



PATIENT INFORMATION

Title: Mr. Mrs. Ms. Dr. Marital Status: Single Married Divorced Widow Sex: Male Female

Name: Today's Date: / /

Nickname: Date of Birth: / / Social Security: - -

Address: City: State: Zip:

Phone: - - Work Cell Home E-Mail:

Preferred Appt Reminder (please circle one): Text Voice Call E-Mail

Emergency Contact: Name: Relationship: Phone: - -

Preferred Pharmacy: Cross Roads:

INSURANCE INFORMATION

Insurance Carrier: Insurance Phone:

Member ID Number: Group Number:

Employer Name: Address:

Insured Name and DOB: Insured Social Security:

How did you hear about our office? (Please check all that apply)

Interested In: (Please check all that apply)

- Website, Please list which site
Google
Drive By or Walk- In
Facebook
Referred by

- Hormone Replacement
General Wellness
Weight Loss
Pain Management
Other

HIPAA – AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

I hereby authorize medical providers and personnel of Solaris Medical Wellness to discuss my protected health information with:

Name: Relationship:

Name: Relationship:

I understand that I have the right to revoke this authorization, in writing, at any time.

PATIENT PRINTED NAME

PATIENT SIGNATURE

DATE

### HEALTH HISTORY

Please list the approximate date of your most recent exams:

Blood work \_\_\_\_\_ EKG \_\_\_\_\_ Physical \_\_\_\_\_ Hospitalization \_\_\_\_\_

If test results were abnormal, please describe \_\_\_\_\_

Please list current providers rendering ongoing treatment

NAME/SPECIALITY	PHONE/LOCATION	TREATMENT
1.		
2.		
3.		

Please list any illnesses that you are currently being treated for

1.	4.
2.	5.
3.	6.

Please circle if you or immediate family member has history of the following:

Heart Murmur (mitral valve prolapse)	Y	N	HIV or AIDS Positive	Y	N
Anemia or any bleeding disorder	Y	N	Stomach Ulcers	Y	N
Diabetes	Y	N	Pacemaker	Y	N
Epilepsy or seizures	Y	N	Psychosis	Y	N
Migraines	Y	N	Cancer	Y	N
Fainting or dizziness	Y	N	Enlarged lymph nodes	Y	N
Liver disease	Y	N	Radiation therapy	Y	N
Shortness of breath or chest pain	Y	N	Slow-healing mouth sores	Y	N
Hypertension (controlled / uncontrolled)	Y	N	Venereal disease	Y	N
Thyroid disease (goiter)	Y	N	Recurring Infections	Y	N
Heart attack or stroke	Y	N	Glaucoma	Y	N
Kidney disease	Y	N	Arthritis	Y	N

Please list all surgeries and their dates

1.	5.
2.	6.
3.	7.
4.	8.

Please list all current medications, including vitamins, supplements and any other over the counters

1.	5.
2.	6.
3.	7.
4.	8.

Please list ALL food and drug allergies

1.	3.
2.	4.

Tobacco Use? Yes No If so, how much/day? \_\_\_\_\_ Alcohol Use? Yes No If so, how often?

\_\_\_\_\_

4917 S Alma School Road, Suite 1 ♦ Chandler, Arizona ♦ 85248

Phone 480.802.6617 ♦ Fax: 480.802.5711 ♦ www.solarismedicalwellness.com

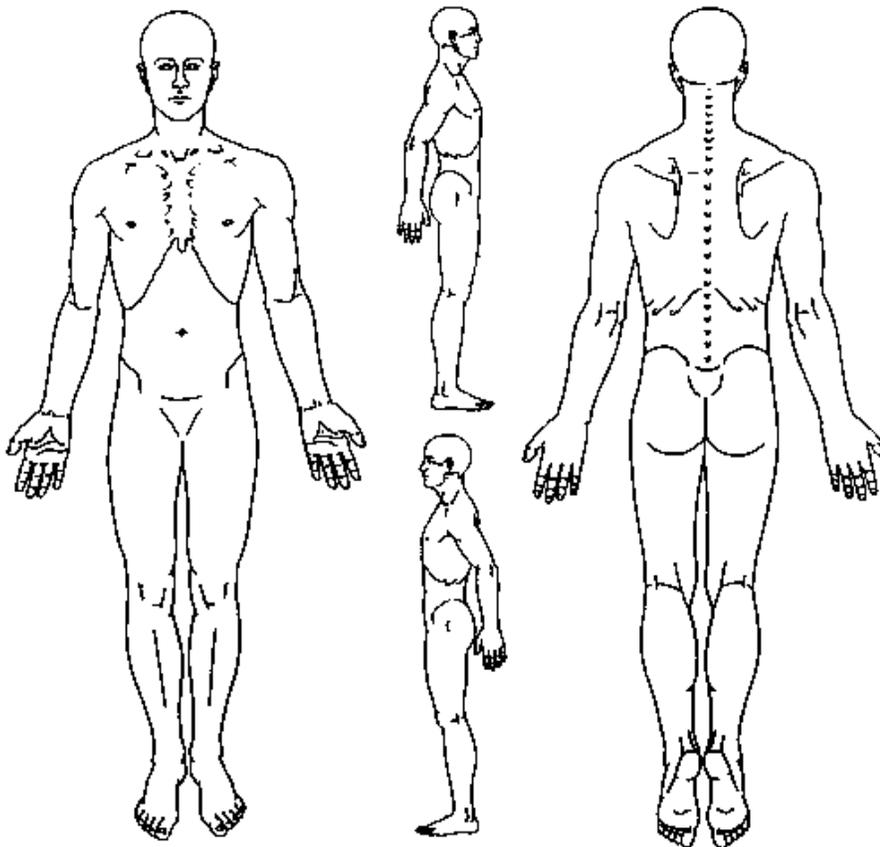
WOMEN: Are you pregnant or nursing? Yes No Any chance of pregnancy? Yes No On birth control? Yes No

### HORMONE DEFICIENCY SYMPTOMS

WOMEN				MEN			
Memory Loss/Brain Fog Often	Rarely	Sometimes		Memory Loss/Brain Fog Often	Rarely	Sometimes	
Anxiety/Stress Often	Rarely	Sometimes		Anxiety/Stress	Rarely	Sometimes	Often
Depression	Rarely	Sometimes	Often	Depression Often	Rarely	Sometimes	
Hot Flashes Often	Rarely	Sometimes		Decrease in Muscle Strength Often	Rarely	Sometimes	
Night Sweats	Rarely	Sometimes	Often	Sleeping Problems	Rarely	Sometimes	Often
Fatigue	Rarely	Sometimes	Often	Fatigue Often	Rarely	Sometimes	
Irritability	Rarely	Sometimes	Often	Irritability Often	Rarely	Sometimes	
Loss of Libido	Rarely	Sometimes	Often	Loss of Libido Often	Rarely	Sometimes	
Weight Gain	Rarely	Sometimes	Often	Weight Gain	Rarely	Sometimes	Often
Vaginal Dryness Often	Rarely	Sometimes		Lack of Morning Erection Often	Rarely	Sometimes	

### PAIN MANAGEMENT AND CHIROPRACTIC

If you have pain, please circle the degree of pain you have (0 being no pain and 10 being excruciating pain), then list the quality of pain (aches, stabbing, numbness, etc.) as well as frequency (daily, weekly, intermittently, etc.)



#### PAIN IDENTIFICATION KEY

- C = Cramping
- A = Aches
- P = Pins/Needles
- B = Burning
- S = Stabbing
- N = Numbness
- T = Throbbing
- SH = Sharp
- TE = Tender
- O = Other

# FINANCIAL POLICY

## Welcome

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care. Your clear understanding of our practice financial policy is important to our professional relationship. We make every effort to keep our fees reasonable while at the same time covering the cost of the services we provide. Payment of your bill is considered part of your overall treatment. In order to keep healthcare costs to an absolute minimum, we have adopted the following policies.

## Fees and Payments

Fees are standard and based on the complexity of your visit. Payment in full is required at the time of your visit and can be made with cash, Visa, MasterCard, or Discover. Insurance co-payments are due at the time of service. We will not bill your secondary insurance for co-payments. If you are unable to pay your co-payment at your visit, your appointment may need to be rescheduled.

While, filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. Your insurance is a contract between you, your employer and the insurance company, we are not party to that contract. Before your visit, contact your insurance company to verify that we are participants in your plan, and that the services you intend to receive are covered. In order for us to file a claim, you must present a CURRENT copy of your insurance at each visit and communicate any changes in your personal information.

### **IT IS YOUR RESPONSIBILITY TO PROVIDE THE CURRENT INFORMATION AT EACH VISIT.**

Not all services are a covered benefit in all policies, so it is very important that you understand the provisions of your individual policy. Insurance companies select certain services that they will not cover, therefore we can't guarantee payment of all claims by your insurance company. Reduction or rejection of your claim does not relieve you of your financial responsibility.

## Self-Pay

In order to address the needs of our patients without insurance and patients with coverage limitations, we offer a discount off of our standard fees. This discount acknowledges the lower cost involved in billing and collections when a claim does not need to be submitted to a third party payer. In order to qualify, payment needs to be made **IN FULL** prior to or on completion of your visit or procedure. Any remaining balance is not eligible for a discount.

## Family Medical Leave Act and Disability Paperwork

If your employer requires Family Medical Leave Act (FMLA) or Disability paperwork to be completed by your provider, we are happy to complete these forms for you; however there is a 5-7 business day turnaround and a charge of \$75.00, payable in advance.

## Medical Records

In order to be in compliance with Arizona State law and HIPAA regulations, we charge a flat fee of \$25.00 for records exceeding 15 pages. However, as always, if a collaborating physician (primary care or specialist) requests portions of your record to assist in your care, there is no charge.

## Miscellaneous Charges

Lab Charges -- Depending on your insurance, you may get a separate bill from the lab facility that performs your lab work. These charges should be discussed directly with the lab facility.

Late arrivals -- If you arrive late for a scheduled appointment, you may be asked to reschedule your appointment or wait for an open appointment time on that day's schedule.

Cancellations -- If you are unable to keep a scheduled appointment, you must call at least one (1) business day in advance or we may consider you a "no-show."

No-shows -- If you miss your appointment, you may be charged a \$25.00 fee for a missed appointment or a \$75.00 fee for a missed procedure or surgery. This fee will need to be paid prior to rescheduling. As permitted by state law, you may be discharged as a patient following three (3) no-shows in a one-year period (365 days).

## Card-On-File Process

When you check into a hotel or rent a car, you are required to provide a credit card to cover the cost of any incidental charges and/or pay your bill. This process benefits both you and company by making the checkout process easier, faster, and more efficient. We have implemented a similar process at Solaris. You will be provided the option to save a credit card when you check-out for your visit. The information will be held securely until a request is submitted by you to remove, change or update the card. The "Card-on-File" program simplifies payments for you and eases the administrative burden on your provider's office. If you have any questions about the card-on-file payment method, please let us know.

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## ARBITRATION AGREEMENT

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2: All Claims Must be Arbitrated:** It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

**Article 4: General Provision:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

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