Abundance Wellness

Jana Bunsic D.O.

Thank you for your interest in wanting to establish a life long relationship at our practice. **Prior** to filling out the application to become a new patient please read this carefully. Please complete the check list on the last page before faxing or bringing in application. If information **is not complete** your application **cannot** be processed. The application process may take up to two weeks for a determination.

Our practice is a functional/integrative medicine, and osteopathic practice. Therefore, we look to heal the body with a variety of medical techniques, lifestyle changes and natural supplements. If you are searching for this type of provider please proceed. We look forward to facilitating higher health for you in the future. Also **be aware**, Dr.Bunsic **will not** prescribe any controlled substance at any time.

I, ________________________ agree to follow Dr.Bunsic's integrated

Print Name

approach for medical treatment.

____________________________________ ________________

Signature: Date:

New Patient Request Form

Patients Name:______________________________ DOB:___________________________

Provider Request:____________________________ Current PCP:____________________

Date Requested:_____________________________

Smoker: __Yes_or_No_Wanting help to quit?__Yes_or_No

Reason for wanting to be seen:____

Consultation Only:____________________________ PCP Change:____________________

Please list ALL current medications:

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

Please list all medical conditions:

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

Please list any recent hospitalization/outpatient procedures:

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

Please list any Specialists seen:

____________________ ____________________
____________________ ____________________
____________________ ____________________

Comments:

Patient Signature

Administrative use only below this line

HS Account # ________________

Approved ☐ Declined ☐

Reason for being declined:

Insurance

Signature ____________________ Date ________________

Once determination is made, send a copy of this sheet to Administration for tracking purposes

HEALTHSTAR PHYSICIANS, P.C.
PATIENT INFORMATION SHEET

PLEASE PRINT

Date ____________________

Patient ____________________ Home Phone ____________________

Last Name First Name Middle Name

Street Address ____________________

Zip ________ City ____________ State ____

Social Security Number ____________________

Sex ☐M ☐F Age ________ Birthday ____________ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐YES ☐NO IF YES, WHAT ARE THEY? ____________________

Patient's Employer (If child, mother's name and employer) ____________________

Business Address ____________________ Employer ____________________

Occupation ____________________ Phone ____________________

Spouse's Name (if child, father's name and employer) ____________________

Business Address ____________________ Employer ____________________

Who is responsible for this account ____________________

Relationship to Patient ____________________

Social Security # ____________________ Spouse's Social Security # ____________________

Do you have Medical Insurance? ☐ NO ☐ YES If yes, ____________________

Name of Primary Insurance ____________________ Insured Name ____________________ Birthday ____________

Contract # ____________________ Group # ____________________ Insured SS # ____________________

Name of Secondary Insurance (if any) ____________________ Insured Name ____________________ Birthday ____________

Contract # ____________________ Group # ____________________ Insured SS # ____________________

☐ Medicare ☐ Medicaid/TennCare Claim ID# ____________________

In case of emergency, who should be notified? ____________________ Phone ____________________

Have you ever been seen by a Healthstar Physician before? ☐YES ☐NO If yes, which physician? ____________________

How did you learn of our practice? ____________________

Former Physician ____________________

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with ____________________

Name of Insurance Company

and assign directly to HEALTHSTAR PHYSICIANS, P.C. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

I, the undersigned, authorize Healthstar Physicians or any agents thereof, to notify me by telephone answering machine, mail, etc. regarding appointment, lab/diagnostics, billing and collection information.

____________________ ____________________

Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION AND RELEASE

I request the payment of authorized Medicare benefits be made either to me or on my behalf to HEALTHSTAR PHYSICIANS, P.C. for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form, of elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

I, the undersigned, authorize Healthstar Physicians or any agents thereof, to notify me by telephone, answering machine, mail, etc. regarding appointment, lab/diagnostics, billing and collection information.

____________________ ____________________

Signature of Insured/Guardian Date

Authorizations

I, hereby authorize the following individuals, other than myself, to receive information regarding my health care, lab/diagnostic results, appointments, billing and collections.

____

______________________________ ______________

Signature of Patient or Authorized Representative Date

I, hereby authorize Healthstar Physicians to submit a blood sample for HIV and or HBV testing as deemed necessary by my physician.

______________________________ ______________

Signature of Patient or Authorized Representative Date

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CHECK LIST FOR A COMPLETED APPLICATION

****PLEASE INITIAL EACH BUBBLE STATING THAT YOU HAVE COMPLETED EACH****

1. ◯ COPY OF INSURANCE CARD
2. ◯ **SMOKING STATUS BOX CHECKED**
3. ◯ CURRENT PCP ANSWERED
4. ◯ REASON FOR WANTING TO BE SEEN ANSWERED
5. ◯ CONSULTATION OR PCP CHANGE ANSWERED

I ________________________**(PRINT NAME),** HAVE COMPLETED THE CHECK LIST AND HAVE ANSWERED THE ENTIRE PATIENT REQUEST FORM TRUTHFULLY AND TO THE BEST OF MY KNOWELEDGE, AND I UNDERSTAND ANY MISSING INFORMATION WILL RESULT OF AN UNPROCESSED APPLICATION.

______________________________ ____________________

SIGNATURE **DATE**