Health Questionaire

Past Medical History:
Have you ever had (or have) the following: (Please check if "yes", leave blank if "no")

Heart Disease	yes ___	Diabetes	yes ___	Anxiety/Depression	yes ___
Kidney / Liver Disease	yes ___	Anemia	yes ___	Hepatitis	yes ___
Thyroid Disease	yes ___	Cancer	yes ___	Bleeding Tendencies	yes ___
Lung Disease	yes ___	Ulcers	yes ___	Any other Disease?	yes ___

(Please List any other Health Issues:_____

Previous Hospitalizations/Surgeries/Serious Illnesses or Injuries: When?

_____ _____

_____ _____

_____ _____

Allergies:_____

History of Anesthesia (Reaction?): _____

Medications: (Include non-prescription):_____

Patient Social History:

Marital Status:	Single: ___	Married: ___	Separated: ___	Divorced: ___	Widowed: ___
Use of Alcohol:	Never ___	Rarely: ___	Moderate: ___	Daily: ___	
Use of Tobacco:	Never ___	Quit: ___ (If so, When? _____)		Current packs/day: _____	
Use of Drugs:	Never ___	Type/ Frequency: _____			

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____
	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

NAME: _____ DOB: _____

Live Well
Family Medicine Center
OF NAPLES

Financial Policy

Thank you for choosing **Live Well Family Medicine Center of Naples**. We are committed to the success of your treatment. Accurate information and prompt payment will allow us to continue giving you the best possible care.

Your insurance policy is a contract between **you** and **your insurance company.** It is your responsibility to know and understand the benefits for what is covered and not covered by your policy. It is your responsibility to check with your health plan if our office is contracted with your insurance product AND with your carrier. (For example, we may be an Aetna **PPO** provider, but might not be an Aetna **EPO** provider.)

A. If you DO NOT have insurance coverage, full payment is due at the time services are rendered.

B. If you have insurance coverage:

1. You must provide current, accurate health insurance information and your insurance card along with a current I.D. at the time of service. Claims that are denied, due to inaccurate insurance information, will become the patient's responsibility.
2. Office co-payments are due prior to seeing the provider.
3. As a courtesy, we will file a maximum of two claims to your insurance company for each date of service. If the insurance plan does not respond within 60 days, the unpaid balance becomes the patient's responsibility.
4. As a courtesy we will file claims with your secondary insurance.
5. Eligibility of coverage must be verified through the health plan at the time of service. If we are unable to verify, payment in full will be required.

C. Patient-responsible balances older than 60 days will be subject to late charges of $20.00 and/or with interest.

D. Returned checks will be assessed a $25.00 fee and are subject to referral to the District Attorney's Office.

E. A $25.00 charge will be assessed for failure to cancel or reschedule an appointment 24 hours in advanced.

F. Outside laboratory costs are billed separately by the processing lab.

G. Live Well Family Medicine Office requires a $20.00 fee for all Disability, Employment or Insurance forms or letters. Payment is due at the time your forms are dropped off.

I authorize payment of my medical benefits to Live Well Family Medicine Center of Naples for services rendered.

By my signature below, I agree to the terms of this financial policy and acknowledge that I have received a copy.

Signature _____ **Date** ____/____/____

(Parent or Guardian if patient is minor)

Patient Name _____

Live Well
Family Medicine Center

1649 Termino Ave.
Long Beach, CA 90804

David Shen, M.D.
Board Certified Family Medicine

Nicole Shweiri, M.D.
Board Certified Family Medicine

Rebecca Young, D.O.
Board Certified Family Medicine

Tel. 562-434-7777 Fax 562-433-3737

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.	BIRTHDATE

ADDRESS	APT#	CITY	STATE	ZIP

SS#	HOME TELEPHONE #	WORK TELEPHONE #	CELL PHONE #	SEX	MARITAL STATUS

EMPLOYER	EMPLOYERS ADDRESS	CITY	STATE	ZIP

DRUG ALLERGIES, IF KNOWN	IF STUDENT PROVIDE STATUS FULL-TIME PART-TIME

INSURED INFORMATION

LAST	FIRST NAME	M.I.	RELATIONSHIP TO PATIENT SPOUSE CHILD PARENT OTHER

ADDRESS, IF DIFFERENT FROM PATIENTS	CITY	STATE	ZIP

INSUREDS EMPLOYER	EMPLOYERS ADDRESS	CITY	STATE	ZIP

BIRTH DATE (REQUIRED)	SS# (REQUIRED)	EMERGENCY CONTACT TELEPONE NUMBERS

INSURANCE INFORMATION

1.PRIMARY INSURANCE PLAN	GROUP NUMBER	POLICY NUMBER

TYPE OF PLAN OR COVERAGE

HMO PPO EPO MEDI-CAL MEDICARE MEDICARE SUPPLEMENT CASH OTHER

POLICY OWNERS NAME (GUARANTOR)	PRIMARY CARE PROVIDER

2.SECONDARY INSURANCE PLAN	GROUP NUMBER	POLICY NUMBER

TYPE OF PLAN OR COVERAGE

HMO PPO EPO MEDI-CAL MEDICARE MEDICARE SUPPLEMENT CASH OTHER

POLICY OWNERS NAME (GUARANTOR)	PRIMARY CARE PROVIDER

3.TERTIARY INSURANCE PLAN	GROUP NUMBER	POLICY NUMBER

TYPE OF PLAN OR COVERAGE

HMO PPO EPO MEDI-CAL MEDICARE MEDICARE SUPPLEMENT CASH OTHER

POLICY OWNERS NAME (GUARANTOR)	GROUP NUMBER	POLICY NUMBER

PLEASE LIST ANY MEMBERS OF YOUR IMMEDIATE FAMILY THAT HAVE BEEN TREATED BY OUR PHYSICIAN(S) AND THE PHYSICIAN(S) NAME.

REFERRED BY:	STREET ADDRESS	CITY	STATE	ZIP

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for professional services when rendered unless prior arrangements are made. I request that payment of authorized medicare/other insurance company benefits be made on my behalf to Live Well Family Medicine of Naples, Inc. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the social security administration and healthcare financing administration or its intermediaries or carriers, any information needed for this or a related Medicare claim or other insurance claim. I permit a copy of this authorization to be used in place of the original and request that payment of medical insurance benefits be made payable to Live Well Family Medicine of Naples, Inc. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.(section 1128b of the social security act and 31 u.s.c 3801-3812 provides penalties for withholding this information.)

PATIENTS SIGNATURE_____ INSUREDS SIGNATURE_____ DATE_____

revised 6/27/2008

email:

Live Well
Family Medicine Center

1649 Termino Ave.
Long Beach, CA 90804
562-434-7777 | Fax 562-433-3737
www.livewellmed.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print):

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _

Phone: _____

RELEASE MY MEDICAL RECORDS FROM:

NAME: _____

TEL: _____

FAX: _____

David Shen, M.D.
Nicole Shweiri, M.D.
Rebecca Young, D.O.

Please send medical records no later than: _____

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient: _____ Date: _____

*IF MORE THAN 20 PAGES PLEASE MAIL TO ADDRESS ABOVE *

Patient Record of Disclosures

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):
Home Telephone_____
O.K. to leave a message:
With spouse_____
With detailed information_____
Leave message with call-back number only_____

Cell Telephone_____
O.K. to leave a message:
With detailed information_____
With call-back number only_____

Written Communication_____
O.K. to mail to my home address_____
O.K. to mail to my work address_____
O.K. to fax to this number_____
Other_____

Please list any family members names you would allow us to release your Medical information to. _____

_____

_____
Patient signature Date

_____
Print name Birth date

Live Well
Family Medicine Center

I have been provided with a copy of the Notice of Privacy Practices for David Shen, M.D. and Nicole Shweiri M.D. as it is currently in effect, I have read and understand that I am entitled to receive a paper copy of the notice at any time I request one. Live Well Family Medicine Center reserves the right to make changes to the notice and an updated copy will be available on subsequent office visits.

Patient name: _____

Patient's signature:_____

Date:_____

For office use only:
Documentation of a patient's inability, refusal or choice not to read the notice or sign the acknowledgement.

1/2008

Notice of Privacy Practices

Effective date 01/01/2009

Live Well Family Medicine Center of Naples

David Shen, M.D. & Nicole Shweiri, M.D.

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your health information.

Please review this notice carefully.

A. Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your health information (also called protected health information or (PHI). We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI.

1. Our practice may use your PHI to treat you, for example we may ask you to have laboratory tests and use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you or disclose your PHI to a pharmacy when ordering a prescription for you. Additionally, we may disclose your PHI to others who may assist in your care. We may also disclose your PHI to other health care providers for purposes related to your treatment.
2. Our practice may use and disclose your PHI in order to bill and collect payment for services and items you may receive from us. For example, we may contact your health insurer to certify eligibility and benefits and we may provide your insurer with details regarding your treatment. We may also disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
3. Our practice may release your PHI to a friend or family member that is involved in your care. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.
4. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

-Maintaining vital records, such as births and deaths
-Reporting child abuse or neglect
-Preventing or controlling disease, injury or disability.
-Notifying a person regarding potential exposure to a communicable disease
-Notifying a person regarding a potential risk for spreading or contracting a disease or condition.

The use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note that we are required to retain records for your care.
If you have any questions regarding this notice or our health information privacy policies, please contact our office staff (562) 434-7777.