David P. Nebbeling, D.O. PLLC
Advanced Osteopathic Health
3918 W St. Joe Hwy. Lansing, MI 48917
Ph (517)323-1833/ Fax (517) 853-0534

PATIENT INFORMATION
PLEASE PRINT CLEARLY, FILL OUT COMPLETELY AND SIGN

Full Legal Name:____ **Date:**______________

Address:____ **Apt #:**___________

City:_____________________________ **State:**____________________________ **Zip:**__________________

SS#:_____________________________**Birth date:**_________________________**M:**_______**F:**_________

Home Phone:______________________ **Business:**_____________________ **Cell:**_____________________

Emergency Contact:__________________________________**Realtionship:**___________________________

Phone:______________________________________

E-Mail Address:____

☐ **Please check to allow us to periodically send informational reports**

IMPORTANT NOTICE
WE CANNOT TREAT PATIENTS WHO DO NOT HAVE A PRIMARY CARE PHYSICIAN
Patients must maintain a Primary Care Physician for their regular medical care

Physician's Name:___________________________________ **Phone:**_______________________

Pharmacy Name:_____________________________________ **Phone:**_______________________

Do you authorize staff to leave test results on an answering machine or voice mail?___________

This facility offers Natural and Integrative Medical care not normally covered by insurance. We are "fee for service" clinic and full payment is required at the time of your visit/treatment. For your convenience we accept cash, check, Visa, Master Card and Discover.

Some insurance companies will reimburse a portion of the charges. As a courtesy two copies of your billing receipt will be provided. One is for your tax records and the other you may turn into your insurance company. However, we cannot guarantee you will receive any repayment.. It is up to you as the patient to confirm your coverage, submit your claims and follow up with them should a problem arise. *Special note: due to the type of facility we are you CANNOT bill to Medicare. We are sorry for any inconvenience.

By signing below I hereby signify that I have read all the information contained on this page, declare what I have written to be true, understand my financial responsibilities and agree with them

Patient/Guardian:____ **Date:**_________

Advanced Osteopathic Health * 3918 W. St. Joseph Hwy * Lansing, MI 48917

HEALTH HISTORY

Name: ______________________________ _____ ___________________________ Date: ________

First M. Last

Age: ______ Date of Birth: ____/____/____ How did you hear about us? ____________________

Marital Status: (please circle one) Married Single Widowed Divorced

Employment status: (please circle one) employed Unemployed Retired Student

Name of Employer: ____

Reason for your visit: ____

____

____

When did your symptoms first appear / date of injury? ____

Have you experienced there or similar symptoms / conditions in the past? ______ YES _____ NO

If yes, please elaborate: ____

____

What activities aggravate your symptoms? ____

____

____

What treatment (s) have already received for your conditions? __________________________________

____

____

Do Your symptoms interfere with your:

___ Daily activities ___ Work ___ Recreation ___ Sleep ___ Other

List all your previous surgeries and when they were performed:

Type of Operation **Date**

____

____

____

Did you experience any surgical / anesthesia complications? ___ Yes ___ NO

If yes, please elaborate: ____

List all current and previous:

Infections	Viruses	Inflammation

Please indicate below all medical conditions you have been:

___ High Blood Pressure	___ Migraines	Other Medical conditions:
___ Heart disease	___ Cancer	___________________________
___ Glaucoma	___ Anemia	___________________________
___ Hypothyroid	___ High Cholesterol	___________________________
___ Diabetes	___ Depression	___________________________

List the types, strength, and purpose for all <u>prescription medications</u> you are currently taking:

Medication	Strength	Condition

List all non-prescription medications, vitamins, and supplements you are currently taking:

____

____

____

____

____

Dental History (to be completed by Dr.Nebbeling):

Root Canals: ____

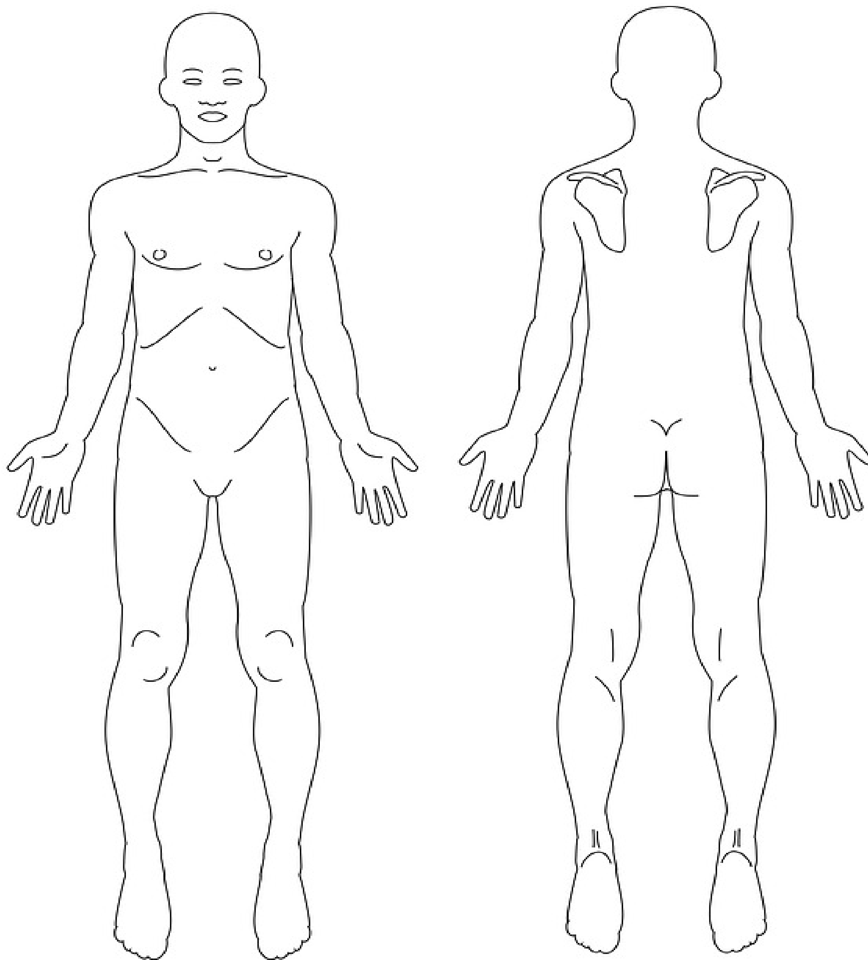
Abscesses: ____

Amalgams: ____

Patient Name: ____ DOB: _________

Please mark areas of **pain,** **scars**, or **injury** on the illustration below and give a brief description of symptoms you are experiencing.

/// = Pain XXX = Scars OOO = injury/infection



Explanation:

____

____

____

____

Advanced Osteopathic Health
3918 W St Joe Hwy, Lansing MI 48917
Ph(517)323-1833 Fax(517)853-0534

HIPPA-SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

1. **RELEASE OF INFORMATION:** Dr. Nebbeling may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease of HIV to any person or corporation (1) which is or may be liable or under contract to Dr. Nebbeling for reimbursement for services rendered. Dr. Nebbeling may also disclose on an anonymous basis, any education and/or medical research for the collection of statistical data pursuant to State or Federal law, status or regulation.
2. **INSURANCE:** I understand that Dr. Nebbeling has no contract, expressed or implied, with any insurance plan. I understand and agree that as an individual I am obligated to pay the full charges of all services rendered to me by Dr. Nebbeling.
3. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Dr. Nebbeling. I will pay my account at the time the service is rendered or will make financial arrangements satisfactory to Dr. Nebbeling for payment. I understand that if my account becomes over 90 days delinquent I will be notified in writing that it will be sent on to a collection agency unless payment is made.
4. **DIVORCED PARENTS:** We do not second party bill. The parent bringing the child to our facility will be responsible for required payment at the time of service.
5. **PRIVACY PLAN:** I agree that I have been given the opportunity to read and receive a copy of Dr. Nebbeling's Notice of Privacy Practices.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

____
Patient/Guardian Name (print) **Date**

____
Patient/Guardian Signature **Date**

Advanced Osteopathic Health * 3918 W. St. Joseph Hwy * Lansing, MI 48917

MEDICARE PRIVATE CONTRACT

I,_________________________________, the undersigned have read the following, understand, agree with and will abide by this entire contract with Dr. David P. Nebbeling per the Social Security Act.

- Dr. Nebbeling is excluded from all Medicare contracts under the Social Security Act
- I, as the beneficiary or legal representative, accept full responsibility for payment of the physician's charges for all services rendered by the physician's
- I understand that Medicare limits do not apply to what the physician may charge
- I understand that it is fraudulent for me to submit a claim to Medicare and agree not to do so. Nor can I ask the physician to submit a claim to Medicare.
- I understand that Medicare payments will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim has been submitted
- I enter into the contract with the knowledge of the right to obtain Medicare-covered items and services from other physicians who have not opted out of Medicare
- I understand that Medigap plans do not, and other supplemental plans may elect not to make payments for items and services not paid by Medicare
- I am not entering into this contract at a time when I require emergency (life threatening) care
- I understand I can be provided with a photocopy of this contract before services are rendered under this contract
- I understand that this contract will be retained and remain in effect indefinitely
- I understand that this contract is made available to HCFA upon their request

____   _______________

Patient   Date

Advanced Osteopathic Health * 3918 W. St. Joseph Hwy * Lansing, MI 48917

NEEDLE STICK AGREEMENT

The treatments administered in this practice often require the use of needles, which increase the risk of additional sticks and exposure to blood borne pathogens. To ensure the safety of those participating in your care, we ask you to carefully read the following questions and answer as accurately and honestly as possible. The information you provide will remain strictly confidential.

Please place an **"X"** next to those that apply:

___ I have tested positive for **Hepatitis** __A __ B __ C

___ I have been intimate with a person (s) known to have Hepatitis within the past:

____ Year(s) ____ Months ___ Days

But I have tested negative in the last: ____ Year(s) ____ Months ____ Days

___ I have been around a person(s) know to have Hepatitis but have never been exposed to their bodily fluids.

___ I have **AIDS**.

___ I have been tested positive for HIV.

___ I have been intimate with a person(s) known to have AIDS or is HIV positive within

the past: ____ Year(s) ____ Months ____ Days

but I have tested negative in the last: ____ Year(s) ____ Months ____ Days

___ I have been around a person(s) know to have AIDS or are HIV positive but have never been exposed to their bodily fluids.

___ None of the above.

I, the undersigned, agree to have my current condition treated by hypodermic injection and/or Intravenous infusion. If an accidental needle stick occurs to Dr. Nebbeling or any member of his staff, I agree to submit myself to a blood test immediately to determine my Hepatitis and JHIV status. I agree to submit all necessary testing under my insurance, and understand that I am financially responsible for any uncovered expenses.

I have read and understood the terms of the Needle Stick Agreement. Any questions I had were answered to my full satisfaction.

____ _______________

Patient/Guardian Name Date

David P. Nebbeling, D.O. PLLC
Advanced Osteopathic Health
3918 W St. Joseph Hwy. Lansing, MI 48917
Phone: (517) 323-1833 Fax: (517)853-0534

CANCELLATION POLICY

Our policy states that we reserve the right to charge $50.00 for missed or cancelled appointment without 24 hour notice, and a $25.00 fee for a missed or cancelled IVs appointment. A notice will be sent to you and a charge will be place on your credit card on file.

Date: ______________

Print Name: ____

Signed: ____

Notice

Your appointment was scheduled on _________________________________ for ____services.

____ You did not give 24 notice of cancellation

____ You did not call to cancel the appointment

Therefore there is an OFFICE CALL/PREP FEE of $50.00 that will be charged to your credit card on file. You will be notified with a phone call regarding this charge.

Thank You for your prompt attention to this matter.

Sincerely,

Cynthia A. Lakin
Front Office Manager

Advanced Osteopathic Health * 3918 W. St. Joseph Hwy * Lansing, MI 48917

General Waiver and Release of Liability Form

In consideration of David P. Nebbeling, D.O., providing medical procedures, treatment and initiating a personalize program for health purposes, I agree as follows:

I fully understand and acknowledge that:

a) there may be risk involved with any medical procedure, therapy, or program
b) my participation in said medical procedure, therapy, or program is fully voluntary and under my own volition,
c) that Dr. Nebbeling may evaluate and diagnosis differently from traditional medical specialists and that he has not dissuaded me in any way from seeking a 2nd opinion or other forms of treatment,
d) that Dr. Nebbeling offers a holistic form of treatment involving lifestyle changes, specific nutritional supplements, and various forms of therapy,
e) I recognize and understand the potential risk that may exist and have elected to proceed with the advised medical protocol provided by Dr. Nebbeling.

I, on behalf of my personal, my representatives and my heirs hereby voluntarily agree to release, waive, discharge, hold harmless, defend and indemnify Advanced Osteopathic Health and David P. Nebbeling, D.O., its owners, agents, officers, and employees from any and all claims, suits or causes of action. I specifically understand that I am releasing, discharging and waiving any claims or actions that I may have presently or in the future for regarding any treatment, procedures, or protocols performed by Dr. Nebbeling and his staff.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING, I AGREE IT IS MY INTENTION TO EXEMPT AND RELIEVE DAVID P. NEBBELING, D.O. AND ADVANCED OSTEOPATHIC HEALTH AND ITS ASSOCIATES/EMPLOYEES FROM LIABILITY FOR PERSONAL INJURY, FINANCIAL DAMAGES, OR WRONGFUL DEATH CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE.

___________________________________	____________________
PRINT NAME	DATE OF BIRTH
___________________________________	____________________
SIGNATURE	DATE
___________________________________	____________________
SIGNATURE OF PARENT/GUARDIAN (if applicable or under 18 years old)	DATE
___________________________________	____________________
WITNESS	DATE

Payment policy

Thank you for choosing this office to help you with your medical needs. We are a fee for service office. Because of the complexity of health insurance and the lack of cooperation to consider alternative methods as an option for medical health and healing, we are unable to assist with any insurance matters or disputes. This would also include the receipt to any insurance reimbursement checks, this will need to be coordinated between you and your insurance company.

We are also limited in providing information for Social Security Disability. Our standard fee is $75 to complete the request form and provide copies of records, we are unable to provide any additional information for this purpose.

We do not complete assessment form for insurance or Workmen's Comp, these forms need to be completed by a family physician, physical therapist, or phycologist, or other appropriate professionals.

Thank you,

Advanced Osteopathic Health