



## NEW PATIENT PACKET

• welcome to our clinic •

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### First Visit Checklist:

- Completed Intake Form**  
Please bring the completed intake forms with you to your appointment. If you would like to send us your forms *before the day of your appointment*, you may scan and email them to: [info@thegolgiclinic.com](mailto:info@thegolgiclinic.com).
- Bring Lab or Imaging Reports**  
If you have notes or reports from previous doctors visits that you feel might help us in treating you, please bring them to your first appointment.
- List of Current Medications/Supplements**  
This includes over-the-counter and prescription medication, herbs, vitamins, supplements & homeopathics.
- Parking**  
Parking is available in the Caras Park Lot behind our building or on Front Street.
- Don't Go Upstairs**  
When you enter our building, **don't** go upstairs. Upon entering our building, we're located on the main level (second floor) of 113 W. Front Street. Upstairs is actually the third floor.
- Plan to Arrive on Time for Your Appointment**  
There is complimentary tea available in our reception area.
- Payment is Expected at the Time of Service**  
Cash, check, Mastercard, Visa and Discover are all accepted. Please see our insurance billing policies attached.



**Adult Health Intake**

**Context of Care Review**

Successful *health care* and *preventive medicine* are only possible when the physician has a complete understanding of the patient, physically, mentally, and emotionally. The nature of your responses to the following questions, as well as your thoughtfulness and honesty, will go a long way toward improving our understanding of you and will greatly aid us in addressing your health needs.

Why did you choose to come to this clinic?

What do you know about our approach?

What three expectations do you have from your visit to this clinic?

- 1)
- 2)
- 3)

What long term expectations do you have from working with this clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment toward addressing the underlying cause(s) of your symptoms?  
Rate from 0 to 10 (10 being 100% committed).

0%    0    1    2    3    4    5    6    7    8    9    10    100%

In what behaviors or lifestyle habits do you regularly engage, which you believe *support* your health?

In what behaviors or lifestyle habits do you currently engage, which you believe are *self-destructive*?

What potential *obstacles* do you foresee in addressing the lifestyle factors that are undermining your health?

What obstacles might you see in adhering to the therapeutic protocols that I will be sharing with you?

Who do you know that will sincerely and consistently *support* you with the beneficial lifestyle changes you will be making?

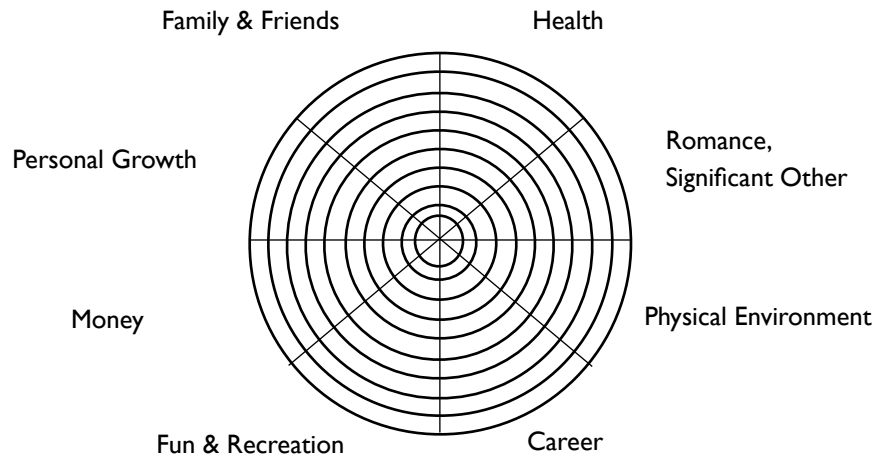
What do you love to do?

**Wheel of Balance**

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, starting from the center point.



Are you currently receiving healthcare?  No  Yes

If **yes**, where and from whom? \_\_\_\_\_

If **no**, when and where did you last receive health care? \_\_\_\_\_

What was the reason? \_\_\_\_\_

What are your most important health problems? List as many as you can, in order of importance.

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_
- 7) \_\_\_\_\_

**Personal Medical History:** Please *circle* any that apply to you; *now or past*.

- |                         |                     |               |                            |                        |
|-------------------------|---------------------|---------------|----------------------------|------------------------|
| Diabetes (type I or II) | High Blood Pressure | Heart Disease | Breast Cancer              | Other Cancer           |
| Mental Illness          | Epilepsy            | Stroke        | Kidney Disease             | Hypo/Hyperthyroid      |
| Glaucoma                | Asthma              | Anemia        | Arthritis                  | Cysts (breast/ovarian) |
| Hay Fever               | Eczema              | Fibroids      | Inflammatory Bowel Disease |                        |

Other Recurrent, Chronic, or Severe Illness(es):

\_\_\_\_\_

Please list any **surgeries, hospitalizations, imaging** (CT, MRI, EEG, EKG), include **dates**:

\_\_\_\_\_

Do you have allergies to medications?  No  Yes

If yes, list medication & reaction: \_\_\_\_\_

Do you have food allergies or environmental sensitivities?  No  Yes

If yes, please list allergy and reaction:

\_\_\_\_\_ Reaction: \_\_\_\_\_  
\_\_\_\_\_ Reaction: \_\_\_\_\_  
\_\_\_\_\_ Reaction: \_\_\_\_\_

Vaccines: please list name & date of the most recent \_\_\_\_\_

Childhood Illnesses: please circle any that apply.

Chicken Pox Mononucleosis Rubella Mumps Measles  
Tuberculosis Strep Throat Diphtheria Rheumatic Fever Typhoid Fever  
Scarlet Fever German Measles

Preventative Screening Test: please list the most recent date and test's result.

Routine Blood Tests: Date \_\_\_\_\_ Results:  Normal  Abnormal  
 Sigmoidoscopy or  Colonoscopy: Date(s) \_\_\_\_\_ Results:  Normal  Abnormal  
Women:  Pap smear: Date \_\_\_\_\_ Results:  Normal  Abnormal  
 Mammogram: Date \_\_\_\_\_ Results:  Normal  Abnormal  
 Dexascan (osteoporosis): Date \_\_\_\_\_ Results:  Normal  Abnormal  
Men:  PSA (prostate): Date \_\_\_\_\_ Results:  Normal  Abnormal

Social History

Home

With whom do you live? \_\_\_\_\_ Pet(s): \_\_\_\_\_

Do you have a religious or spiritual practice?  No  Yes, explain: \_\_\_\_\_

Watch TV?  No  Yes, # hours per week: \_\_\_\_\_

How often do you take vacations? \_\_\_\_\_

Read?  No  Yes, # hours per week: \_\_\_\_\_

Exercise?  Never  Yes, current  Yes, past

What type: \_\_\_\_\_ minutes/day: \_\_\_\_\_ times/week \_\_\_\_\_

Tobacco Use

Cigarettes:  Never  Quit, date: \_\_\_\_\_  Current, packs/day: \_\_\_\_\_ for \_\_\_\_\_ yrs

Other:  exposed to 2nd hand smoke  Pipe  Cigar  Snuff  Chew

Alcohol Use

Do you drink alcohol?  Never  Past, # drinks/wk \_\_\_\_\_  Current, # drinks/wk \_\_\_\_\_

Drug Use

Have you ever used recreational drugs?  No  Yes, explain: \_\_\_\_\_

Caffeine Intake

Never  Quit  Yes, I drink (circle) coffee/caffeinated tea/soda/cocoa: \_\_\_\_\_ c/day

Mental Health

Have you had any times of major psychological trauma?  No  Yes

Age: \_\_\_\_\_ Explain: \_\_\_\_\_

Age: \_\_\_\_\_ Explain: \_\_\_\_\_

Age: \_\_\_\_\_ Explain: \_\_\_\_\_

Have you received mental health counseling?  No  Yes

**Toxic exposure**

Have you had daily or prolonged exposure to toxic chemicals, pesticides, paints, lead, mercury?  No  Yes

If yes, what type & when: \_\_\_\_\_

**General**

What time of day is your energy the best: \_\_\_\_\_ worst: \_\_\_\_\_ Is this a change?  No  Yes

Current height: \_\_\_\_\_ Current weight: \_\_\_\_\_

As an adult, what has been your (women: non-pregnant) maximum weight: \_\_\_\_\_

minimum weight: \_\_\_\_\_

**Diet**

Do you follow a specific diet?  No  Yes

If yes, please *circle*:

Vegetarian Vegan Paleolithic Anti-inflammatory Blood-type Atkins Low-fat/low calorie Gluten-free Dairy-free

Other \_\_\_\_\_

What do you typically eat?

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

To drink: \_\_\_\_\_

What is your heritage? (please *circle*)

Caucasian Black Hispanic Native American Asian Other: \_\_\_\_\_

**Family History:** Please indicate any *known* health conditions; and *age at death* if applicable.

mother: \_\_\_\_\_

father: \_\_\_\_\_

siblings: \_\_\_\_\_

siblings: \_\_\_\_\_

siblings: \_\_\_\_\_

siblings: \_\_\_\_\_

grandparents (maternal) \_\_\_\_\_

grandparents (paternal) \_\_\_\_\_

**Thank you. We look forward to helping you in any way we can.**

## Patient Compliance Policies

### Consent to Treatment

\_\_\_\_\_ I authorize The Golgi Clinic to treat me/my child. I understand methods of treatment used in this practice may include, but are not limited to: homeopathic, herbal, craniosacral, and/or physical medicine, as well as others deemed appropriate. I am at liberty to seek alternate opinions or care, and may discontinue treatment at any time. I will not hold The Golgi Clinic responsible for treatment outcomes should I choose to disregard the doctors medical advice and treatments.

### Pharmacy Policy

\_\_\_\_\_ Most insurance companies *do not* cover the medicinal items that we prescribe and/or dispense. We can provide paperwork for reimbursement from medical savings plans (FSA or HSA) as well as help billing insurance for reimbursement of the cost. Patients are responsible for payment at the time of order. **We do not accept returns on homeopathic medicines or probiotics.** Credit or gift certificates will be issued for all other returns.

### Premier Services

\_\_\_\_\_ The Golgi Clinic, LLC provides premier services to a small number of patients and their families whose schedules do not accommodate regular business hours. For those appointments, the doctors will see patients or offer email/telephone consultations outside regular office hours. Please contact the office for further information.

### Payment Policy

\_\_\_\_\_ The Golgi Clinic, LLC expects payment on the day of service. This reduces our billing costs and allows us to keep costs down for you. Full payment of expected patient responsibility at the time of service is based on your insurance coverage. For patients who are not covered by insurance, we may offer a cash discount for payment-in-full.

\_\_\_\_\_ We will submit charges to your insurance carrier when complete patient information is received. If insurance payment is delayed more than 60 days, you will be expected to pay the full balance. If nonpayment from your insurance carrier is due to documentation needed from our office, we will make all customary efforts to supply such information. We will not fraudulently change diagnoses or procedural codes from the supporting documentation in order to receive a better outcome from your carrier. We do supply some services that insurance carriers do not consider a covered benefit, such as IV therapy, genetic testing, and infertility testing. For any non-covered services, we require payment in-full at the time of the visit. Any payments received from your insurance carrier after you have paid your balance will be refunded to you within 30 days of receipt of overpayment.

\_\_\_\_\_ In the event we are unable to collect payment directly from you, your account will be sent to a collection agency. You acknowledge and agree you will be responsible for any and all collection agency fees and reasonable attorney's fees and costs that may be incurred as a result of nonpayment. These charges are the sole responsibility of the patient and will not be billed to any insurance carrier.

### Cancellation Policy

\_\_\_\_\_ To help us better serve our patients, the Golgi Clinic requires 24 hours notice to cancel or reschedule your appointment. **Any appointment changes made with less than 24 hours notice will incur a \$50 fee for established patients and \$100 for new patients.** Please call our office to change or cancel your appointment. *Email is not a valid form of communication.*

**Golgi Insurance Policies**

- \_\_\_\_\_ I acknowledge that The Golgi Clinic, LLC my release to third party payers requested medical and/or other information necessary to process my claim(s). I hereby assign to The Golgi Clinic, LLC all benefits which are payable from any third party payer who is responsible for payment of my Golgi Clinic expenses. I authorize and direct all third party payers to pay all benefits directly to the Golgi Clinic, LLC (Dr. Teresita Martinez and Dr. Jeffrey Friess).
- \_\_\_\_\_ Patient and/or person legally and financially responsible for patient’s medical bills agree to pay patient’s account regardless of the existence of insurance or other third party liability. Full payment will be made promptly if patient’s insurance benefits do not cover the cost of the visit or a balance remains after all insurance payments are made.
- \_\_\_\_\_ It is the patient’s responsibility to know their covered benefits and deductible met to-date before each appointment.

**Credit Card Policy**

- \_\_\_\_\_ I authorize the Golgi Clinic to keep a secure, digital copy of my credit card on file and authorize the use of said credit card for office visits via phone, email or Skype, and other appointment-related costs, including insurance co-pay/co-insurance, payment of outstanding appointment balances, missed appointment fees, medicinal supplement purchases and shipping costs.
- \_\_\_\_\_ All new appointments require a credit card deposit to hold the appointment. This ensures we keep no-shows to a minimum and enables our scheduling process to run seamlessly.

**PLEASE READ AND SIGN:**

I certify that I have read and understand the above information to the best of my knowledge. I agree to be responsible for payment of all services rendered on my behalf or my dependents, including fees above those designated as “usual and customary” by my insurance carrier, costs of collection and reasonable attorney’s fees, if the account is not paid in a timely manner.

\_\_\_\_\_  
Name (or responsible party name)

\_\_\_\_\_  
Signature of responsible party

\_\_\_\_\_  
Date



**Notice of Privacy Practices**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your healthcare.

It is important that you understand that your information can be used and shared in the following ways:

- To give you medical treatment or other types of health care, multiple providers may be involved in your treatment, both directly and indirectly
- To bill you or a third party for payment for services provided to you
- To assist law enforcement officials in response to criminal activities and to avert a threat to an individual or to public health safety (as in outbreaks of communicable disease)
- In response to a court or administrative order
- We may share your health information with a person(s) that *you have named* to be involved with your health care: I hereby authorize **privileged, confidential information about my treatment to be shared with the following people:**

\_\_\_\_\_ print name(s) of authorized people

You have the following rights relating to the medical records we keep about you:

- Right to inspect your health record and to receive a copy of your health record upon request
- Right to amend information in your health record you believe is inaccurate or incomplete
- Right to know to whom we have disclosed your health information
- Right to ask for limits on the health information data we give out about you
- Right to receive communication from us about your health information in alternate ways
- Right to a paper copy of the complete Notice of Privacy Practices

**I acknowledge having received and read all the above-stated policies of The Golgi Clinic and will comply with them in all respects. If my insurance company requires the release of medical records, I hereby give my permission by signing this form.**

\_\_\_\_\_ Print Name (or name responsible party if patient is a minor)

\_\_\_\_\_ Signature (responsible party signature if minor)

\_\_\_\_/\_\_\_\_/\_\_\_\_ Date

**How Do I Check My Insurance Benefits\*?**

The Golgi Clinic is contracted (in-network) with most **BlueCross** and **PacificSource** insurance companies. If you have insurance and would like us to bill them for the cost of your office visit, please use this helpful questionnaire to assist you in determining what will be paid. If we are *not* in-network with your plan, you may have out-of-network benefits with your PPO and may be reimbursed a portion of your expenses at our clinic.

If we are billing insurance on your behalf, please fill out Section A, below. If we are out-of-network with your insurance, or we are in-network and you would like to verify your benefits prior to your appointment, Section B (below) is for your information only.

[Section A]

Primary Insurance Company: \_\_\_\_\_ Customer Service #: \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_

[Section B]

1. When did my coverage begin and when is it valid thru?

Beginning Date of Coverage \_\_\_\_\_ Ending Date of Coverage \_\_\_\_\_

Does my insurance plan follow a Fiscal or Calendar Year Schedule? \_\_\_\_\_

2. Do I need a referral from my primary care physician (PCP) for alternative services? Y N

3. What are my benefits for the following services? \*Be sure to find out whether your plan includes Out-of-Network coverage for the following benefits.

Specialties:

Naturopathic: # of Visits \_\_\_\_\_; Co-pay/ Co-Insurance \_\_\_\_\_; Year Max \_\_\_\_\_

Physical Therapy: # of Visits \_\_\_\_\_; Co-pay/ Co-Insurance \_\_\_\_\_; Year Max \_\_\_\_\_

Lab work: % Coinsurance \_\_\_\_\_; Year Max \_\_\_\_\_

Annual Preventive Exam: Subject to Deductible? Y N; # used to date \_\_\_\_\_

4. What is the insured person's **individual** deductible for the year and has any or all of it been met?

Deductible \$ \_\_\_\_\_; Amount of Deductible met so far \$ \_\_\_\_\_ Date today \_\_\_\_\_

5. Does the insured person's plan have a **family** deductible? Y N

Deductible \$ \_\_\_\_\_; Amount of Deductible met so far \$ \_\_\_\_\_ Date today \_\_\_\_\_

6. Am I subject to either deductible to see Dr. Friess or Dr. Martinez? Y N

If so, for which specialties does the deductible apply? (circle) Office Visit / Physical Therapy / Lab Work

The most common CPT codes used at the clinic are 99205, 99204, 99215, 99214 and 97140 x 3.

What was the name of the representative I spoke with? \_\_\_\_\_

Please bring this form with you to your appointment. If you have trouble getting the information you need, please feel free to call the clinic for assistance. **\*Please be aware that this is not a guarantee of payment, if an insurance company gives you inaccurate information they may not honor the benefits that were quoted.**