Patient Registration History

Dr. Randy Lundell D.O.
Mountain Springs Family Medicine
468 South Main Street
Spanish Fork, Utah 84660
(801) 504-6117

1. PATIENT INFORMATION

Date _____

Social Security Number_____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Race: ☐White ☐Black Or African American ☐Black Hispanic or Latino

☐Native Hawaiian or Latino ☐American Indian or Native Alaskan ☐Asian

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Language Preference: ☐ English ☐ Spanish ☐ Other _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

Spouse's SS# _____

Spouse's Employer _____

3. PHONE NUMBERS

Primary phone(_____) _____

Secondary phone(_____) _____

E-mail _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

2. INSURANCE

Please fill out insurance information even if we took a copy of your card

Primary Insurance Co._____

ID #_____

Subscriber's Name_____

Birthdate _____ SS# _____

Relationship to Patient_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Secondary Insurance Co._____

ID #_____

Subscriber's Name_____

Birthdate _____ SS# _____

Relationship to Patient _____

MEDICARE/MEDIGAP AUTHORIZATION IF APPLICABLE

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to my or on my behalf to Mountain Springs Family Medicine, for any services furnished to me by them.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine their benefits for related services.

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Mountain Springs Family Medicine, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Mountain Springs Family Medicine, may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. The consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Beneficiary, Guardian or Personal Representative

_____
Please print name of Beneficiary, Guardian or Personal Representative

_____ _____
Date Relationship to Beneficiary

TREATMENT CONSENT

I hereby consent and give my permission t the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____
Signature of Beneficiary, Guardian or Personal Representative Date

_____ _____
Please print name of Beneficiary, Guardian or Personal Representative Relationship to Patient

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Financial Policy/ HIPPA Acknowledgement
Attention: Important Insurance/Payment Information

- Each patient, not the insurance company, is responsible for payment for all charges to his/her account at the time services are rendered unless special arrangements have been made.
- It is your responsibility to pay any deductible amounts, coinsurance or any other balance not paid by your insurance company
- In the event that your insurance company refuses payment for services rendered, you will be responsible for payment in full. A denial from your insurance company does not release you from your financial obligations to us.
- The primary responsibility for dealing with your insurance company is yours, not ours. We provide assistance for you as a courtesy.
- Payments on accounts billed are expected within 30 days.
- Delinquent accounts will be charged interest at 1.5% per month
- The undersigned specifically agrees to pay all reasonable attorneys fees and court costs in the event legal action is taken to collect an account. The undersigned further aggress to pay an additional amount representing up to 40% of the principal balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with said collection action processing.

I have read and understand the Financial Policy/Payment information policy above and agree to its terms.

_____ _____

Signature of Beneficiary, Guardian or Personal Representative Date

_____

Print Name

Notification and Acknowledgement of Notice of Privacy Practices Regarding Protected Health Information

Our Notice of Privacy Practices provides detailed information about how we may use and disclose protected health information about you. As a [patient/covered individual] you have a right to a copy of that notice. You may obtain a copy of Our Notice of Privacy Practices from our office at:

Dr. Randy Lundell, DO
Health Rejuvenation Institute
468 South Main Street
Spanish Fork, UT 84660

We reserve the right to change the notice, and if we do, you may obtain a copy of the revised Notice from the same location noted above.

Please acknowledge your receipt of this notification by signing below.

_____ _____

Signature of Beneficiary, Guardian or Personal Representative Date

_____

Print Name

Patient Registration History

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Mountain Springs Family Medicine
468 South Main Street
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Office Policies

Cancellation of an Appointment

Please be courteous and call promptly if you are unable to attend an appointment. We require that you call 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to medical care.

How to Cancel Your Appointment

To cancel appointments, please call (801)504-6117. If you do not reach the receptionist, you may leave a detailed message on the voice mail.

No Show Policy

A "no show" is someone who misses an appointment without canceling it 24 hours in advance of your scheduled appointment. No-shows inconvenience those individuals who need access to medical care in a timely manner. Our no-show fee is $20.

Late Arrival

If you arrive 10 minutes late for your scheduled appointment, please be aware that you may be asked to reschedule. It is best to always plan on arriving 5-10 minutes early to your appointment. A fee of $20 will be assessed for patients arriving later than 10 minutes after the scheduled appointment.

By signing this agreement, you are attesting that you understand that if you fail to give a minimum of 24 hours notice of cancellation or if you "no show" to an appointment, **you will be assessed a $20.00 no-show fee**. You are also attesting that you understand that this charge will be billed directly to you, not your insurance company.

_____ _____

Signature of Beneficiary, Guardian or Personal Representative Date

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This portion is **OPTIONAL. If you would like to release your healthcare information to a spouse, family member etc. then fill this form out.**

Authorization to Release Healthcare Information

Patient's Name:_____ Date of Birth:_____

I request and authorize Health Rejuvenation to release my healthcare information to the patient named above to:

Name (s):_____

Address:_____City:_____State:_____Zip code:_____

The request and authorization applies to: (Please check one and list if applicable)

○ Healthcare information only relating to the following treatment, condition, or dates:

_____

_____

○ All Healthcare information (including any and all office notes, hospital records, lab reports, radiology images and medication logs)

_____ _____

Signature of Beneficiary, Guardian or Personal Representative Date

_____

Print Name

Medical Symptoms Questionnaire

Patient Name _____ Date _____

Rate each of the following symptoms baed upon your typical health profile for the past 14 days.

Point Scale

0 - ***Never or almost never*** have the symptom
1 - ***Occasionally*** have it, effect is ***not severe***
2 - ***Occasionally*** have it, effect is ***severe***
3 - ***Frequently*** have it, effect is ***not severe***
4 - ***Frequently*** have it, effect is ***severe***

HEAD

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia **Total** _____

EYES

_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
(Does not include near or far-sightedness) **Total** _____

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss **Total** _____

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation **Total** _____

MOUTH/THROAT

_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolsored tongue, gums, lips
_____ Canker sores **Total** _____

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating **Total** _____

HEART

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain **Total** _____

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing

Total _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain

Total _____

JOINTS/MUSCLE

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness

Total _____

WEIGHT

_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight

Total _____

ENERGY/ACTIVITY

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
Restlessness

Total _____

MIND

_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities

Total _____

EMOTIONS

_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression

Total _____

OTHER

_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge

Total _____

Grand Total _____

Health Rejuvenation Institute

468 South Main St. Spanish Fork, UT 84660 • Phone (801) 504-6117 • Fax (801) 504-6328

Name:_____

Date of Birth:_____

Date:						
Desired Weight						
Days of exercise weekly						
Servings of fruits daily						
Servings of vegetables daily						
Hours of nightly sleep						
H2O oz. per day						
Stress Level (1-10)						
Relationship satisfaction (1-10)						

Please circle yes or no:						
Do you smoke?	YES NO					
If yes- how much						
Do you drink alcohol?	YES NO					
If yes- how much						
Do you take Fish oil?	YES NO					
Do you take a Multivitamin?	YES NO					
Do you take Vitamin D?	YES NO					

Date last received:						
Colonoscopy						
Results						
Mammogram						
Results						
PAP Smear						
Results						
Dexa Scan						
Results						