LIFE FITNESS CENTER – PATIENT REGISTRATION FORM

Today's date:			PCP:		
PATIENT INFORMATION (PLEASE PRINT LEGIBLY)					
Patient's Last Name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Dr. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Social Security Number:			Driver's License #:		
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Mailing address:		City:	State/Zip Code:		
Email address:	Home Ph #:	Cell Ph#:	Other #:		
Occupation:	Employer:	Employer phone no.:			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Insurance Co. Ph.#:
Name of Primary Insurance:	Subscriber's Name:	Member ID# Group #:	
Patient's relationship to subscriber: ❑ Self ❑Child ❑ Other _____			
Name of Secondary Insurance or Mental Health Insurance :	Subscriber's Name:	Member ID# Group#:	

IN CASE OF EMERGENCY OR IF UNABLE TO REACH

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. Please initial each of the following:

____1. I authorize my insurance benefits be paid directly to Life Fitness Center and/or to the provider of LFC.
____2. I understand that I am financially responsible for any balance including copayments, deductibles, non-covered service, all services rendered after a maximum allowed by my policy has been reached.
____3. I understand that it is the policy of Life Fitness Center that I pay for all services at the time service is rendered, unless other arrangements have been made.
____4. I acknowledge my responsibility to know and understand the terms and conditions of my health insurance coverage. I further understand that the information Life Fitness Center receives from my insurance company is never a guaranteed and is used only as a guideline.
____5. I hereby authorize the release of limited medical information to my insurance company as required for billing and/or payment.
6. Do you have voicemail or answering machine? Yes or No. If yes, is it ok to leave a detailed message? Yes or No
____7. I agree to arbitration of any legal/financial disputes rather than judge and jury.
____8. I understand that I am financially responsible for any missed appointments.

Patient/Guardian signature *Date*

SYMPTOMS LIST: Check off any of these symptoms which have been most bothersome or have occurred frequently during the **last 4 weeks**

FOCUS

WELL-BEING CHART

Name: _____

☐ Male ☐ Female Age:_____Today's Date: _____

Instructions: *This Well-Being Chart is a confidential document between you and your doctor. It is intended to help you and your doctor discuss your well-being openly and candidly. Your doctor may ask you more questions about some of these items to pinpoint problems you may have. Please answer each question in the space provided.*

Have you taken any medications in the last 4 weeks? ☐ Yes ☐ No

If yes, please list: _____

Do you smoke cigarettes? ☐ Yes ☐ No

GENERAL SYMPTOMS

- ☐ Fever
- ☐ Repetitive senseless thoughts
- ☐ Repetitive senseless behaviors
- ☐ Fainting or feeling faint
- ☐ Tremors, trembling, or shakiness
- ☐ Seizures
- ☐ Easy bruising
- ☐ Skin rash
- ☐ Violent behavior
- ☐ Constant worry
- ☐ Irritability
- ☐ Tension
- ☐ Headache
- ☐ Feeling in a dreamlike state
- ☐ Fearful feelings
- ☐ Fear of losing control
- ☐ Jumpiness
- ☐ Restlessness
- ☐ Sweating
- ☐ Dizziness, lightheadedness
- ☐ Keyed up, on edge
- ☐ Agitation
- ☐ Nervousness
- ☐ Trouble concentrating
- ☐ Insomnia, trouble sleeping
- ☐ Decrease in sex drive
- ☐ Trouble making decisions
- ☐ Sad/depressed, down in the dumps
- ☐ Lack of/loss of interest in things
- ☐ Helpless feelings
- ☐ Fatigue-lack of energy
- ☐ Weakness
- ☐ Increase or decrease in appetite
- ☐ Increase or decrease in weight
- ☐ Frequent crying or weeping
- ☐ Frequent thoughts of death or suicide
- ☐ Worthless feelings
- ☐ Excessive feelings of guilt
- ☐ Hopeless feelings
- ☐ Feeling life is not worth living
- ☐ Sleeping too much
- ☐ Frequent negative thinking
- ☐ Memory problems
- ☐ Fear of doing something uncontrollable
- ☐ Fear of dying
- ☐ Chills
- ☐ Seeing or heading things that are not there
- ☐ Fear of going crazy

EYES AND EARS

- ☐ Double Vision
- ☐ Difficulty in focusing vision
- ☐ Eye pain
- ☐ Sinus pain
- ☐ Increase or decrease in tearing

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Chest discomfort
- ☐ Heart pounding

GASTROINTESTINAL

- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn
- ☐ Rectal bleeding
- ☐ Black tarry stools
- ☐ Stomach pain
- ☐ Food intolerance
- ☐ Abdominal bloating

RESPIRATORY/NOSE/ THROAT/MOUTH

- ☐ Cold (influenza)
- ☐ Nasal congestion
- ☐ Nosebleeds
- ☐ Hay fever
- ☐ Cough wheezing
- ☐ Shortness of breath
- ☐ Pain when breathing

URINARY

- ☐ Frequent urination
- ☐ Painful urination
- ☐ Difficulty in passing urine
- ☐ Blood in urine

OTHER SYMPTOMS NOT LISTED ABOVE – PLEASE SPECIFY:

_____

_____

_____

_____

_____

_____

_____

MEDICAL DISCLAIMER: This chart is intended as a screening device to assist you in informing your doctor about your medical/emotional condition.

Office comments:

_____

_____

_____

_____

THIS AREA FOR OFFICE USE ONLY

A complete evaluation is necessary to establish a diagnosis.

LIFE FITNESS CENTER

A Medical Group APC

LOS ANGELES
200 E. Del Mar Blvd., Ste. 208
Pasadena, California 91105
Tel: (626) 578-7111
Fax: (626) 578-7161

HAWAII
411 Huku Lii Pl., Ste. 302
Kihei, Hawaii 96753
Tel: (808) 891-1411
Fax: (808) 891-1422

Please answer and complete as much as possible. Thank you for choosing and trusting us.

1. Identifying data:

   Patient Name:_____ Age: ____ Gender: _____

   Marital Status:_____ Referred By:_____ Phone: ( ) _____

   Family MD:_____ Phone: ( ) _____

   Therapist:_____ Phone: ( ) _____

   If a child or adolescent accompanied by: Mother ( ) Father ( ) other ( )

2. **Your present problems, symptoms, and causes**:

   _____

   _____

   _____

   _____

   _____

   _____

3. **On a scale of 1-10 (with 1 being least likely; and 10 being most likely) please answer the following questions:**

   a) Are you motivated to change? _____ b) How disruptive to your life is the problem? _____ c) How important is it for you to change? _____ d) Frequency of problem (circle): daily several times a week several times a month

4. **Your goals of treatment and barriers:**

   _____

   _____

   _____

5. **Personal/Social Strengths:** _____

   _____

6. **Circle any problems that exist:** Hyperactivity – Dec. Attention Span – Distractible – Impulse Control – Starting Tasks- Finishing Tasks – Frustration Tolerance – Accepting Limits – School Performance – Work Performance – Concentration – Anger – Aggression– Following Directions – Cooperativeness – Defiant – Loses Temper – Tantrums – Destruction of Property – Stealing – Running Away – School Truancy- Work Truancy

   _____

7. **Top three problems & age: :** 1)_____ 2)_____ 3)_____

8. **Circle Current Stresses:** Medical – Social – Financial – Education – Occupational – Relationship – Family - Legal

   Explain: _____

9. **Past & Current/Mental Health Care**: (Provider, Dates, Type of Treatment. Inpatient or Outpatient or Substance Abuse etc.)

   _____

   _____

10. **Personal History:**

Location: Born: _____ Raised: _____ How long on Maui: _____

Number of siblings: Brothers Full: _____ Half _____ Step _____ Sisters Full: _____ Half _____ Step _____

Did you live with you parents together: Yes ( ) No ( ) Parents separated/divorced, your age at the time: _____

Then who did you live with until age 18 and older:_____

_____

Childhood (age 12): Happy ( ) Unhappy ( ) Traumatic ( ) Adolescent (age 13-20) Happy ( ) Unhappy ( ) Traumatic ( )

Why: _____

School: Highest grade completed: _____ Grades: _____ Enjoyed it: Yes or No In school now: Yes or No

Childhood Friends: Many: _____ Few: _____ Adulthood Friends: Many: ____ Few: ____ Shy: _____ Outgoing: _____

Single: _____ Married/# of times: _____ Divorced/# of times: _____ Separated/# of times: _____

Current relationship/marital status (circle): Dating: Yes or No How Long? _____

Married/Single/Divorced/Separated How Long? _____ Happy/Unhappy/Fair

Number of sons: ____ full _____ step ____ half_____ ages: _____

Number of daughters: _____ full _____ step _____ half _____ ages: _____

Major problems in childhood and adolescence:

_____

_____

_____

Developmental problems as a child or teen:_____

_____

11. **Family History Mental/Social/Substance/Problems:**

1) Mom's Personality: _____ Quality of Parenting during childhood: _____

2) Dad's Personality: _____ Quality of Parenting during childhood: _____

3) Siblings: _____

4) Others: _____

12. **Personal Habits:** State quantity and any physical, legal, occupational, family, or financial related problems.

	Quantity:	Comment:
Alcohol:		
Drugs:		
Nicotine		
Caffeine:		
Food:		
Exercise:		
Sleep:		
Sexual activity:		
TV/Cable:		
Internet:		
Addictions:		
Other:		

13. **Occupational/Educational History:**

1) Job Description: current or most recent (please circle): _____ 2) Where Employed? _____
FT or PT Enjoy? Yes or No

2) Job Description: current or most recent (please circle): _____ 2) Where Employed? _____
FT or PT Enjoy? Yes or No

3) In School: Yes or No. If yes, Name of School: _____What grade: _____ Major: _____

Grades: _____ Retired or Homemaker. If unemployed, please explain: _____

Job/School Problems: _____ Preferred Job: _____

Disabled: Totally or Partially or Pending (circle): Since when? _____

Why? _____

14. **Living Arrangements:** House or Condo or Apt. Do you rent or own or other? Any Pets: _____
Who do you live with & ages: _____ How long? _____
Are you happy with whom you live with? Y or N Where would you like to live? _____

15. **Friends:** Number: _____ How often do you see them? _____ Want more: Yes or No

16. **Finances:** good or fair or tight or terrible Total monthly debt: $_____ Total debt: $ _____

17. **Spiritual:** awareness, practice? Yes or No Do you attend church? Yes or No Meditate: Yes or No

18. **Medical Conditions:** Healthy: Yes or No **Allergies to: medications/toxins/foods:** _____

List top 5 current medical problems:	Controlled	Not Controlled
1. _____	_____	_____
2._____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

19. **Abuse:** Current or history of Personal, Emotional, Physical, or Sexual Abuse: Yes or No. If yes, please explain: _____
_____

a) Any risk of Elder, Child, or Spousal Abuse: ( ) Yes ( ) No

20. **Suicidal/ Homicidal Ideation/Attempts:** None ( ) Present-No Plan ( ) Present – With Plan ( ) Past History ( )
Explain: _____

21. **Impulsive Behaviors:** Yes ( ) No ( ) Explain: _____
_____

22. **Legal Problems** (Past or Current): _____

23. **Medications Currently:**

Name	Dose	Frequency	Started when	Effectiveness	Compliance
1. _____					
2. _____					
3. _____					
4. _____					
5. _____					

Past medications used for current problems:

	Name	Dose	Frequency	Started when	Effectiveness	Compliance
1.						
2.						
3.						
4.						
5.						

Vitamins/Supplements Currently:

	Name	Dose	Frequency	Started when	Effectiveness	Compliance
1.						
2.						
3.						
4.						
5.						

24. **Personal Assessment during the last month** (circle and explain where appropriate):

1) Appearance: Body Type: Thin – Medium – Overweight – Obese
2) Grooming usually: Neatly Dressed – Sloppily Dressed – Good Self-care – Poor Self-care
3) Attitude: cooperative - uncooperative – guarded – suspicious – angry – arrogant – agitated - passive
4) Physical Activity: calm – restless– hyperactive – tremors–tics –lethargic – less or more than usual
5) Speech: clear –soft – loud– monotone – disorganized – rapid – slow
6) Orientation: normal – person – place – situation – time – any abnormality _____
7) Memory: normal- problems: immediate – recent – past – if decreased relative to normal: yes or no _____
8) Concentration: normal – if abnormal, then: mild impairment – moderate impairment – marked impairment
9) Thought flow: clear – loose – tangential – disorganized – flight of ideas – slow - fast
10) Intelligence: average – slightly above average – high – slightly below average – below average.
11) Suicidal: thoughts – plans – risks (scale of 1-10, 1 least; 10 most): _____
12) Insight into current situation: Good – Average – Fair – Poor
13) Insight into most life situations: Good – Average – Fair – Poor
14) Judgment: good – impaired – mild – moderate – severe – poor
15) Mood and Affect: normal. If abnormal: depressed – unhappy – flat – restricted – anxious – labile – tearful – euphoric
16) Self-Evaluation: no impairment – exaggerated self image – negative self image - detached
17) Self Care: good – fair – poor Self Respect: good – fair - poor
18) Hallucinations: No ( ) Yes ( ) if yes, what kind: _____
19) Delusions: No ( ) Yes ( ). If yes: persecutory – grandiose – paranoid – religious - other.

PLEASE DO NOT WRITE BELOW THIS LINE: FOR PROVIDER USE ONLY

25. **Diagnoses:** DSM V best numerical codes and descriptions:

Axis I: Biological/Chemical syndromes and V Codes.

1. _____ 2._____ 3. _____ 4. _____

Axis II: Developmental Disorders and Personality Disorders: List C= Meets criteria or T= has traits.

1._____2. _____3. _____

Axis III: Physical Disorders

1. _____ 2. _____ 3. _____ 4. _____

Axis IV: Severity of Psycho-Social Stressors: mild – moderate – severe – overwhelming. Causes: health – economic – job related – marital – none - primary support – other _____ Severe: (circle) 1 – 2 – 3 – 4

Axis V: Current GAF_____Highest in past year _____Last year at this time _____

Effects of Stresses: decreased social functioning – decreased job functioning – decreased school participation – decreased family functioning – impaired health – emotional distress.

26. **Brief summary of patient's problems, strengths, and conditions:** _____
_____
_____
_____

27. **Recommendations and Treatment Plan:** Circle.
1. Type of Treatment & Evaluation: individual – couple's – family – group therapy – lab tests –detox – psych testing – med management-approximate length of treatment_____.
2. Goals/Focus of Treatment: Decrease anxiety – decrease depression – eliminate suicidal ideations – reduce grief - decrease anger – sobriety – stop substance abuse – eliminate panic attacks – eliminate phobias – eliminate ADD/ADHD- eliminate OCD – eliminate PTSD – improve impulse control – improve attention/focus – eliminate hallucinations – eliminate delusions – eliminate mood swings – eliminate sexual problems–eliminate agoraphobia – reduce social anxiety – eliminate work problems – eliminate relationship problems – eliminate school problems – eliminate pain - eliminate physical problems- improve exercise – improve nutrition – improve sleep – improve social life – improve spiritual awareness and practice – improve self love, care, respect, success.

28. **Treatment Modalities:** Psychotherapy – med management – vitamins/supplements – nutritional counseling – physical fitness – acupuncture – massage – financial counseling – career counseling – social counseling – time management– journaling – meditation – executive skill development – anti-aging therapy– anger management – bibliotherapy – homework – sobriety program

29. **Medications:** _____
_____
_____

30. **Vitamins/Supplements:** _____
_____

31. **Books:** _____

32. **Evaluation Consultants (i.e. psych testing, lab work, radiology, etc):** _____
_____

33. **Recommended Consultants/Psychotherapist, Nutritionist, P.T., Acupuncture, Meditate, Personal Trainer, Finance Finance Management, Yoga, AA, etc.:** _____
_____

34. **Approximate date/time of next appointment:** _____

Was patient given medication Informed Consent and information regarding medication side effects and risks versus benefits? Yes ( ) No ( )

Was patient told to inform doctor of side effects, allergies, and discontinuations? Yes ( ) No ( )

Was patient told how to reach office, therapist, psychiatrist, etc., if in a emergency situation: Yes ( ) No ( )

NAME OF EVALUATOR AND DEGREE _____ DATE _____

(Please sign or print legibly)

411 Huku Li'i Place, #302
Kihei, HI 96753
Ph: (808) 891-1411

200 E. Del Mar Blvd., #208
Pasadena, CA 91105
Ph: (626) 578-7111

LIFE FITNESS CENTER
Notice of Policies and Practices to Protect the Privacy of Patient Health Information

HIPAA NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCES TO THE INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. <u>USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.</u>

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment, and Health Care Operations: Treatment is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when your provider consults with another health care provider, such as your family physician or another psychologist/psychiatrist/therapist. Payment is when we obtain reimbursement for your healthcare. Examples are when we disclose your diagnosis to your health insurer to obtain reimbursement for your treatment and services provided by Life Fitness Center staff. Health Care Operations are activities that relate to the performance and operation of the practice. Examples are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within the LFC such as releasing, transferring, or providing access to information about you to other parties.
- "Authorization" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

III. <u>Other Uses and Disclosures Requiring Authorization:</u> LFC may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when LFC is asked for information for purposes outside of treatment, payment, or health care operations, LFC will obtain an authorization form from you before releasing this information. LFC will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes your provider may have made about conversations during a private, group, joint, or family counseling session, which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the

extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

IV. **Uses and Disclosers without Authorization:** LFC may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse – If your provider may have reason to believe that a child has been subjected to abuse or neglect, they must report this belief to the appropriate authorities.
- Serious Threat to Health or Safety – If you communicate to your provider a specific threat of imminent harm against another individual or if your provider believes that there is clear, imminent risk of physical or mental injury being inflicted against another individual, they may make disclosures that are believed necessary to protect that individual from harm. If your provider believes that you present an imminent, serious risk of physical or mental injury or death to yourself, they may make disclosures considered necessary to protect you from harm.
- Appointment reminders and health related benefits or services. Examples: LFC may use PHI to provide appointment reminders. LFC may use PHI to give you information about alternative treatment options, or other health care services or benefits LFC offer.
- If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
- If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.
- If disclosure is otherwise specifically required by law.

V. **Patient's Rights and Psychiatrist/License Marriage Family Therapist/Social Worker:**

Patient's Rights:

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information. However, LFC is not required to agree to a restriction your request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (Example: you may not want a family member to know that you are seeking treatment. On your request, LFC will send your bill/correspondence to another address).
- Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. LFC may deny your access to PHI under certain circumstances, but in some cases you may this decision reviewed.
- Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. LFC may deny your request. On your request, your provider will discuss with you the details of the amendment process.

- Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI. On your request, your provider will discuss with you the details of the accounting process.
- Right to Paper Copy: You have the right to obtain a paper copy of the notice from LFC upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with the revised notice either in person or by mail and request that you review and re-sign the form acknowledging and consenting to the changes

VI. **Questions and Complaints:** If you have questions about this notice, disagree with a decision your provider makes about access to your records, or have other concerns about your privacy rights, you may contact LFC Maui at (808) 891-1411 or LFC Pasadena at (626) 578-7111.

If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written complaint to: Life Fitness Center, 411 Huku Li'i Place, #302, Kihei, HI 96753 or Life Fitness Center, 200 E. Del Mar Blvd., #208, Pasadena, CA 91105.

You may also send a written complaint to State of Hawaii Regulated Industries Complaints Office, Department of Commerce and Consumer Affairs, Leiopapa A. Kamehameha Building, 235 South Beretania Street, Ninth Floor, Honolulu, HI 96813.

You have the specific rights under the Privacy Rule and LFC will not retaliate against you for exercising the right to file a complaint.

VII. **Effective Date, Restriction, and Changes to Privacy Policy:** This notice is effective as of April 14, 2003. LFC reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that is maintained. LFC will provide you with a revised notice in person or by mail.

411 Huku Li'i Place, #302
Kihei, HI 96753
Ph: (808) 891-1411

200 E. Del Mar Blvd., #208
Pasadena, CA 91105
Ph: (626) 578-7111

LIFE FITNESS CENTER
Acknowledgement of Receipt of HIPAA Notice of Privacy Practices Form

The Health Insurance Portability and Accountability Act (HIPAA) a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that LFC provides you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached, explains HIPAA and its application to your personal health information in greater detail. The law requires that LFC obtains your signature acknowledging that LFC has provided you with this information.

It is very important that you read this notice carefully before your first session. Any questions are welcomed at that time.

I acknowledge that I have received a copy of the Notice of Policies and Practices to Protect the Privacy of Patient Health Information, effective April 14, 2003.

_____
Print Patient/Guardian Name

_____
Signature of Patient/Guardian

_____
Date Signed

LIFE FITNESS CENTER

A Medical Group, APC

411 Huku Li'i Place, #302
Kihei, HI 96753
P: (808) 891-1411
F: (808) 891-1422

DANIEL M. ASIMUS, M.D., M.S. Ed.
Diplomate of the American Board
Psychiatry * Neurology *Holistic Medicine

200 E. Del Mar Blvd. #208
Pasadena, CA 91105
Tel: (626)578-7111
Fax: (626)578-7161

POLICIES
As of January 1, 2014

At Life Fitness Center we strive to provide the best Integrative Mental Health Care possible. We want to help our patients eliminate their pain, distress, and mental-emotional problems and in addition help them use their own distinct talents and genius to achieve their best health, happiness, and success. We will do our very best and expect our patients to as well. The following policies have been established to ensure the best patient care possible.

1) I agree to notify the office staff at least 48 business hours in advance, excluding weekends, and holidays, if I need to reschedule or cancel my appointment.

2) I agree to pay in full ($50 to $200 depending on the length of session reserved) for any missed or late cancellation/rescheduling of appointment by credit card (master or visa) which I have provided to LFC. In order to reschedule, payment must be made in full when making next appointment. If I have missed several appointments, I may not be able to reschedule.

3) I agree to take my medications ONLY as prescribed and to keep them in a safe secure place. I understand that any lost medications may not be refilled until the next appointment. If medication refills are needed, I must allow at least 48 business hours, excluding weekends and holidays. I understand that some prescriptions are time sensitive, and it is my responsibility to fill before expiring, otherwise, I may not obtain another prescription till next appointment.

4) I agree that an appointment is necessary to assess my condition and for medications to be refilled. If appointments are not kept, medications may not be refilled.

5) I agree to pay a $35.00 charge for returned check. Thereafter, no checks will be accepted, only cash or credit card (master or visa).

6) I agree to only utilize the emergency call system in true emergencies and not for refills, appointment changes, or form completions.

7) I agree that there will be no verbal and/or physical abuse towards LFC staff, other providers, and other patients. LFC reserves the right to refuse services and/or discontinue services.

8) It is my responsibility to provide LFC any changes relating to insurance, phone number, mailing address, etc.

9) I agree to pursue health and happiness and only engage in activities that promote my wellbeing.

By signing below, I agree and understand all the above.

_____	_____	_____
Patient or Guardian(Print Name)	*Patient or Guardian Signature*	*Date*

LIFE FITNESS CENTER

A Medical Group, APC

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DANIEL M. ASIMUS, M.D., M.S. Ed.
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Pasadena, CA 91105
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CREDIT/DEBIT CARD AUTHORIZATION FORM

By completing this form, I authorize Life Fitness Center to charge my credit/debit card an amount of $50.00 to $200.00 for any and all appointments not cancelled or rescheduled within 48 business hours, or if I fail to attend the scheduled appointment.

I further authorize Life Fitness Center to charge my card for any outstanding balances that were not paid by either me and/or my insurance company pertaining to co-payments, deductible, co-insurance, termination of benefits, etc.

By providing the information below, I agree and understand to the above,

Name on Credit Card: _____

Master/Visa Card #:_____ Exp Date: _____

Signature_____ Date Signed:_____

Print Name: _____