Lotus Center of Health New Patient Intake Form

Visit Date:

PATIENT INFORMATION

Patient name *(last, first, M.I)*: | **Preferred Name:**

Gender Identity: | **Date of birth**: | **Age:**

Sex at birth: | **Pronouns:**

Address: | **Phone Number:**

SSN#: | **Primary care:**

Email: | **Specialists:**

Emergency contact name/relationship/number: | **Pharmacy:**

Reason for visit: ☐ Routine ☐ Problem

What have you tried?:

Did it help?:

ALLERGIES

Allergy:	Reaction:

CURRENT MEDICATIONS: *Include prescribed, over-the-counter drugs, vitamins, herbal remedies or supplements, inhalers, etc.:*

Name of medication (space on back if needed)	strength/dose	Frequency	Reason for taking

PERSONAL MEDICAL HISTORY (space on back)

☐ Yes ☐ No	**High blood pressure**	☐ Yes ☐ No	**Heart disease**	☐ Yes ☐ No	**Seizures**
☐ Yes ☐ No	**Migraines**	☐ Yes ☐ No	**CVA/TIA/Stroke**	☐ Yes ☐ No	**Liver/Gall bladder disease**
☐ Yes ☐ No	**High cholesterol**	☐ Yes ☐ No	**Diabetes**	☐ Yes ☐ No	**Kidney disease**
☐ Yes ☐ No	**Blood clotting disorder/DVT**	☐ Yes ☐ No	**Cancer**	☐ Yes ☐ No	**Mental health issue**
☐ Yes ☐ No	**GYN disorder**	☐ Yes ☐ No	**Thyroid/endocrine disease**	☐ Yes ☐ No	**Other: (space on back)**

SURGICAL HISTORY

Year	Type of surgery	Reason for surgery

FAMILY HISTORY

Family history of major illnesses? *(mother, father, siblings)* please list: ☐ Yes ☐ No

Relatives with breast, ovarian, uterine, or colon cancer? If yes, who & age: ☐ Yes ☐ No or unknown

SOCIAL HISTORY

Do you smoke cigarettes or vape? ☐ Yes - How many/day? ☐ How many years? ☐ ☐ Quit, year: ☐ ☐ No

Do you drink alcohol? ☐ Yes - How many/day? ☐ How many/week? ☐ ☐ No

Do you use drugs? ☐ Yes - describe ☐ ☐ No

Exercise regularly? ☐ Yes ☐ Moderate (walking, yoga) ☐ ☐ Vigorous (running): ☐ ☐ No

Do you feel safe in your own home? ☐ Yes ☐ No - explain ☐

Do you have any history of emotional, physical, sexual abuse? ☐ Yes - *type?* ☐ ☐ No

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Current job/school: ☐

PREGNANCY SUMMARY

TOTAL PREGNANCIES ☐ FULL TERM ☐ PREMATURE ☐ MISCARRIAGES ☐ ABORTIONS ☐ # OF CHILDREN ☐

(Please list all pregnancies in order, including miscarriages, premature births, stillbirths, ectopics (tubal), and abortions)

Year	Pregnancy outcome (e.g. vaginal delivery, c-section, miscarriage, abortion)	Length of Pregnancy (wk/mo)	Weight	Sex	Problems/Complications (e.g. preterm labor, high blood pressure, diabetes, blood transfusion, infection)
				☐ Boy ☐ Girl	
				☐ Boy ☐ Girl	
				☐ Boy ☐ Girl	
				☐ Boy ☐ Girl	
				☐ Boy ☐ Girl	

GYNECOLOGIC HISTORY

Age when you had your first period: ☐ years old

Menstrual periods: ☐ Regular ☐ Irregular

Last menstrual period (first day) ☐ / ☐ / ☐

Flow: ☐ Light ☐ Moderate ☐ Heavy

Days between cycles: ☐ Days of bleeding: ☐

How severe is your cramping? Mild ☐ Moderate ☐ Severe ☐

When was your last pap smear?: (month/year) ☐ ☐ Normal ☐ Abnormal

Ever had an abnormal pap? ☐ Yes, date of last abnormal pap smear? (month/year) ☐ ☐ No

Have you needed any of the following for an abnormal pap smear? ☐ Yes (check all that apply) ☐ No treatment required

☐ Colposcopy (year: ☐) ☐ LEEP/Laser/ Conization (year: ☐) ☐ Cryosurgery (year: ☐)

Pap spears normal since treatment? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No

Current partners: ☐ Male ☐ Female ☐ Both ☐ Other ☐ n/a

New sexual partner since last screening for sexually transmitted infections? ☐ Yes ☐ No

Current method of birth control: ☐

INFECTION HISTORY

☐ None ☐ Chlamydia ☐ Gonorrhea ☐ Genital Herpes ☐ Trichomoniasis

☐ Syphilis ☐ HIV/AIDS ☐ Genital warts/HPV ☐ Pelvic Inflammatory disease ☐ Other: ☐

PREVENTIVE CARE

Have you ever had a mammogram? ☐ Yes - date: ☐ ☐ No ☐ n/a ☐ Normal ☐ Abnormal

Have you ever had a bone density scan? ☐ Yes - date: ☐ ☐ No ☐ n/a ☐ Normal ☐ Abnormal

Have you ever had a colonoscopy? ☐ Yes - date: ☐ ☐ No ☐ n/a ☐ Normal ☐ Abnormal

Have you received the HPV (Gardasil) vaccine? ☐ Yes ☐ No Shots received (choose one) ☐ 1 ☐ 2 ☐ 3

Please use space below to explain further if needed:

☐

Lotus
CENTER OF HEALTH

(910) 726-9976
www.lotuscenterofhealth.com
1721 New Hanover Medical Park Dr
Wilmington, NC 28403

HIPAA Compliance Patient Consent Form

(This form must be completed by the patient**)**

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change. If so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

You consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. The practice may condition receipt of treatment upon execution of this consent.

Call, email, or send a text to you to confirm appointments? ☐ YES ☐ NO

Leave a message on your answering machine at home or cell phone? ☐ YES ☐ NO

Discuss your medical condition with a family member or designated individual? ☐ YES ☐ NO

IF YES, please name the members allowed: _____

This consent was signed by (print name): _____

Signature: _____ Date: _____

IF minor -please print your name and relationship to minor: _____

Parent/Guardian Signature: _____ Date: _____

Lotus
CENTER OF HEALTH

(910) 726-9976
www.lotuscenterofhealth.com
1721 New Hanover Medical Park Dr
Wilmington, NC 28403

Filing Insurance Claims

To file any claims, we must have the most recent insurance information. The information below should be completed in **full.** Failure to provide accurate information could result in a denied insurance claim and any unpaid balance will be your responsibility.

*This information is only required if you are a dependent on the Insurance Policy.

Subscriber Name: _____
Subscriber Date of Birth: _____
Subscriber Primary Address: (if different from patient): _____
_____
Subscriber Relationship to patient: _____

Billing

We encourage all patients to sign up for the Practice Fusion patient portal or provide us with a valid email. ***Any invoices for outstanding balances will be sent through text, the patient portal or email with a secure link to pay your balance online. Any outstanding balance must be paid within 30 days. If you have a balance and return for an appointment before 30 days, you will be required to pay your outstanding balance before being seen.*** If you have any questions about the portal, please ask one of our receptionists.

I have read and understand the above:

Patient name (printed): _____
Patient Signature: _____
Date: _____

Lotus
CENTER OF HEALTH

(910) 726-9976
www.lotuscenterofhealth.com
1721 New Hanover Medical Park Dr
Wilmington, NC 28403

No-Show, Late Arrival & Cancellation Agreement

Our goal is to provide excellent care in a timely manner. This means attending scheduled appointments, if an appointment must be changed, it is important to do so as early as possible, so we may schedule wait-list patients in open slots.

- I shall give at least 24-hour notice if I need to change or cancel an appointment.
- I understand that late cancellations (less than 24-hour notice) may be reviewed on an individual basis. Repeated late cancellations may result in a missed appointment fee of $100.
- I understand that multiple reminders by phone and/or email serve as opportunities for patients or caregivers to confirm, cancel or reschedule an upcoming appointment.
- I understand that missing (no-show) appointments will result in a $100 fee. These situations will be considered on a case-by-case basis and could result in a dismissal from the practice.
- I understand that rescheduling an appointment may result in a delay in scheduling my next appointment.
- I understand that arriving 15 minutes or more late for an appointment will result in that appointment being rescheduled. Repeated late arrivals may result in a no-show fee of $100.

We understand that emergencies, illnesses and unforeseen situations occur. We ask that you make every effort to keep your appointment. Missed appointments and late cancellation may be reviewed on an individual basis.

I understand and agree to the above:

Patient name (printed): _____

Patient signature: _____

Date: _____

Lotus
CENTER OF HEALTH

(910) 726-9976
www.lotuscenterofhealth.com
1721 New Hanover Medical Park Dr
Wilmington, NC 28403

Lotus Zero-Tolerance Practice Policy

Lotus Center of Health operates a zero-tolerance policy for any abuse or bad behavior towards our staff and patients. This could be physical, verbal or online abuse.

All practice staff have a right to care for others without fear of being attacked, abused, or treated badly in any way. To successfully provide our services, mutual respect between staff and patients must be in place. Our staff aims to be polite, helpful, and sensitive to all patients' individual needs and circumstances. We respectfully remind patients that we are people who are working hard to provide excellent care while navigating many simultaneous demands.

Aggressive behavior, be it physical, verbal or online, will not be tolerated and may result in you being removed from the practice and, in extreme cases, the authorities contacted.

In order for Lotus to maintain good relations with our patients, we ask you to read and take note of the occasional types of behavior we have seen, which are unacceptable:

- Using disrespectful or derogatory language, shouting or raising of voices
- Any physical violence towards a member of our team or other patients
- Racist, xenophobic, sexist, homophobic or other intolerant language, discrimination or sexual harassment
- Being aggressive, belligerent, bullying or manipulating towards staff
- Causing damage to, or theft of, any equipment from the practice premises, staff or patients
- Obtaining drugs and/or medical services fraudulently
- Posting slanderous online content

The removal of patients from our practice is an exceptionally rare event and is a last resort in an impaired provider-patient relationship. We value successful relationships based on mutual respect and trust. When the relationship has irreversibly broken down, the practice will consider all factors before removing a patient from care.

If a patient is discharged from Lotus, they would have access to our healthcare services for emergency purposes only for 30 days. After that, we are not required to provide care for that individual. Please sign below acknowledging that you have read and understand the above information.

Patient signature: _____ Date: _____

Print name: _____

TERMS OF RECEIPT OF MEDICAL CARE OR TREATMENT

CONSENT FOR TREATMENT: The patient is under the control of the attending physician. The undersigned consents to any medical treatments or procedures (except for invasive procedures which require special consent), X-ray, examination, diagnostic and laboratory procedures, medications, injections, taking of photographs or video for clinical, education or identification purposes, and hospital services rendered to the patient of the general and special instructions of the attending physician(s) or other providers assisting in the care of the patient. The undersigned is aware that the practice of medicine is not an exact science and acknowledges that no guarantee or assurance has been made or implied to the patient as to the result that may be obtained from examination or treatment. The undersigned has been informed of his/her patient rights and responsibilities.

RELEASE OF INFORMATION: The undersigned hereby authorizes Dr. Sarah Gore, DO to disclose the patient's medical record or other medical information to any person or corporation which is or may be liable for all or part of Dr. Sarah Gore's charges or to any person or corporation who has the responsibility for reviewing such charges, including but not limited to medical service organizations, health maintenance organizations, insurance companies, employers, welfare funds, or peer review organizations. The undersigned agrees that Dr. Sarah Gore, DO may copy medical record(s) which is/are to be sent to a receiving facility in the event that the undersigned may be transferred to another care provider/facility. The undersigned acknowledges and consents that the medical records, laboratory results, radiology reports and billing information may be sent or disclosed to another medical facility, physician office, or provider involved in the care of the patient or responsible for any part of the patient's charges.

REQUEST FOR PAYMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION FOR MEDICARE PATIENTS: The undersigned requests payment of authorized Medicare benefits, if any, for any services furnished to the patient by Dr. Sarah Gore, DO and hereby assigned to Dr. Sarah Gore, DO. The undersigned authorizes Dr. Sarah Gore, DO to submit a claim for such services to Medicare. The undersigned authorizes any holder of medical or other information about the patient to release to Medicare, or its agents, claims processors or utilization reviewers, any information needed to determine these benefits or benefits for related services.

ASSIGNMENT OF INDIVIDUAL BENEFITS: If the undersigned is entitled to medical benefits of any type whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient, the undersigned authorizes Dr. Sarah Gore, DO to submit a claim for such services, and benefits are hereby assigned to Dr. Sarah Gore, DO for application on the patient(s) bill. It is agreed that Dr. Sarah Gore, DO may receive any such payment and shall discharge the paying insurance company of any and all obligations under the policy to the extent of such payment. The undersigned and/or patient are responsible for charges not covered by the insurance company. The undersigned certifies that the patient information contained on this form that is given by or on behalf of the patient is applying for payment from all third-party payors is correct.

FINANCIAL AGREEMENT: The undersigned understands and agrees that the patient and our guarantor are financially responsible to Dr. Sarah Gore, DO for charges for medical services or treatments provided to, or on behalf of, the patient if such services are not covered by the hospitalization plan, insurance, or Medicare. The undersigned certifies that he/she has read the foregoing and is the patient or guarantor of this bill or is duly authorized by the patient as the patient's general agent to execute the document and accept the terms. In the event that my account(s) is not satisfied in full my account may be reported to the credit bureaus. The undersigned hereby agrees that upon the discharge of the patient by Dr. Sarah Gore, DO, the undersigned will be responsible for the patient and will make necessary arrangements to have the patient transferred from Dr. Sarah Gore, DO.

I HAVE READ OR HAVE HAD EACH OF THE SECTIONS READ TO ME, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED.

By affixing my signature below, I affirm that I am the patient, or I am authorized to act on behalf of the patient to sign this document verifying consent to the above stated terms.

Patient Signature _____ **Date** _____

Guarantor Signature _____ **Date** _____

Relationship to Patient _____

THIS FORM IS PART OF THE PERMANENT MEDICAL RECORD