company, you will be expected to pay in full at the time of visit.

We accept cash, checks, or major credit cards. It is our policy to charge a $35 fee for returned check.

We follow the fee schedules set forth by the Board of Professional Regulation for charging for reproduction of medical records. We charge a $15 fee for completion of forms (ie: FMLA forms/Short Term Disability Forms)

When you schedule an appointment, time is specifically allocated for you. We ask that you notify us at least 24 hours in advance if you are unable to keep your appointment to avoid a $25 “No Show” fee for established patient and $50 “No Show” fee for new patient. If three appointments are missed, you will be dismissed from the practice for non-compliance.

We reserve the right to take lawful actions including referring your account to a collections agency and report to one or more credit bureaus for non-payment.

Thank you for taking time to review our financial policy. If you have any questions, please ask to speak with our Practice Manager.

Patient/Authorized Representative Name: ____

Signature: ______________________________ Date: ______________________ ______

FINI HEALTH AND WELLNESS

UNITED MEDICAL Clinic of PA

Patient Consent for Use and Disclosure of Protected Health Information

The individual whose signature appears below hereby attests to the following statements:

With my consent, UNITED MEDICAL CLINIC of PA, LLC/FINI HEALTH AND WELLNESS GROUP, PLLC, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Please refer to Notice of Privacy Practices for a more complete description of such uses and disclosures.)

With my consent, UNITED MEDICAL CLINIC of PA, LLC/FINI HEALTH AND WELLNESS GROUP, PLLC may disclose my PHI to the following individuals (family, relatives, or friends) who may assist in my care:

Name	Relationship	Home #:	Work #:	Cell #:

Please indicate name, contact numbers, and relationship of individuals to whom UNITED MEDICAL CLINIC of PA, LLC / FINI HEALTH AND WELLNESS GROUP, PLLC may release PHI.

I have the right to review the Notice of Privacy Practices prior to signing this consent. UNITED MEDICAL CLINIC of PA, LLC/ FINI HEALTH AND WELLNESS GROUP, PLLC reserves the right to revise its Notice of Privacy Practices at anytime. A written copy of our Notice of Privacy Practices may be obtained by forwarding a written request to our office.

CONSENT FOR CALLS TO HOME

With my consent, UNITED MEDICAL CLINIC of PA, LLC/ FINI HEALTH AND WELLNESS GROUP, PLLC may call my home or other designated location and leave message on my voice mail or with a person in reference to any item that may assist UNITED MEDICAL CLINIC of PA, LLC/ FINI HEALTH AND WELLNESS GROUP, PLLC in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

CONSENT FOR MAIL

With my consent, UNITED MEDICAL CLINIC of PA, LLC/ FINI HEALTH AND WELLNESS GROUP, PLLC may mail to my home or other designated location any item that may assist UNITED MEDICAL CLINIC of PA, LLC/ FINI HEALTH AND WELLNESS GROUP, PLLC in carrying out TPO such as appointment reminder cards and patient statement as long as they are marked CONFIDENTIAL.

CONSENT FOR E-MAIL

With my consent, UNITED MEDICAL CLINIC of PA, LLC/FINI HEALTH AND WELLNESS GROUP, PLLC may e-mail to my designated e-mail address any message in reference to any item that may assist in my care.

UNITED MEDICAL CLINIC of PA, LLC/ FINI HEALTH AND WELLNESS GROUP, PLLC may contact me for TPO use, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

I have the right to request that UNITED MEDICAL CLINIC of PA, LLC / FINI HEALTH AND WELLNESS GROUP, PLLC restricts how it uses or discloses my PHI to carry out the TPO, However, UNITED MEDICAL CLINIC of PA, LLC/FINI HEALTH AND WELLNESS GROUP, PLLC is not required to agree to my requested restrictions, but, if it does, it is bound by this agreement.

By signing this form, I am consenting to UNITED MEDICAL CLINIC of PA, LLC's/FINI HEALTH AND WELLNESS GROUP, PLLC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that UNITED MEDICAL CLINIC of PA, LLC/FINI HEALTH AND WELLNESS GROUP, PLLC has already made disclosure in reliance upon my prior consent. If I do not sign this consent, UNITED MEDICAL CLINIC of PA, LLC/ FINI HEALTH AD WELLNESS GROUP, PLLC may decline to provide services to me.

Signed by: ______________________________ ______________________________

Signature of Patient or Legal Guardian Relationship to Patient

______________________________ ______________________________

Patient's Name Date

____

Patient Medical History Form

Patient Name: ____ **Date of Birth**: _____/_____/_____

To help the doctor serve you better, please complete the information below. Thank you!

Allergies: □ No known Allergies (If yes, please list all Drug, Food, and Environmental Allergies below:)

____

____

Medications: Preferred Pharmacy: ________________________ Location: ________________________________

Please list all current Over the Counter and Prescribed Medications with their corresponding dosages: (if known)

NAME OF MEDICATION	STRENGTH	HOW OFTEN?

Personal Medical History: Did you in the **Past**, or do you **Currently** have problems with any of the following? (Please check all that apply to YOU) and tell us, to the best of your knowledge:

CONDITION	PAST	CURRENT	DATE/ AGE ONSET:	DATE/AGE RESOLVED:
ABDOMINAL PAIN- CHRONIC				
AGITATION				
ALCOHOL ABUSE/ ADDICTION				
ALLERGIES				
ANEMIA				
ARTHRITIS				
ASTHMA				
BACK PAIN-RECURRENT				
BLEEDING EASILY				
BLOOD IN URINE/HEMATURIA				
BLOODY OR TARRY STOOLS				
BONE FRACTURE OR JOIN INJURY				
CANCER				
CATARACTS				
CHEST PAIN				
CHICKEN POX				
CHRONIC COUGH				
CHRONIC FATIGUE				
COLD NUMB FEET				
COLITIS				
CONSTIPATION				
CROHN'S DISEASE				
DECREASE IN FLOW OR FORCE OF URINE				
DECREASED HEARING				
DEPRESSION/MOODINESS				
DIABETES				
DIARRHEA				
DIFFICULTY SWALLOWING				
DIVERTICULOSIS				
DIZZY SPELLS				
DOUBLE OR BLURRED VISION				

***Patient Medical History Form** continued…*

Patient Name: ____ **Date of Birth:** _____/_____/_____

CONDITION	PAST	CURRENT	DATE/ AGE ONSET:	DATE/AGE RESOLVED:
DRUG ABUSE/ADDICTION				
EAR INFECTIONS- FREQUENT				
ECZEMA				
EPILEPSY				
EYE PAIN				
FAILING VISION				
FAINTING SPELLS				
FEELINGS OF WORTHLESSNESS				
FOOT PAIN				
GALL BLADDER TROUBLE				
GERMAN MEASLES				
GLAUCOMA				
GOUT				
HEADACHES/MIGRAINE				
HEART DISEASE				
HEART MURMUR				
HEARTBURN				
HEMORRHOIDS				
HERNIA				
HERPES				
HIGH BLOOD PRESSURE				
HIGH CHOLESTEROL				
HOARSENESS- PROLONGED				
IRREGULAR PULSE/HEART PALPITATIONS				
JAUNDICE/ HEPATITIS				
KIDNEY STONES				
LEG PAIN- WHEN WALKING				
LOSS OF APPETITE – RECENT				
LOSS OF CONTROL OF BLADDER-URINATION				
MEASLES				
MEMORY LOSS				
MENTAL ILLNESS				
MUMPS				
NERVOUSNESS				
NOSE BLEED- FREQUENT OR RECURRENT				
NUMBNESS-TINGLING SENSATIONS				
OSTEOPOROSIS				
OTHER:				
PAINFUL URINATION				
PEPTIC ULCER				
PERSISTENT NAUSEA/ VOMITING				
PHOBIAS				
PNEUMONIA/ PLEURISY				
POLIO				
PSORIASIS				
RASHES/HIVES				
RECENT HAIR LOSS				

***Patient Medical History Form** continued…*

Patient Name: ________________________________ **Date of Birth:** ____/_____/_____

CONDITION	PAST	CURRENT	DATE/ AGE ONSET:	DATE/AGE RESOLVED:
RECENT UNEXPECTED WEIGHT CHANGE				
RHEUMATIC FEVER				
RINGING IN EAR				
SCARLET FEVER				
SEVERE DEPRESSION				
SHORTNESS OF BREATH WHILE ACTIVE				
SHORTNESS OF BREATH WHILE AT REST				
SINUS TROUBLE				
SLEEPING DIFFICULTY				
SORE THROAT- FREQUENT				
STROKE				
SUICIDAL IDEATIONS				
SWOLLEN ANKLES				
THYROID DISEASE				
TREMOR				
TROUBLE WITH CONCENTRATION				
TUBERCULOSIS				
URETHRAL DISCHARGE				
URINATION MORE THAN TWICE AT NIGHT				
URINE/BLADDER INFECTIONS – FREQUENT				
VARICOSE VEINS/PHLEBITIS				
VENEREAL DISEASE				
WHEEZING				

Procedures and Surgeries: ▫ NONE (If yes, please list all Procedures/Surgeries and indicate when. Ex.: Tonsillectomy-2005

Procedure/ Surgery:	When:

Family History: Does any of the below condition apply to your relative(s)? If so, please mark (x) accordingly.

TYPE	MOTHER	FATHER	SISTER	BROTHER	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcohol Abuse								
Allergies								
Anemia								
Arthritis								
Asthma								
Bleeding Easily								
Cancer: 1.								
2.								
3.								
4.								
Diabetes								
Epilepsy								
Glaucoma								
Headache/ Migraine								

***Patient Medical History Form** continued…*

Patient Name: ________________________________ **Date of Birth:** _____/_____/_____

TYPE	MOTHER	FATHER	SISTER	BROTHER	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Heart Disease								
High Blood Pressure								
High Cholesterol								
Mental Illness								
Osteoporosis								
Severe Depression								
Stroke								
Thyroid Disease								
Other:								

Social History:

ALCOHOL USE:	TYPE (PLEASE CIRCLE)	AMOUNT AND FREQUENCY
□ CURRENT □PAST □ NEVER □ QUIT SINCE: _______________		
TOBACCO USE:	TYPE (PLEASE CIRCLE)	AMOUNT AND FREQUENCY
□ CURRENT □PAST □ NEVER □ QUIT SINCE: _______________		
SUBSTANCE/DRUG USE:	TYPE (PLEASE CIRCLE)	AMOUNT AND FREQUENCY
□ CURRENT □PAST □ NEVER □ QUIT SINCE: _______________		
EXERCISE AND PHYSICAL ACTIVITY:	TYPE (PLEASE CIRCLE)	AMOUNT OF TIME AND FREQUENCY
□ NONE □ REGULAR □ OCCASIONAL		

Pregnancies:

Please complete below for all pregnancies including abortions, miscarriages, etc.

DATE/ TIME	NUMBER OF WKS. PREGNANT	PREGNANCY/ DELIVERY OUTCOME	LENGTH OF LABOR	SEX OF THE BABY	WEIGHT	ANESTHESIA	HOSPITAL
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

Do you have Living Will or Advanced Directive? □ YES □ NO

I certify that the information contained herein is complete and accurate to the best of my knowledge.

____

Patient Signature Date

***Patient Medical History Form** continued…*

Patient Name: ______________________________ **Date of Birth:** _____/_____/_____

Employment and Education

Status:	Work Hazards:	Activity Level:
☐ Employed ☐ Retired ☐ Disability ☐ Student ☐ Part-Time ☐ Unemployed Other: ____________________ **Do you operate any hazardous equipment?** Y / N	☐ Hazardous Materials ☐ Heavy Lifting/Twisting ☐ Loud Noises ☐ Medical/Clinical Work ☐ Repetitive Motion ☐ Shift/Night Work ☐ Vibration Other: ____________________	☐ Desk/Office ☐ Occasional Physical Work ☐ Moderate Physical Work ☐ Heavy Physical Work Other: ____________________

Previous Employment/School:	Highest Education:	School Concerns:
____________________ ____________________ ____________________ ____________________ Additional Information: ____________________ ____________________	☐ None ☐ Elementary School ☐ High School/GED ☐ Middle School ☐ Some College ☐ Bachelor's Degree ☐ Master's Degree ☐ Adv. Graduate or Ph.D.	☐ Learning ☐ Health ☐ Social ☐ Cultural ☐ Communication ☐ Other: Additional Information: ____________________ ____________________

Home and Environment

Marital Status:	Lives With:	Living Situation:
☐ Single ☐ Married ☐ Married (Living Together) ☐ Life Partner ☐ Separate ☐ Never Married ☐ Divorce ☐ Widowed ☐ Annulled Other: ____________________	☐ Self ☐ Children ☐ Family ☐ Father ☐ Foster Family ☐ Grandparents ☐ Mother ☐ Roomate(s)/ Friend(s) ☐ Siblings ☐ Significant Other ☐ Spouse Other: ____________________	☐ Home/Independent ☐ Home with Assistance Physical Work ☐ Homeless/Shelter Other: ____________________ **Number of Children:** _____

Environment Screening

Have you experience any abuse in your house hold? ____________________ ____________________ ____________________ ____________________ ____________________	**Do you feel unsafe at home?** Y / N **Do you have a safe place to go?** Y / N **Do you have Family/Friends available to help?** Y / N	**Have you notified any Agencies about your abuse?** Y / N **Agency(s)/Others Notified:** ____________________ ____________________

Patient Medical History Form *continued…*

Patient Name: ____ **Date of Birth**: _____/_____/_____

Nutrition and Health

Briefly write your routine diet:	Type of Diet:	OTHER:
	□ Regular □ Low Fat □ Calorie Restricted □ Low Sodium □ Diabetic □ Renal □ Dysphagia Diet □ Total Parenteral Nutrition □ Ketogenic Diet □ Kosher □ Vegetarian □ Low Carbohydrate Other: ____________________________	Diet Restrictions: ______________________________ ______________________________ Caffeine intake amount: ______________________________ **Do you want to lose weight?** Y / N

Vitamins/Alternative Health	Eating Disorders:	OTHER:
Vitamins/Supplements: ____________________________ ____________________________ Uses Alternative Healthcare: ____________________________ ____________________________	□ Bulimia □ Anorexia Nervosa □ Overeating Other: ______________________________ ____________________________________ ____________________________________	**Sleeping concerns?** Y / N ________________________________ ________________________________ **Feeling highly Stressed?** Y / N ________________________________ ________________________________

Exercise and Physical Activity

Exercises	Exercise Type:	Self Assessment
How many times per week? □ Never □ 1-2 times □ 3-4 times □ 5-6 times □ Daily Other: ______________________________	**Duration (Average # of minutes):** _________ □ Aerobics □ Running □ Bicycling □ Swimming □ Organized Team Sports □ Walking □ Weight Lifting □ PE Class □ Yoga Other: ____________________________________	□ Poor Condition □ Fair Condition □ Good Condition □ Excellent Condition Other/Comment: __________________________ __________________________ __________________________

Patient Medical History Form *continued…*

Patient Name: ____ **Date of Birth**: _____/_____/_____

Sexual Activity

Activity	Orientation:	Contraceptive Use Details
Are you Sexually Active? Y / N **When were you first active?** **Age:**______ **Number of lifetime partners**: ______ **Number of current partners**: ______	**Self describe orientation:** □ Heterosexual □ Bisexual □ Homosexual □ Transgender Other: ___________________________ **Do you use condoms?** Y / N	□ Abstinence □ Birth Control Implant □ Birth Control PATCH □ Birth Control PILL □ Birth Control SHOT □ Condoms □ Intrauterine Device □ Vaginal Ring □ None Other Contraceptive Use/Comment: ________________________________

History of Abuse	Orientation:	Other Related Concerns:
Have you ever been sexually abused? Y / N Comment: ______________________________ ______________________________ ______________________________	**Self describe orientation:** □ Heterosexual □ Bisexual □ Homosexual □ Transgender Other: ___________________________	