JAKOB JAGGY, M.D.
"Holistic Medicine is an Art and a Science"
22603 Parrotts Ferry Road
PO Box 329 • Columbia CA 95310
Phone 209-588-8900 Fax 209-588-9995

Dear Patient,

Welcome to the Foothill Center for Holistic Medicine. We would like to thank you for selecting our office for your primary care needs. In order to provide you with the best possible service and to inform you of your responsibilities we have enclosed additional forms.

Please take a few minutes to read, sign and date these forms and bring them in with you at the time of your visit. If you have recent lab reports that are relevant to your visit please bring those as well. It would also be helpful if you bring the address and phone number of any medical doctor that we might obtain further information about your history. And finally, please fill out the 'Sequence of Life Events form'. This helps me gain insight into the origins of your illness.

Please note that our office is "fragrant free" in consideration for those that are sensitive/allergic to various odors. We kindly ask that you refrain from wearing all perfumes, essential oils, etc.

Thank you,

Jakob Jaggy, MD

PATIENT INFORMATION

PLEASE PRINT

PATIENT'S NAME ____ MALE/FEMALE (CIRCLE)

DATE OF BIRTH ___________________________ SOCIAL SECURITY # _______________________

MAILING ADDRESS ______________________________ CITY ______________ ZIP ____________

HOME PHONE _____________WORK PHONE _____________________ CELL___________________

EMAIL ADDRESS ____

OPTIONAL QUESTIONS: PRIMARY LANGUAGE__________ ETNICITY ____________ RACE __________

MARTIAL STATUS SINGLE MARRIED WIDOWED DIVORCED SEPARATED

The following information is to be completed by parent/guardian/person financially responsible for the patient.

NAME OF RESPONSIBLE PERSON ___________________________ HOME PHONE ________________

ADDRESS IF DIFF FROM PATIENT ____

EMPLOYER ____ PHONE _____________________

WHOM MAY WE CONTACT IN AN EMERGENCY: NAME _____________ PHONE ____________________

INSURANCE INFORMATION

PRIVATE INSURANCE CO. ___________________________ GRP # ____________ ID# ___________

ADDRESS ____ PHONE _____________________

MEDICARE NUMBER ________________________________ OTHER __________________________

I ALSO HEREBY AUTHORIZE release of information requested by any insurance company and/or its representatives.
I HEREBY AUTHORIZE payment directly to the doctor and/or authorized providers of medical services by my insurance company of benefits due me for medical and/or surgical care rendered to me.
I understand that there is a $15.00 charge on all returned checks.

I will notify you of any changes in my health status or any of the above information.

SIGNED ___________________________ RELATIONSHIP TO PATIENT ____________ DATE_______

FOOTHILL CENTER FOR HOLISTIC MEDICINE
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Please be advised of our Office Policy

Acknowledgement of Responsibility

In order to properly bill your insurance company, it is your responsibility to provide us with your most current insurance information. If for any reason any of the services are not covered or have not been approved by your health plan you will be financially responsible for the balance due.

If your eligibility shows that it was not in effect as of the date of service, it is your responsibility to contact your insurance carrier to clear up any misunderstanding there may have been. If this claim is denied you then are responsible for the payment for the services provided for you.

Co-pay's and deductibles are due at the time of service.

If you do not have insurance coverage at this time it is your responsibility to complete the payment at the time of service.

We require a 48-hour cancellation notice. If you fail to meet this requirement you will be responsible for the office charge for the time that was allotted to you.

Please note any services provided for you outside of this office will be a separate billing charge.

Thank you for your cooperation in these matters.

I acknowledge and assume full financial responsibility for health care services rendered to me in accordance with the provisions as mentioned above.

Patient Name ___________________________________ Date __________________

Patient or Legal Representative Signature

____

Jakob Jaggy, MD, Inc
Foothill Center for Holistic Medicine
Columbia, CA 95310

Name: ______________________________ Date: ____________________

HIPAA Notice of Privacy Practices

Can we leave a message on your cell?	Yes____	No ____
Can we leave a message at home?	Yes____	No ____
Can we leave a message with anyone in your household?	Yes____	No ____
Can we leave a message at your work?	Yes____	No ____
Can we leave a message send a message using email?	Yes____	No ____

A Message To Our Patients About Arbitration

Our goal is to provide medical care to our patients in a way that will avoid disputes. We know that most problems occur as a result of miscommunication. So, if you have concerns about your medical care, please discuss them with us.

Please read the attached contract entitled **Physician-Patient Arbitration Agreement**. By signing the contract, we are agreeing that any dispute arising out of the medical services you receive will be resolved in binding arbitration before an arbitration panel instead of by a lawsuit in a court of law.

Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

We believe that the method of resolving disputes in arbitration spares the parties some of the rigors of a court trial and the negative publicity which may accompany judicial proceedings.

Thank you.

Name ____________________________

HEALTH HISTORY

Medications:

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Preferred Pharmacy: ____

Supplements:

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Allergies:

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Surgeries:

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Past Medical Problems:

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Family History:

Father: ____

____

Mother: ____

____

Siblings: ____

____

Other: ____

____

SEQUENCE OF LIFE EVENTS

List all major events in your life that have affected your health negatively and what illness was a consequence of that. For example: trauma to the back or head, surgeries, major illness, emotional or mental trauma. List each one in a separate box with date of event.

Name ____________________________

Overall Questionnaire

Please rate your symptoms from 0-10
0= No symptoms
10= Maximum intensity symptoms

Fatigue	
Dry skin	
Brittle Nails	
Hair loss	
Feeling cold	
Weight Gain	
Dizzy with position change	
Energy Fluctuation	
Salt Craving	
Get shaky if hungry	
Tired mid-afternoon	

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CONSENT FOR TREATMENT

I am aware that Dr. Jakob Jaggy practices holistic medicine. It is with this information that I request the services as provided and prescribed by Jakob Jaggy M.D.

I also acknowledge and agree to pay $80.00 for no-show appointments. I understand after 3 no shows I will be discharged from the practice. I agree to pay $35.00 fee for returned checks.

If parent or guardian of a minor, I have read and understood the California Minor Consent Laws.

If the minor has dual custody, I have provided Dr. Jaggy's office with the decree covering medical decision-making, and contact information for all responsible parties.

If I am a caretaker or guardian for the patient, I have provided Dr. Jaggy's office with legal documents relevant to medical decision-making, and contact information for all responsible parties.

Printed name of Patient: ____

Signature of responsible party: _____________________________________
Date: ______________

Printed Name of responsible party: _________________________________

Schedule of Fees for Services

Photocopies.

- Chart Copies $25
- Lab, medication, office visits, statements $1 per page
- List of supplements, office visits and/or misc. forms for HSA, taxes, etc.
  $5-15 (depending on length of the list)

Prior Authorizations (pharmacy, MRI, etc.) $15

Sports Physicals $90

Forms completion

- Employment physical, sports physical, disability, patient-assistance programs, life insurance letters, narrative reports, etc. $10 per form (if filled out without office visit)

Refills requested outside an office visit.

- Triplicates $5

PLEASE BE AWARE DR. JAGGY IS NOT A PAIN MANAGEMENT DOCTOR. IF THIS IS THE TYPE OF PHYSICIAN YOU REQUIRE, WE SUGGEST YOU CONSIDER ANOTHER M.D.

If you are on narcotics please be aware that Dr. Jaggy will not take over prescribing those medications.

No-shows.

- $80 per office visit missed. Three missed visits (without notifying our office within 48 hours) the patient will be dismissed from the practice or they will pay $80 to be reinstated.
- New Patients will be charged $100 prior to their first visit which will be used toward co-pays. This amount will not be refunded in case of a no-show or in case the cancellation did not happen at least 48 hours before the visit. New Patient no-shows will have to pay in advance a $80 'second try' fee to be able to get another New Patient appointment.

Name ______________________________

Woman's Questionnaire

Please rate your symptoms from 0-10
0= No symptoms
10= Maximum intensity symptoms

Water retention	
Breast tenderness	
Vaginal dryness	
Hot flashes during the day	
Night sweats	
Emotional/crying easy	
Anxiety	
Insomnia	
Foggy thinking	
Poor muscle tone	
Low Libido	
Urinary incontinence	
Moody	
Cramps	
Migraines	