

CONFIDENTIAL PATIENT INTAKE INFORMATION

Patient Name: _____
First Middle Last

Name patient prefers to go by: _____

Birth Date: _____ Gender: Male Female

SSN: _____

Street: _____

City: _____ State: _____ Zip: _____

Contact Information

Home: _____

Work: _____

Cell: _____

Email Address: _____

For Pediatric Patients:

Father's Name _____

Mother's Name _____

We will **NOT** confirm your existence as a patient in this clinic or correspond with any family member or other person you have not specifically authorized. If you have another family member or caregiver with whom you wish for us to correspond, you will need to list them below.

Name _____

Relationship _____

ABOUT OUR FEES

Doctor's fee for initial visit (60 minutes):	\$ 345.00
Doctor's fee for on-going management visit (40 minutes):	\$ 225.00
Hyperbaric Oxygen Treatment (per 50 minute session):	\$ 95.00

All services of Carmel Clinic for Functional Medicine are elective and voluntary for the purpose of helping you achieve your personal health goals. If in collaboration with the doctor you elect to undergo any level of diagnostic testing, the doctor will discuss any related fees with you during the course of your evaluation so you may choose what level of testing and associated care you feel is best for you and your health goals.

Your initial consultation is how you get to know the doctor and how the doctor gets to know you and your health goals. Getting to know you and understanding your health goals is a process that begins prior to your first visit. This process begins with the doctor's review of your medical history forms and preliminary functional assessment questionnaire that they will review prior to your first visit.

Your initial consultation encompasses up to 60 minutes with the doctor. This time is valuable for both you and the doctor and is a commitment. Given the amount of time the doctor commits in advance and during your consultation, we require first-time patients post 50% of their initial consultation fee in order to secure an appointment.

CANCELLATION POLICY

If for any reason you do not attend your **initial appointment** the \$172.50 (50% of \$345) is forfeited. Initial fee is only refundable upon 14 days advance notice. Please give careful consideration to this policy when scheduling your initial consultation.

Notification of cancellation or change of a **follow-up visits** must be received within 72 hours of scheduled appointment time. If 72 hours notice is not received, you will incur a charge of \$ 225.00. As such, a valid credit card must remain on file in the event this occurs.

PAYING FOR YOUR SERVICES

You are responsible for filing any claims to your own insurance company for possible reimbursement; we provide coded medical invoices appropriate for submission to any/all insurance carriers for reimbursement within the limitations of your particular health plan's benefits structure.

Option One

For your convenience you may satisfy your office fees via Mastercard, VISA, American Express, Discover, personal check or cash.

Option Two

For our patients who are not able to satisfy their fees at the rate they are incurred, we offer no interest payment plans through our financial partners, Care Credit. To enroll, please click on the 'Apply Care Credit' link on our website.

POLICIES AND CONSENT

Please read and understand each item then initial each.

- _____ I am aware that Carmel Clinic for Functional Medicine is **NOT** a Medicare or Medicaid participating provider.
- _____ I am aware that I am personally responsible for all charges associated with my care, and that payment in full is due at the time of service.
- _____ I am aware that if I choose to proceed with laboratory testing, the laboratories used are out-of-network for all insurances.
- _____ I understand that lab fees must be paid to the clinic at the time the doctor orders them, as the clinic will be incurring lab charges on your behalf.
- _____ I am aware that any prescribed medical foods must only be taken under the supervision of the doctor, and as such must be dispensed through a licensed pharmacy or directly from Carmel Clinic for Functional Medicine.
- _____ I am aware that healthcare is not an exact science and I acknowledge that **NO** guarantees have been made to me as to the results of the examinations, tests, diagnoses or treatment by Carmel Clinic for Functional Medicine or any representative thereof.
- _____ I understand that all laboratory test results require doctor interpretation before copies will be provided to the patient. I understand that I must attend an office visit with the doctor to receive interpretation and guidance.
- _____ I am aware that Carmel Clinic for Functional Medicine recommends that medications **NOT** be discontinued without the consent of the prescriber.
- _____ I am aware that Carmel Clinic for Functional Medicine does **NOT** recommend that pregnant or nursing mothers take nutrient therapy.
- _____ I understand that Carmel Clinic for Functional Medicine does not participate with any insurance plan and **NO** guarantees have been made to me with regard to reimbursement.
- _____ I understand that for the protection of all clinic patients, Carmel Clinic for Functional Medicine will not accept the return of any dispensed nutrients, opened or unopened.
- _____ I understand that due to the potential for insurance fraud under **NO** circumstance will Carmel Clinic for Functional Medicine issue a refund for any service or laboratory test, even if a lab kit is returned and the specimen has not yet been collected.
- _____ I understand that no doctor of Carmel Clinic for Functional Medicine will serve as my primary care physician.

I fully understand the above listed policies, and I do hereby voluntarily consent to evaluation and care with Carmel Clinic for Functional Medicine and the treating doctor including: physical exam and any mutually agreed upon diagnostic testing.

Patient Signature

HEALTH HISTORY

Please circle all conditions that you have or have had in the past.

- | | | |
|------------------------|------------------------------|----------------------|
| Cancer | Esophagitis | Hypothyroidism |
| Eczema | Peptic Ulcer | Hyperthyroidism |
| Psoriasis | Gastro Esophageal Reflux | Skin Conditions |
| Allergic Rhinitis | Colitis | Alzheimer's |
| Arthritis | Irritable Bowel | Parkinson's |
| Chronic Sinusitis | Pancreatitis | Asthma |
| Dementia | Gall Bladder Dysfunction | Seizure Disorder |
| Chronic Fatigue | Hepatitis | Liver Disease |
| Multiple Sclerosis | Fibrocystic Breast Cancer | Endometriosis |
| Vascular Disease | Kidney Problems | Fibroid Tumors |
| Fibromyalgia | Urinary Tract Infections | Ovarian Disease |
| Chemical Sensitivities | Benign Prostatic Hypertrophy | PMS |
| Heart Disease | Thrush | Menopause |
| Postpartum Depression | Stroke | Athletes Foot |
| Hypertension | Nail Fungus | Glaucoma |
| High Cholesterol | Ring Worm | Night Blindness |
| Diabetes | Yeast Infections | Herpes or Cold Sores |
| Restless Legs | Burning Mouth | Shingles |
| Autism | Asperger's | ADD/ADHD |
| Anxiety | Depression | Obsessive Compulsive |

Other _____

Past Surgeries: _____

Past Hospitalizations: _____

Other Treatments or Pertinent Tests: _____

Is there any special need or concern you have or would like me to be aware of?

PLEASE LIST ALL MEDICATIONS AND SUPPLEMENTS YOU ARE TAKING

Med/Supplement	Dosage	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you have a primary provider or pediatrician please list below.

Name _____ Office Phone _____
Street _____
City _____ State _____ Zip _____

PRIVACY POLICY

THIS NOTICE DESCRIBES HOW PERSONAL MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY OUR OFFICE AND HOW YOU CAN ACCESS THAT INFORMATION.

PLEASE READ THIS NOTICE CAREFULLY

We are committed to maintaining the privacy of your protected health information (PHI), which includes information about your condition, care and treatment you receive from us. The creation of a record detailing the care and services you receive helps this office provide you with quality care. This notice details how your PHI may be used and disclosed to third parties. This notice also details your rights regarding your PHI.

CONSENT

The Clinic may use and/or disclose your PHI provided for the purpose of:

- **Treatment** - In order to render the health care services you require, the Clinic will provide your PHI to those health care professionals whether on the Clinic staff or not, directly involved in your care so they may understand your health condition and needs.
- **Payment** - In the event we must seek counsel or a collection service for any unpaid fee related to your care, we may disclose certain pieces of information related to your care.
- **Health Care Operations and Provider Coordination** - We may compile, use and/or disclose your PHI in order to coordinate your care with other licensed physicians.

NO CONSENT IS REQUIRED FOR THE FOLLOWING:

- De-Identified information.
- Business Associate.
- Your personal representative: any person who, under applicable law, has the authority to represent you and is in making decisions related to your health.
- Emergency Situations.
- Communication Barriers.
- Public Health Activities.
- Abuse, Neglect, or Domestic Violence.
- Health Oversight activities required by law.
- Judicial and Administrative Proceedings.
- Law Enforcement.
- Coroner or Medical Examiner.
- Organ or Tissue Donation.
- Research as regulated by governmental requirements.
- Avert a threat to Health and Safety.
- Specialized Government Functions.
- Workers Compensation.
- National Security and Intelligence.
- Military Veterans.

YOUR RIGHTS

You have the right to revoke any authorization and/or consent or request a restriction, in writing, at any time. To request a revocation, you must submit a written request to the Clinic's Privacy Officer. For certain restriction requests the Clinic is not obligated to agree, but will do so for all reasonable requests.

**THIS COPY OF YOUR RIGHTS AND THE COPY
OF THE PRIVACY POLICIES IS YOURS TO KEEP.**

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY

I have been provided a copy of, and have read the privacy policy for Carmel Clinic for Functional Medicine as evidenced by my signature below.

Patient/Guardian Signature

Date _____

Staff Member Signature attesting that
Patient was given a copy of the Privacy
Policy, in the event that the patient did not
or refused to sign.

Date _____

PRELIMINARY FUNCTIONAL ASSESSMENT QUESTIONNAIRE

Acid foods upset	rare	occasional	often
Nervous stomach	rare	occasional	often
Reduced Appetite	rare	occasional	often
Frequent Sour Stomach	rare	occasional	often
Reduced Urine output	rare	occasional	often
Stomach Butterflies	rare	occasional	often
Indigestion following meals	rare	occasional	often
Always feel hungry	rare	occasional	often
Frequent Vomiting	rare	occasional	often
Constipation	rare	occasional	often
Diarrhea	rare	occasional	often
Weight Gain	rare	occasional	often
Weight Loss without trying	rare	occasional	often
Decreased sugar tolerance	rare	occasional	often
Abnormal Thirst	rare	occasional	often
Abdominal Bloating	rare	occasional	often
Weight gain around hips	rare	occasional	often
Excessive Appetite	rare	occasional	often
Irritable before meals	rare	occasional	often
Shaky when hungry	rare	occasional	often
Eating relieves tiredness	rare	occasional	often
Light headed if meals missed	rare	occasional	often
Sweets upset stomach	rare	occasional	often
Meats upset stomach	rare	occasional	often
Metallic Taste in mouth	rare	occasional	often
Coated Tongue	rare	occasional	often
Frequent Foul Smelling Gas	rare	occasional	often

Eyes Sensitive to Light	rare	occasional	often
Unable to Relax	rare	occasional	often
Nerve-like pain	rare	occasional	often
Eyes blink often	rare	occasional	often
Difficulty Swallowing	rare	occasional	often
Eyelids or Face twitch	rare	occasional	often
Difficulty holding a gaze	rare	occasional	often
Restless	rare	occasional	often
Can't work under pressure	rare	occasional	often
Headaches upon rising	rare	occasional	often
Impaired hearing	rare	occasional	often
Failing memory	rare	occasional	often
Splitting Headaches	rare	occasional	often
Afternoon Headaches	rare	occasional	often
Ringing in Ear or Ears	rare	occasional	often
Dizziness	rare	occasional	often
Blurred Vision	rare	occasional	often

Cold Extremities	rare	occasional	often
Easily Chilled	rare	occasional	often
Pulse speeds after meals	rare	occasional	often
Racing Pulse at Rest	rare	occasional	often
Slow Pulse (Below 65)	rare	occasional	often
Increased Blood Pressure	rare	occasional	often
Decreased Blood Pressure	rare	occasional	often
Weakness	rare	occasional	often
Poor Circulation	rare	occasional	often
Respiratory Difficulty (Asthma)	rare	occasional	often
Heart Palpitates if missed meal	rare	occasional	often
Numbness of Hands or Feet	rare	occasional	often
Swollen Ankles	rare	occasional	often
Shortness of Breath on Exertion	rare	occasional	often
Shortness of Breath at Rest	rare	occasional	often
History of Anemia	rare	occasional	often
Frequent Nose Bleeds	rare	occasional	often
Dull Pain in Chest	rare	occasional	often

Dry Mouth	rare	occasional	often
Dry Eyes or Nose	rare	occasional	often
Flush Easily	rare	occasional	often
Thin Moist Skin	rare	occasional	often
Dry or Scaly Skin	rare	occasional	often
Course Hair	rare	occasional	often
Tendency to Hives	rare	occasional	often
Brown Spots on Skin	rare	occasional	often
Itching Skin or Feet	rare	occasional	often
Loss of Hair	rare	occasional	often
Frequent Skin Rashes	rare	occasional	often

Cold Sweats Often	rare	occasional	often
Excessive Body Odor	rare	occasional	often
Watery Nose or Eyes	rare	occasional	often
Swollen or Puffy Eye Lids	rare	occasional	often
Hoarseness of Voice	rare	occasional	often
Slow to Get Going	rare	occasional	often
Sensitivity to Cold (Chill Easily)	rare	occasional	often
Insomnia	rare	occasional	often
Heat Intolerance	rare	occasional	often
Fatigue Easily	rare	occasional	often
Sleepy During Day	rare	occasional	often
Hot Flashes	rare	occasional	often

Morning Joint Stiffness	rare	occasional	often
Muscle Cramps (Charlie Horse)	rare	occasional	often
Restless Legs	rare	occasional	often
Joint Pain	rare	occasional	often
Burning Feet	rare	occasional	often

Unusual Sweet Cravings	rare	occasional	often
Awaken after a few hours of sleep	rare	occasional	often
Sigh Frequently	rare	occasional	often
Highly Emotional	rare	occasional	often
Easily enraged	rare	occasional	often
Mental Sluggishness	rare	occasional	often
Reduced Initiative	rare	occasional	often

Frequent Colds or Flu	rare	occasional	often
Frequent Asthma or Bronchitis	rare	occasional	often
Bruise Easily	rare	occasional	often
Frequent Urination	rare	occasional	often
Wounds Heal Slowly	rare	occasional	often

IMPORTANT

Please list below your five (5) greatest health concerns in order of importance.

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

Please tell us briefly how you heard about Carmel Clinic:
