A M A R A

MED SPA

Kristin Tarbet, MD, Mike Symond, MD & Gay Sleight, PA-C

# PATIENT INFORMATION

Patient Name: _____

Address: _____

City: _____State: _____ Zip: _____

Home Phone: (_____) _____Cell: (_____) _____

Age: _____Date of Birth: _____

Email: _____

Gender: Male Female Marital Status: M S W D

Social Security Number: _____

Employer: _____

Employer Address: _____

Employer Phone: (_____) _____

Nearest Relative: _____

Address: _____

Phone #: (_____) _____ Relation: _____

**Responsible Party or Spouse**

Name: _____

Address: _____

City: _____State: _____ Zip: _____

Home Phone: (_____) _____

Date of Birth: _____ SS#: _____

Employer: _____

Employer Address: _____

Employer Phone: (_____) _____

**Credit Policy & Financial Agreement**

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 are made in advance.

I authorize insurance benefits to be paid directly to Kristin Tarbet, MD/Mike Symond, MD/Gay Sleight, PA-C. I also authorize the physician to release any information acquired in the course of my evaluation or treatment to the insurance company.

Payments on accounts billed are expected within 30 days.

Delinquent accounts will be charged interest at 1½% per month. I agree to pay collection costs and/or reasonable attorney's fee if any delinquent balance is placed with an agency or attorney for collection or suit.

I/We agree to pay all attorney's fees, court costs, filling fee (including charges of commissions), that may be assessed by any collection agency retained to pursue this matter. I/We further understand that this may be as much as 50% of the principal owing. I/We further agree to pay interest at the rate of 1 ½% per month (18% per year).

**ATTENTION: IMPORTANT INSURANCE INFORMATION**

**Since it is vital that our patients understand our relationship with insurance companies this statement is necessarily straightforward to prevent any possible misunderstandings, disagreements or disappointments.**

**If you believe that your medical needs are covered by insurance, please be aware that the health insurance contract you have is between you and your insurance company, not Amara and your company. We work with your insurance company on all claims, however the insurance company does have a final say as to what is and is not covered. In the event that your insurance company refuses payment for services rendered, you will be responsible for payment in full.**

**LAB INSURANCE MAY NOT COVER ALL FEES**

**If you have insurance, all labs costs are submitted to your insurance company by the Laboratory, not by Amara. We can't guarantee the payment to the lab company by your insurance, as the contract you have is between you and your insurance company.**

**Patient Initials: _____**

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, private insurance and other health plans to Kristin Tarbet, MD/Mike Symond, MD/Gay Sleight, PA-C. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information and records necessary to secure the payment. To the extent necessary to determine liability for payment, and obtain reimbursement, I authorize disclosure of portions of my medical records. A photocopy of the assignment is considered as valid as original.

_____ _____

Signature of Patient Date

_____ _____

Signature of Responsible Party Date

_____ _____

Witness Date

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Name: _____ DOB: _____ Date: _____

Present/Previous Occupation: _____ Marital Status: S M D W

## Past Medical History

- ☐ High blood pressure
- ☐ Hear attack
- ☐ Heart failure
- ☐ Heart valve problems
- ☐ Liver disease/Hepatitis
- ☐ Anemia
- ☐ Depression
- ☐ Mental illness
- ☐ Stroke/Mini stroke
- ☐ Brain Tumor
- ☐ Cancer: _____
- ☐ Diabetes: Type I or Type 2
- ☐ Gout
- ☐ Epilepsy/Seizures
- ☐ Abnormal Clotting
- ☐ Permanent Make up: _____
- ☐ Over-active thyroid
- ☐ Under-active thyroid
- ☐ Asthma
- ☐ Lung problems
- ☐ Ulcers
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Other: _____

Women: # of pregnancies: _____ # of live births: _____

Have you had any surgeries?

| Type of Surgery | Hospital | Year |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Please list your medications, include herbs/vitamins.

| Medication | Dose | Medication | Dose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Family Medical History

Have any of your blood relatives had any of the diseases listed above?

| Relative: | Living? | Deceased? | List Diseases: | Cause of Death |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Sister/s | | | | |
| Brother/s | | | | |
| Grandparents | | | | |

## Personal & Social History

List members in household

| Name: | Birthday |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

Do you have smoke detectors in home? Y / N
Do you use a seatbelt? Y / N
Do you exercise? Y / N How often? _____
Do you use Alcohol? Y / N How often? _____
Did you ever use alcohol? Y / N How long? _____
Do you smoke cigarettes/chew tobacco? Y / N How often?___ X ____
Do you ever use illegal drugs? Y / N
If yes, what kind? _____
Did you ever use illegal drugs? Y / N
If yes, what kind? _____

Immunizations:

Did you complete your childhood series? Y / N
Last Tetanus booster? _____ Last Hep B series? _____
Last Pneumonia shot? _____ Last Flu shot? _____
Last TB skin test? _____ Other: _____

Have you ever had any of following procedures? What year?

Chest X-ray:_____ ECG:_____ Holter:_____ Stress test:_____
Echocardiogram:_____ Angiogram:_____ PFT's:_____ Overnight oximetry:_____
Sleep study:_____ PSA:_____ Pap smear:_____ Mammogram:_____

Do you have any allergies to medications? Y/N If yes, please list what kind of reaction?

_____

Are you seeing any specialists? Y/N If yes, please list:

_____

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# PRIVACY PRACTICES ACKNOWLEDGEMENT

## Acknowledgement Form

I am aware of, have received or been offered a copy of Amara's Notice of Privacy Practices and I have been given the opportunity to review it.

Date: _____

Birth date: _____

Patient Printed Name: _____

Patient Signature: _____

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