Shine Health & Wellness ◆ 960 E. Green Street, Ste #206◆ Pasadena, CA 91106

# REQUIRED PATIENT INFORMATION FOR INSURANCE BILLING

**(PATIENT)**

**LAST NAME:** _____ **FIRST:**_____ **MI:** _____ **DOB:**_____/_____/_____ **SEX: M** _____**F**_____

**STREET:** _____ **APT #:**_____ **CITY:** _____ **ST:**_____ **ZIP:**_____

**SS#** _____ **H. PHONE:** _____/_____ **WK PHONE:** _____/_____ **CELL PHONE:** _____/_____

**MARRIED:** ___ **SINGLE:** ___ **DIV:** ___ **OTHER:** ___ **EMAIL:** _____ **REFERRED BY:** _____

**SPOUSE NAME:**_____ **SPOUSE'S CELL #** _____/_____ **SPOUSE'S WK#**_____/_____

**EMERGENCY CONTACT NOT LIVING WITH YOU:** _____ **RELATION:**_____ **PH #:** _____/_____

# PRIMARY INSURANCE INFORMATION

**(INSURED)**

**(IF PRIMARY INSURED IS NOT THE PATIENT, LIST SPOUSE, PARENT OR OTHER INFORMATION OF PRIMARY INSURED BELOW)**

**INSURED NAME:** _____ **DOB:** _____/_____/_____ **SS#** _____ **SEX: M**_____**F**_____

**INSURANCE CO:** _____ **ID#**_____ **GROUP #**_____

**PATIENT'S RELATIONSHIP TO INSURED**_____

(Please include the social security number and date of birth of the primary insured for your insurance to be billed.)

# SECONDARY INSURANCE INFORMATION

**(INSURED)**

**(IF SECONDARY INSURED IS NOT THE PATIENT, LIST SPOUSE, PARENT OR OTHER INFORMATION OF SECONDARY INSURED BELOW)**

**INSURED NAME:** _____ **DOB:** _____/_____/_____ **SS#** _____ **SEX: M**_____**F**_____

**INSURANCE CO:** _____ **ID#**_____ **GROUP #**_____

**PATIENT'S RELATIONSHIP TO INSURED**_____

Initial each box

# PAYMENT POLICIES

- ☐ **You are financially responsible for anything your insurance does not cover. All Co-Pays are due and payable at each visit. The amount your insurance will allow and pay for and your responsibility is determined by your insurance company and the policy you have chosen. Your claim will be processed according to the benefits of your insurance plan. The deductible, co-insurance and co-pay are your financial responsibility. It is your responsibility to know and understand your insurance plan, your deductible and your co-insurance. These fees may also apply:**
- ☐ **$5 FEE FOR CO-PAYS NOT PAID AT TIME OF SERVICE.**
- ☐ **$50 NO SHOW FEE FOR ANY MISSED APPOINTMENT that was not cancelled or rescheduled 24 hours prior to the appointment. Please be considerate and call at least 24 hours before your appointment if you cannot come in.**
- ☐ **$35 NSF CHARGE FOR ANY RETURNED CHECK FROM THE BANK**

**If you are a private pay patient without insurance, all charges are due at the time of visit. We do not send statement to private pay patients.**

# PRESCRIPTION POLICY

**Please do not wait until your last pill to call for a refill. There is a 72 hour turn around for prescription refills. If you have not seen the Physician in six months, the prescription will be denied. Assignment of benefits are payable to the doctors.**

**PLEASE SIGN AND DATE THIS DOCUMENT SHOWING THAT YOU HAVE READ AND UNDERSTAND OUR POLICIES.**

**SIGNATURE** _____ **DATE:** _____ **(Revised 01/15/2018)**

SHINE
HEALTH AND WELLNESS

# Welcome to Shine Health and Wellness

**Please review below to get acquainted with our office and policies:**

**Communication:** We can answer general and non-urgent matters during office hours. Due to our commitment to providing our patients the best possible care, if we miss your call during business hours, please leave a message and we will do our best to return your call the same day, within business hours. You can also send *general and non-urgent* messages through Elation patient portal. We do our best to respond to messages within 72hrs. Weekends & holidays do not apply.

**Emergencies:** Please call 911 or go to your nearest Emergency Center.

**Prescriptions:** Please have your pharmacy contact our office for refills. You may also call the office or send your prescription refill request via message through Elation patient portal. Please allow 3 business days for approval and the prescription to be submitted to pharmacy. Prescription refills are not submitted after hours, weekends or holidays. An office visit within 6 months is required to obtain refills for non-controlled substance medications. For a controlled substance we require an office visit within the past 3 months. Please call our office to make a follow-up appointment **PRIOR** to running out of your medication. We cannot refill medications prescribed by other physicians, unless approved by the physician from a previous office visit.

**Cancellations/ No Shows:** Please provide at least a 24hr notice if you cannot keep your appointment. Failure to cancel your initial appointment with at least 24 hours' notice, will result in a $125 cancellation fee, charged to the c/c given at the time the initial appointment was created. There is a $50 cancellation fee for follow up appointments.
We keep a waiting list for patients wanting these appointments, so this allows us to help these patients get seen sooner and those in need of urgent care. If you have multiple last-minute cancellations or no shows, you may be asked to find another physician.

**Appointments:** If you are a new patient, registration forms must be received PRIOR to your initial appointment to avoid re-scheduling. Our goal is to see patients in a timely manner. If you will be more than 15 minutes late to your appointment, please call our office to see if we need to reschedule your appointment.

**Test Results:** Your provider must review lab results prior to being uploaded to your portal. You are responsible for scheduling your follow up appointment to review lab results. The lab results will be posted to your Elation patient portal prior to your appointment. Please allow up to 2 weeks for Quest/Labcorp lab results and up to 4 weeks for specialty labs to be posted to your Elation patient portal.

**Payment Policy:** It is your responsibility to verify if the physician is contracted with your insurance and whether or not services are in or out-of-network. Co-pay is due at the time of service.
Please inform us within 30 days if there are any changes to your personal or insurance information to help facilitate payment by your insurance.
Balances are due upon receipt. You may pay by phone, fax, or mail.
If you have any questions about billing or an invoice, you may contact our billing provider which will be listed on any statement or call our office directly.

SHINE
HEALTH AND WELLNESS

# Welcome to Shine Health and Wellness

**Additional Services:** Completing paperwork for schools, FMLA claims, disability, etc. requires 7 business days for the forms to be completed and returned to you.

**Privacy/HIPPA Notice:** I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical records at any time and can request a copy of it by paying the appropriate fee (if applicable). I understand that my medical record will be kept for a minimum of seven, but no more than ten, years after the date of my last visit.
Please refer to *Notice of Privacy Practices* page for more detailed information.

By signing below, you acknowledge that you have read and agree to Shine Health and Wellness office policies and have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA)

Patient Signature: _____ Date: _____

960 E. Green Street, Suite 207, Pasadena, CA 91106
p (626) 317-0207 | f (626) 317-0192

SHINE
HEALTH AND WELLNESS

# Consent for Integrative Medical Treatment

**As a patient I have the right to be informed** about my condition and recommended care. This disclosure is to help me become better informed so I may make the decision to give or withhold my consent as whether or not to undergo care having had the opportunity to discuss potential benefits, risks, and hazards involved.

**I hereby request and voluntarily consent to examination and treatment** with integrative medical care, possibly including homeopathic medicines, vitamins, minerals, supplements, IV therapies, ozone therapies, injections, detoxification treatment modalities, lab testing, frequency specific microcurrent, nutrition recommendations, etc. for me (or for the patient named below, for whom I am legally responsible) by Shine Health and Wellness and Kimberley Shine, MD and/or Paulina To, PA-C, and/or other licensed medical providers, or those working or training at the office who now or in the future may treat me while employed by, working or training with, or serving for back up for the aforementioned. I can request further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material, risks of the procedure or treatment.

**I understand that the U.S Food and Drug Administration has not fully evaluated or approved** nutritional, herbal and homeopathic supplements, compounded IV's/injections, ozone therapies, bioidentical hormone replacement therapies; however, they have been widely used in Europe and the U.S for years. I understand that, as with drugs, hormones, nutritional supplements, herbal, and homeopathic remedies, ozone, nutritional IV therapies and injections may exhibit some side effects in certain sensitive individuals, may interact with certain allopathic medications or lab tests, or show symptoms, due to certain pre-existing disease conditions. I do not expect the medical provider to be able to anticipate and explain all risks and complications, and I wish to rely on the medical provider to exercise judgment in recommending the dietary supplements, medications, and treatment, that the medical provider feels at the time, based on the facts then known, is in my best interest. I understand that if I do not take the supplements or treatments as recommended, I may not get the desired result or may increase chances for an adverse effect.

**It is my responsibility** to keep my medical provider up to date with all the current medications and supplements that I am taking, so that he/she can make the best-informed recommendations for my care.

**I have the opportunity** to ask questions and discuss with my provider to my satisfaction:

- my suspected diagnosis or condition
- the nature, purpose, and potential benefit of the proposed care
- the inherited risks, complications, potential hazards, or side effects of the treatment or procedure
- the probability or likelihood, of success
- reasonable available alternatives to the proposed treatment or procedure
- the possible consequences if treatment or advice is not followed and/or nothing is done

**I further acknowledge** that no guarantees or assurances have been made to me concerning the results intended from the treatment.

**I understand that** integrative medicine, evaluation and treatment may include, but is not limited to: collecting specimens for laboratory evaluation, ordering diagnostic imaging, prescription of certain medications and nutritional supplements, IV therapy, medical ozone treatment/therapy, bio-identical hormone replacement therapy, injections, counseling, dietary therapies, infrared sauna, colonics, and homeopathic or other alternative remedies. I understand that the medical providers at Shine Health and Wellness have been trained in a diverse range of diagnostic and treatment options. I understand that Shine Health and Wellness is highly specialized and based upon evidence-based medicine, including functional medicine and holistic principles. As such, they may recommend different tests; may interpret standard tests differently; may propose different treatments, or may administer standard treatments differently than most conventional physicians as many perspectives exist in medicine and in some cases there may be a disagreement among qualified medical experts. Care rendered may therefore be seen by some as outside standard of care or medically unnecessary. Diagnosis and treatment may include some services that are considered non- traditional, nonconventional, or alternative medicine. These services may not be recognized as standard medical practices and may be considered by insurance companies to be experimental or investigational. Along with training, the rationale for these differences is based on clinical experience and ongoing continuing education in evidence based functional and integrative medicine.

**By signing this form**, I acknowledge I have carefully read, or have had read to me, and understand the above consent. I give my permission and consent to care and authorize medical treatment by Shine Health and Wellness and their staff, and I am fully aware of what I am signing. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment and I may ask my physician for a more detailed explanation.

_____
PRINT PATIENT NAME

_____
SIGNATURE OF PATIENT (OR GUARDIAN)

_____
DATE SIGNED

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# Physician Patient 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 incompletely rendered, will be determined by the submission to arbitration as provided by California law, and not to a lawsuit or resort to court process except as California 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 the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term 'patient' herein shall mean both the mother and the mother's expected child(ren). Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

**Article 3 - Procedures and Applicable Law**
A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses, and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California supreme court judge, to preside over the manner. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure 1280-1295 and the Federal Arbitration Act (9 U.S.C. 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

**Article 4 - Retroactive Effect**
The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

**Article 5 - Revocation**
This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

**Article 6 - Severability Provision**
In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this 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.**

Patient Signature: _____ Date: _____

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# MSQ – MEDICAL SYMPTOM QUESTIONNAIRE

Name: _____ Date: _____

The Medical Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are completing this after your first time, then record your symptoms for the last 48 hours ONLY.

## POINT SCALE

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

## DIGESTIVE TRACT

___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Belching or passing gas
___ Heartburn
___ Intestinal/Stomach pain

*Total* _____

## EARS

___ Itchy ears
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss

*Total* _____

## EMOTIONS

___ Mood swings
___ Anxiety, fear or nervousness
___ Anger, irritability or aggressiveness
___ Depression

*Total* _____

## ENERGY/ACTIVITY

___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness

*Total* _____

## EYES

___ Watery or itchy eyes
___ Swollen, reddened or sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel vision (does not include near or far-sightedness)

*Total* _____

## HEAD

___ Headaches
___ Faintness
___ Dizziness
___ Insomnia

*Total* _____

## HEART

___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain

*Total* _____

## JOINTS/MUSCLES

___ Pain or aches in joints
___ Arthritis
___ Stiffness or limitation of movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness

*Total* _____

## LUNGS

___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficult breathing

*Total* _____

## MIND

___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Poor physical coordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Slurred speech
___ Learning disabilities

*Total* _____

## MOUTH/THROAT

___ Chronic coughing
___ Gagging, frequent need to clear throat
___ Sore throat, hoarseness, loss of voice
___ Swollen/discolored tongue, gum, lips
___ Canker sores

*Total* _____

## NOSE

___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus formation

*Total* _____

## SKIN

___ Acne
___ Hives, rashes or dry skin
___ Hair loss
___ Flushing or hot flushes
___ Excessive sweating

*Total* _____

## WEIGHT

___ Binge eating/drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight

*Total* _____

## OTHER

___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge

*Total* _____

## GRAND TOTAL _____

## KEY TO QUESTIONNAIRE

Add individual scores and total each group. Add each group score and give a grand total.

• Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100

# Notice of Privacy Practices

Effective Date: 09/18/2017

**Your Information. Your Rights. Our Responsibilities**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

## Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

## Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care
- Market our services

## Our Uses and Disclosures

- We may use and share your information as we:
  Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Comply with the law
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

**Your Rights**

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

You may access your health records electronically through a secure, online portal:

- Communicate via email with your doctor
- View your medical record including lab and imaging reports
- Request appointments and see past appointments
- Update your medical information such as family medical history
- Verify your information, such as your medications are complete

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper or electronic copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

**Your Choices**

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In the following cases we will never share your information unless you give us written permission:

- Marketing purposes
- Most sharing of psychotherapy notes
- Any substance abuse treatment records

**Our Uses and Disclosures**

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if they want to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

**Questions or Complaints**

If you have questions or are concerned that any of your privacy rights have been violated, please contact our Office Manager:

Shine Health & Wellness
Attn: Office Manager
960 E. Green Street #206
Phone: 626-317-0207
Fax: 626-317-0250

You also have the right to complain to the Secretary of Health and Human Services at:

Office of Civil Rights
U.S. Department of Health and Human Services
Federal Building, Suite 5-100
90 Seventh Street
San Francisco, CA 94103

You will not be retaliated against for filing a complaint.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site and portal.