

SCHEDULE A

SCHEDULE A SUBSCRIPTION CONCIERGE MEDICAL PRACTICE: Home Based Medicine offers optional, private-pay Concierge Services. These services are provided under a separate agreement and are not covered or reimbursed by Medicare or any other insurance. Participation is voluntary and not required to receive medically necessary services covered by Medicare.

Travel Outside the Service Area: Home visits beyond the standard area may incur an additional travel convenience fee based on time, distance, and access. This fee is not covered by insurance and will be charged to the Patient's authorized payment method.

Membership Options (Service Area):

1	Annual Membership Individual (12 months) \$500 discount for two members of the same household (\$9500)	\$5,000
2	Quarter (three months) trial or quarterly installments	\$1,250
3	Episodic Trial (2 weeks). Short term, time limited issue, May incur additional charge for outside of service area	\$ 399 or more

Concierge Membership Convenience Fees for Enhanced Personalized Care: Patients may elect to pay a **non-covered, non-clinical administrative fee** (the "Concierge Fee") that supports enhanced access and additional conveniences not reimbursed by Medicare. The Concierge Fee is not a payment for any covered services and does not affect eligibility for Medicare-covered care. It is non-refundable for the current quarter or any previous period. This fee is the sole responsibility of the patient and includes:

- Complimentary virtual 15 minute Meet & Greet
- Direct, priority communication with the physician and care team
- Priority same- or next-day scheduling
- Extended, unhurried visits
- Electronic communication (email, text, secure portal)
- Completion of non-covered forms or letters
- Invitations to educational or community events
- Flexible scheduling (e.g., in-home visits, telehealth, or digital touchpoints)

Health Information & Digital Communications Platform

Membership includes access to a secure, private platform for storing personal health data and supporting electronic communication with the Practice. This feature is not reimbursed by Medicare and includes:

- Health education and informational content
- Asynchronous updates and messaging
- Communication regarding care goals and preferences

This platform does **not replace** any Medicare-covered services and is offered only as part of the private Concierge Membership.

Program Fees may be paid by check or credit card annually, quarterly, or before episodic care.

Mailing address: Gurpreet K Padam MD PC, 101 S. San Mateo Drive, Suite 106, San Mateo, CA 94401

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

Gurpreet K Padam MD PC, DBA Home Based Medicine, DBA California Lifestyle Medicine ("Private Practice") understands that our patient's privacy is important. This Notice of Privacy Practices ("Notice") applies to Private Practice and each of our Business Associates, as applicable. Effective Date: May 1st, 2022

I. Introduction: This Notice of Privacy Practices ("Notice") describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI.

II. Uses and Disclosures of Protected Health Information

A. Treatment, Payment, and Health Care Operations

- **Treatment:** We may use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This may include communicating with other health care professionals involved in your care.
- **Payment:** We may use and disclose your PHI to obtain payment for the services we provide. This may include billing and collection activities, as well as sharing information with your insurance company or a third-party payer.
- **Health Care Operations:** We may use and disclose your PHI for activities necessary to run our practice. This includes quality assessment, training, compliance, and business management activities.

B. Other Permitted Uses and Disclosures

- **Required by Law:** We may disclose your PHI when required by federal, state, or local law.
- **Public Health Activities:** We may disclose your PHI for public health activities, including reporting of diseases and vital statistics, as required or authorized by law.
- **Health Oversight Activities:** We may disclose your PHI to health oversight agencies for activities such as audits, investigations, inspections, and licensure.
- **Legal Proceedings:** We may disclose your PHI in the course of any judicial or administrative proceeding, in response to a court order or subpoena.
- **Law Enforcement:** We may disclose your PHI to law enforcement officials for specific purposes as required by law or in response to a court order.
- **Emergency Situations:** We may use or disclose your PHI in an emergency situation to provide treatment.

III. Your Rights

A. Right to Access: You have the right to request access to your PHI and it is available to you through the online AthenaHealth patient portal. If you request a printed copy, then provide a written request and we will respond to you within 30 days and there may be a cost for printed PHI.

B. Right to Request Amendments: You have the right to request amendments to your PHI if you believe it is incorrect or incomplete. We will respond to your request within 30 days. An amendment is not guaranteed.

C. Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your PHI.

D. Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain way or at a certain location to protect your privacy.

E. Right to Receive an Accounting of Disclosures: You have the right to request a list of certain disclosures of your PHI.

F. Right to Obtain a Paper Copy of this Notice: You have the right to request a paper copy of this Notice at any time.

IV. Complaints: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services.

V. Changes to this Notice: We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI that we maintain. If we revise our Notice, we will provide you with a copy of the revised Notice at your next visit.

VI. Contact Information: If you have any questions about this Notice, please contact us:

Home Based Medicine 101 S. San Mateo Drive, Suite 106 San Mateo, CA 94401	Phone & Text: (650) 360-9309 Fax: (650) 360-0781 Email: info@homebased.sprucecare.com
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We have not listed every use and disclosure in this notice. For more information see:

<https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/privacy-practices-for-protected-health-information/index.htm>

CONDITIONS OF REGISTRATION

This Agreement outlines the terms under which you, the undersigned patient (“Patient”), may participate in the private direct healthcare services described below and provided by Gurpreet K Padam MD PC, doing business as Home Based Medicine (“HBM” or the “Practice”).

HBM requires all patients to verify and understand their insurance benefits prior to receiving any care. Although the Practice will verify and bill your insurance, coverage and accuracy of information from your insurer cannot be guaranteed. By signing below, you acknowledge that you have read, understood, and agree to this policy.

FINANCIAL RESPONSIBILITY AND BILLING POLICY: By receiving services from this practice, you agree to the following:

- **Insurance Billing for Covered Services:** The practice will bill your insurance for all covered services—including scheduled and unscheduled visits, and any evaluation, treatment, or medical advice provided in person, by phone, or through secure digital or electronic communication (e.g., secure portal messaging, email, phone, photo review, and e-visits) that involve clinical decision-making or medical advice when billing requirements are met. Billing is offered as a courtesy. You remain financially responsible for any portion not paid by your insurance, including denials, delays, partial payments, and non-covered services.
- **Your Responsibilities:** You are responsible for verifying your coverage, network participation, exclusions, and referral requirements directly with your insurer. You must notify the practice in advance of any changes to your insurance or address. If updated insurance is presented on the day of service, payment in full is due at the time of the visit.
- **Co-Payments and Deductibles:** You are responsible for all co-payments and deductibles. Co-payments are due at the time of service. If your deductible is unmet, we will bill your insurance and send you a statement for any remaining balance. You are responsible for any allowed but unpaid portion as determined by your plan.
- **Self-Pay and Non-Covered Services:** Fees may apply for services not covered by insurance, including out-of-network visits, non-medically necessary care, and administrative tasks. These fees will be disclosed in advance when possible.
- **Third-Party Billing:** Other providers involved in your care such as specialists, labs, or pharmacies may bill you separately.
- **Billing Terms:** Payment is due within 14 days of the statement date. A \$20 late fee applies to overdue balances. After three notices, unpaid accounts may be referred to collections, and you will be responsible for all related costs, including attorney fees and interest at the maximum legal rate. The practice may withhold services or discharge patients for failure to pay.

ELECTRONIC PRESCRIPTIONS AND ONLINE ACCESS TO MEDICAL RECORDS: I voluntarily authorize the Practice to electronically transmit prescriptions to my chosen pharmacy, review pharmacy benefits, and medication history as long as a valid physician-patient relationship exists or until I revoke consent. I understand the Practice uses AthenaHealth as its patient portal, and I accept AthenaHealth’s terms and conditions available on their website.

REFERRALS: When referred to specialists, radiology, or labs, it is my (patient or DPOA) responsibility to confirm whether the provider is in-network and what services are covered under your insurance. Practice may share medical records with other providers to ensure continuity of care. We share medical records with other health care providers to allow and promote continuity of care among providers.

APPOINTMENTS AND SCHEDULING: Appointments are allotted sufficient time per patient. For urgent issues, I will contact the office promptly to facilitate timely scheduling. Cancellations require at least one full business day’s notice; otherwise, a \$100 late cancellation or no-show fee may apply.

VACATIONS, ILLNESS AND TIME OFF FOR PRACTICE PHYSICIANS: Physicians may be unavailable due to vacations, illness, professional obligations, or emergencies. The Practice will make reasonable efforts to provide advance notice for planned absences. When necessary, care may be rescheduled, provided via telehealth, or managed by a covering provider. Contact information for covering providers will be shared for non-urgent matters when available.

HOME SAFETY: I agree to maintain a safe environment by securing weapons, ensuring a smoke- and drug-free space, restraining pets during visits, and providing safe access and parking for the provider. I will arrange for a caregiver if needed. Failure to meet these conditions may result in postponed, canceled, or declined visits to ensure safety for all parties. I acknowledge that home-based care provides convenience and personalized attention but may have limitations compared to facility-based care. Some diagnostic testing or emergency treatments may require referral to external facilities. I agree to maintain communication with my healthcare team and to provide a safe environment for care as requested.

EMERGENCY AND URGENT CARE: Services provided by Home Practice are not a substitute for urgent or emergency medical care. In a medical or psychiatric emergency, I or my representative must call 911 or go to the nearest emergency department. Emergency care is outside the scope of home-based medical services. For urgent issues that cannot wait, I should seek care at an urgent care facility and not wait for a callback.

PATIENT TERMINATION: Practice values our patient relationships and we want to protect all patients' rights. We will only terminate patient relationships with cause and after careful consideration. Reasons for termination include: repeatedly not showing for scheduled appointments, not complying with recommended medical care, being hostile or abusive to staff, not making an attempt or neglecting to pay your account in a timely manner.

FORMS AND MEDICAL RECORDS: A \$100 fee applies per form request (e.g., disability, insurance, school, or FMLA forms), unless completed during a routine physical exam, in which case the fee is waived. Forms will not be completed during sick visits. Please allow a minimum of ten (10) business days for standard processing. Expedited, weekend, or after-hours requests are subject to a \$125 fee. Medical records will be released within fifteen (15) business days upon receipt of a signed written request and a \$50 processing fee, in accordance with applicable state and federal laws. Additional fees apply for large-volume requests, as permitted by law.

ADVANCE CARE PLANNING AND GOALS OF CARE: I consent to participate in discussions about my goals of care, treatment preferences, and advance directives. This may include completing or updating documents such as the Physician Orders for Life-Sustaining Treatment (POLST) and designating a healthcare proxy. These conversations may address code status, preferred care setting, and other end-of-life decisions to ensure care aligns with my values and wishes. If applicable, I consent to receive palliative care focused on improving quality of life, managing symptoms, and supporting serious illness. Services may include physical, emotional, and spiritual support, advance care planning, and coordination with other providers. I understand this care does not replace emergency or curative treatment unless specifically discussed and agreed upon. I may continue to pursue curative or life-prolonging care concurrently, either through this practice or other providers.

AUTHORIZATION FOR FUTURE CONTACT: I authorize HBM and its authorized staff to contact the me (Patient) or the my designated responsible Party after the date of the current visit, for purposes related to the patient's medical care & condition, pending medical results, legal obligations, or care transition purposes, unless I revoke this authorization in writing.

NON-DISPARAGEMENT: I agree to raise any complaints or dissatisfaction directly with the Practice before posting public comments. I will not publish knowingly false or misleading statements about the Practice, its providers, or services.

CONTROLLED SUBSTANCE POLICY: Controlled substances shall be prescribed solely at the discretion of the provider and only when medically necessary following an in-person evaluation. Ongoing prescriptions require

the patient's full compliance with all applicable laws, practice policies, and a signed Controlled Substance Agreement. The patient agrees to disclose all current medications, including over-the-counter drugs and supplements, and to refrain from operating a vehicle or machinery while impaired. Prescriptions will be issued only during scheduled visits and must be filled at a single designated pharmacy. I consent to random drug testing and monitoring through the California CURES database. Any requests for early refills, reports of lost or stolen prescriptions, unauthorized dose changes, evidence of misuse, illicit drug use, or suspected diversion shall constitute a material breach of this agreement and may result in immediate tapering, discontinuation of controlled substances, notification to appropriate authorities, and/or termination of the provider-patient relationship.

ARBITRATION AGREEMENT: I agree that any claim of medical malpractice including negligence, breach of contract, or failure to obtain informed consent will be resolved exclusively through binding arbitration, waiving my right to a court or jury trial. This agreement applies to all care provided by Practice, including its physicians, staff, and representatives, and binds anyone acting on my behalf. Arbitration will be conducted under the California Arbitration Act. I may cancel this agreement within 30 days by written notice. This does not apply to emergency medical care. If any part of this agreement is found unenforceable, the remainder remains in effect.

TELEHEALTH AND COMMUNICATION CONSENT: I consent to receive healthcare via telehealth when clinically appropriate and understand it may have limitations (e.g., physical exam, diagnostic accuracy) and may require in-person follow-up. Telehealth is only available in California and is billed similarly to in-person visits. I am responsible for verifying insurance coverage and ensuring private, secure access to technology. Telehealth and electronic communications are not for emergencies; I will call 911 or seek immediate care when needed. Controlled substances cannot be prescribed remotely.

I consent to HIPAA-compliant electronic communications (e.g., Spruce, ZoomHealth, EMR, fax). If I initiate or accept communication via unsecure channels (e.g., email or text), I accept the confidentiality risks and authorize similar responses from the Practice, releasing it from liability for unauthorized disclosures. All care-related communications—whether in person, via phone, or electronically are documented and maintained in your medical record in accordance with applicable law and best practices.

MEDICAL PHOTOGRAPHY AND AI TOOLS: I authorize the use of medical photography, video, or digital images for clinical care, documentation, education, and quality assurance. I understand AI tools may be used under provider supervision to support documentation and decision-making during my care.

AUTHORIZATION TO TREAT: I voluntarily consent to receive medical care from the Practice, including evaluation, treatment, symptom management, and care coordination, delivered through in-person visits, home-based services, telehealth, digital communication, or other appropriate means. I understand that I may refuse or withdraw consent for any aspect of my care at any time. The Practice will make reasonable efforts to explain the risks, benefits, and alternatives of recommended treatments. I acknowledge that no guarantees are made regarding outcomes and that all medical care involves inherent risks. I agree to actively participate in my care by providing complete and accurate information. If I become incapacitated, I authorize my legally recognized healthcare decision-maker to act on my behalf in accordance with applicable law. This Agreement may not be assigned by the Patient. It supersedes any prior agreements between the Patient and the Practice. Any modification must be in writing and signed by both the Patient (or legal representative) and an authorized representative of the Practice.

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI): I authorize the Practice to use and disclose my PHI, including sensitive information (e.g., mental health, HIV, substance use), for treatment, payment, and healthcare operations in compliance with state and federal law. I consent to sharing my medical information with my designated caregivers, other providers, and facilities as needed for continuity of care. I authorize my past providers to release records to the Practice. I understand that all services and communications whether in-person, telephonic, or digital will be documented in my medical

record and maintained in compliance with applicable state and federal privacy laws. I may revoke this authorization in writing at any time, except where disclosure has already occurred.

CREDIT/DEBIT CARD AUTHORIZATION: I authorize Gurpreet K Padam MD PC DBA Home Based Medicine to charge my credit or debit card with the balance due (Patient Responsibility). If I feel that the Patient Responsibility on my Explanation of Benefits (EOB) is inaccurate, I must resolve this issue directly with my insurance company. I authorize HBM, to charge my credit/debit card for all patient-responsibility balances, including co-pays, deductibles, fees, returned check charges (\$35), form fees, late cancellations/no-shows and unpaid balances over 14 days.

I understand that disputes regarding insurance EOBs must be resolved with my insurer directly. I will provide credit card information securely via phone or patient portal and will not send card details by unsecured means. I agree not to dispute valid charges for services rendered, including applicable fees.

By signing below, I acknowledge that I have read and understood and voluntarily consent to this Private Practice Agreement and Conditions Of Registration above including: Authorization To Release Information & Use And Disclosure Of PHI, Consent And Authorization To Treat, Medical Photography And Artificial Intelligence (AI) Tools, Telehealth Consent, Electronic And Digital Communication Consent, Payment And Billing Policy, Financial Agreement And Responsibility, Arbitration Agreement, Credit Card Authorization, Controlled Substance Policy and office policies detailed above. I had the opportunity to ask questions and I understand and accept all terms outlined above. I voluntarily consent to and authorized to receive medical care from the Practice ("Home Based Medicine"), including evaluation, treatment, symptom management, and care coordination, delivered through in-person visits, home-based services, telehealth, and electronic or digital communication and release of records as appropriate. This agreement is governed by the laws of the State of California. Any legal or regulatory change affecting this agreement shall automatically amend it as needed for compliance. This consent and agreement remains in effect unless and until revoked in writing.

I agree that my electronic signature is legally binding and equivalent to a manual signature for this and all related documents from the Practice.

Patient Name: _____

Date _____

Patient Responsible Party: _____

Signature: _____

CONCIERGE MEMBERSHIP PRIVATE PRACTICE AGREEMENT

This Concierge Private Practice-Patient Agreement (“Agreement”) specifies the terms and conditions under which, you, the undersigned patient (“Patient”) may participate in certain private direct health programs identified in the attached Schedule A (“Services”) offered by Gurpreet K Padam MD PC d/b/a Home Based Medicine (“HBM” or “Practice”). (Patient and Practice are referred to individually as “Party” or collectively as “Parties”).

NO INSURANCE COVERAGE OR UNLIMITED CARE: The Concierge Program or Practice is not health insurance, a prepaid plan, or a guarantee of unlimited services. Program Fees are private payments for non-covered services only. Patients remain responsible for maintaining separate insurance coverage, including Medicare or a private plan, for all medically necessary services not listed in *Schedule A*. It is presumed the Patient is either Medicare-eligible or insured for covered services outside this Agreement.

HEALTH INSURANCE REQUIREMENT: Participation does not replace the need for health insurance. Program Fees are not insurance premiums and are not reimbursable by Medicare or private payers. If the Patient is or becomes Medicare-eligible, they agree not to submit or request submission of claims to Medicare for non-covered Concierge Services. Patients are financially responsible for any non-covered services, denials, or out-of-pocket charges.

MEDICARE PARTICIPATION & LIMITATIONS: For Medicare-eligible patients, Practice will bill Medicare for covered services. The Patient agrees not to submit or request submission of claims for non-covered Concierge Services. Medicare does not reimburse Program Fees or any non-covered services listed in *Schedule A*.

SCOPE, FEES, AND TERM: In exchange for Program Fees, the Practice provides the non-covered services listed in *Schedule A*. The Practice may revise *Schedule A* with 30 days’ notice; continued participation constitutes acceptance. Material changes will require updated written consent. Program Fees apply to a 12-month term beginning on the Agreement date or the date. Fees are due annually or quarterly in advance, payable by check or credit card. Fees are considered substantially earned upon establishing care or delivering the first service. The Practice will bill Medicare or private insurance for covered services rendered outside the scope of *Schedule A*.

RENEWAL & TERMINATION: Fee changes will be communicated at least 30 days in advance. Continued participation after notice constitutes acceptance. Membership auto-renews annually unless cancelled in writing 30 days before renewal. Quarterly or trial memberships must be cancelled at least 15 days before the next billing cycle. Either party may terminate with 30 days’ written notice. Immediate termination may occur for nonpayment, incomplete documentation, non-adherence, unsafe behavior, or regulatory changes. Upon termination, unused annual fees may be prorated after the current quarter.

REFUNDS: Fees for the prior or current quarter or trial period are non-refundable. In case of death or permanent relocation, the estate or authorized representative may request a prorated refund for the unused portion beyond the current quarter. Refunds are subject to review and not applicable to prior or current quarter.

By signing below, I acknowledge that I have read and understood this Agreement, had the opportunity to ask questions and voluntarily consent to agreeing to enrollment in Practice and the terms of this Concierge Membership Private Practice Agreement as detailed in the Schedule A.

Patient Name: _____

Date _____

Patient Representative Name: _____

Signature: _____

Home Based Medicine

101 S San Mateo Dr #106

San Mateo, CA 94401

Phone & Text: (650) 360-9309 | Fax: (650) 360-0781

info@homebased.sprucecare.com | www.HomeBasedMedicine.com

ACKNOWLEDGEMENT OF RECEIPT NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

RECEIPT OF HEALTH INFORMATION PRIVACY PRACTICES

By signing this form, . I acknowledge receipt of the Notice of Health Information Privacy Practices of our office. The notice provides information about how we may and may not use or disclose your protected health information. As such, you should read it in full.

Our Notice of Health Information Privacy Practices is subject to change. If we change it, you may obtain a revised copy at your next visit or by calling (650) 360-9309.

I acknowledge receipt of the Notice of Health Information Privacy Practices of the office of Gurpreet K Padam MD PC

Patient Name: _____

Date _____

Patient Representative Name: _____

Signature: _____

CHRONIC CARE MANAGEMENT (CCM) OPT-IN

INFORMED CONSENT

You are eligible for a new Medicare program that enables us to provide you with care coordination of your care and improve your overall wellness. Chronic conditions are ongoing medical problems like diabetes, high blood pressure, dementia, heart disease, depression, osteoporosis, and many others. These conditions must be managed effectively in partnership between the healthcare team and patient to maintain the best possible overall health and wellness. CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk of further decline.

THE BENEFITS OF SIGNING UP FOR CHRONIC CARE MANAGEMENT SERVICES?

- Coordinate visits with your doctors, facilities, labs, radiology, or others
- Provide access to around-the-clock (24/7) services from your care team.
- Assist with management of medications
- Provide a personalized and comprehensive care plan management
- Assist with scheduling preventive care services, many of which are covered by insurance

WHAT YOU NEED TO KNOW BEFORE SIGNING UP

You will have 24/7 access to your electronic medical record if you ever have questions. Our practice is compliant with HIPAA and all laws related to the privacy and security of Protected Health Information (PHI). As a part of this program, your PHI may be shared between caregivers directly involved with your health.

YOU HAVE THE RIGHT TO:

Discontinue this service at any time for any reason. Because your signature is required to end your chronic care management services, please ask any of our staff members for the CCM termination form. The provider will continue providing CCM services until the end of the month and may bill Medicare for those services.

NOTE: Only one physician can bill for this service for you. Please let your physician or our staff know if you have entered into a similar agreement with another physician/practice.

BENEFICIARY ACKNOWLEDGMENT AND AUTHORIZATION

By signing this Agreement, I agree to the following:

- I consent to the Provider providing CCM Services to you.
- I authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
- I acknowledge that only one practitioner can furnish CCM Services to you during a calendar month.
- I understand that cost-sharing will apply to CCM Services, so you may be billed for a portion of CCM Services even though CCM services will not involve a face-to-face meeting with the Provider.

I agree to participate in the Chronic Care Management program. You have had the opportunity to ask questions about the program, and your queries have been answered to your satisfaction. I hereby consent to participate in this program and authorize the use of your health information for the purposes outlined above.

Patient Name: _____

Date _____

Patient Representative Name: _____

Signature: _____

NEW CLIENT INTAKE

(Put N/A or leave blank if not applicable, send intake forms via HIPAA compliant text, email or fax)

Concierge Membership: Episodic Quarter Trial Annual Telehealth Self-Pay

Full Legal Name _____

Gender: _____

Date of Birth: _____ Marital Status: _____ Spouse/Partner Name: _____

Patient's Residence/Facility Name: _____

Residence phone: _____ Residence Fax: _____

Firearms, pets, smoking, parking or other issues we need to be aware of? _____

Parking for home visiting staff Parking lot or Driveway/Street/Other _____

Health Care Decision Maker Name: _____ Relationship _____

Email: _____ Phone _____ Okay to leave message?: _____

Do you have an Advance Directive (Y / N) _____ POLST _____ Race/Ethnicity:

_____ (Prefer Not to Answer) Language: _____ Interpreter Needed?

(Y / N) _____ Who may we thank for referring you? _____

Billing Info: _____

If different than above (Name) (Relationship)

Billing/Guarantor Address: _____

Email: _____ Phone _____

NEW CLIENT HISTORY

Current PCP: _____ Phone: _____ City/State: _____

Current Known Medical Conditions
<input type="checkbox"/> Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cholesterol <input type="checkbox"/> Heart Disease <input type="checkbox"/> COPD <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Insomnia <input type="checkbox"/> Arthritis <input type="checkbox"/> Chronic Pain <input type="checkbox"/> Cancer <input type="checkbox"/> Thyroid <input type="checkbox"/> Dementia or Memory <input type="checkbox"/> Incontinence
Date of last Medicare Annual Wellness Visit (AWV): _____
Recent Hospitalization (date and place): _____
Family History: _____
Surgeries: _____
Do you smoke? _____ Daily Alcohol: _____
Recreational substances: _____

Education	Highest level of education: _____
Current	Height: _____ ft. _____ in., Weight: _____ lbs
Allergies:	_____
Current Medications (list or attach)	_____
Your preferred	Pharmacy: _____ Lab: _____ Imaging: _____
RPM	Are you interested in Remote Patient Monitoring? (Yes/No): _____
Vaccines	Are you interested in routine RSV, Flu, etc vaccines? (Yes/No): _____