WHOLE FAMILY
MEDICINE

465 Winn Way
Suite 215
Decatur, Georgia 30030
p| 404.377.9010
f| 877.534.4019

PATIENT INFORMATION

PATIENT NAME: ______________________________ SEX: M____ F____

STREET ADDRESS: ______________________________ CITY: ____________

STATE:__________ ZIP:________ DATE OF BIRTH:______________ AGE:________

MARITAL STATUS: S____ M____ D____ W____ SOCIAL SECURITY #:____________

EMAIL ADDRESS:______________________________

HOME #:______________ CELL#:______________ WORK #:______________

EMERGENCY CONTACT:______________________________ PHONE #:____________

RELATIONSHIP TO PATIENT:______________________________

EMERGENCY CONTACT ADDRESS:______________________________

PHARMACY & PHONE #:______________________________
NAME

OTHER FAMILY MEMBERS SEEN HERE:

INSURANCE INFORMATION

SUBSCRIBERS NAME:______________________________ DATE OF BIRTH: ____________

STREET ADDRESS:______________________________

CITY:______________ STATE:______________ ZIP:______________

PATIENTS RELATIONSHIP TO SUBSCRIBER:______________________________

PRIMARY INSURANCE PLAN NAME:______________ ID#________ GROUP #________

SECONDARY INSURANCE PLAN NAME:______________ ID#________ GROUP #________

(BE SURE TO READ WHOLE FAMILY MEDICINE'S OFFICE POLICY DOCUMENT ATTACHED. MORE DETAILED INFORMATION ABOUT PROCEDURES/COVERAGE & BILLING IS DISCUSSED ON THE FOLLOWING PAGES.)

AUTHORIZATION FOR TREATMENT: I consent to examination, treatment and any procedures including emergency treatment deemed necessary and ordered by our physician/providers and I am personally responsible for any charges. **AUTHORIZATION FOR INSURANCE**: I authorize release of any information concerning myself, or child, to my insurance company regarding treatment for services rendered. **AUTHORIZATION FOR INSURANCE BENEFITS**: I authorize my insurance company to send payment directly to Whole Family Medicine, LLC for services covered by the insurance plan. **AUTHORIZATION OF RECEIPT OF PRIVACY NOTICE/PRACTICE POLICY INFORMATION**: I hereby acknowledge that Whole Family Medicine, LLC has provided me a copy of their Privacy Notice/Practice Policy information. **AUTHORIZATION TO CONTACT ME**: I authorize Whole Family Medicine, LLC to contact me by phone electronic mail or US mail to provide a reminder of appointment, gather demographic or insurance information, or to inform me of services or events offered at the facility. I have read Whole Family Medicine's Practice Policies information.

I authorize Whole Family Medicine to send lab results and other personal information to the above email account. I understand this information may contain my date of birth.

______________________________ ______________________________
SIGNATURE DATE

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PATIENT FINANCIAL POLICY

OUR POLICY requires payment at the time of service. If you are a member of a HMO, POS or PPO plan who has chosen us as your provider of care, it is your responsibility to:

- Provide us with the information required in filing a claim: the insurance card, patient ID number employer, date of birth, address and social security number. The above information is requested on the Patient Registration form, completed during the initial or subsequent visit.

- Pay your deductible, co-payment, or total balance at time of service, if applicable. Failure to do so can and will result in a $50.00 surcharge to your account.

- Make sure we have a current referral form on file if required by your insurance plan. If we do not have a referral on file at the time of your visit, your insurance company may hold you responsible for all charges. You may also be sent back to your Primary Cary Physician prior to begin treated in order to obtain a referral authorization.

It is our responsibility to:

- Submit a claim to the insurance carrier provided
- Provide the insurance carrier with the necessary information, to determine the medical and surgical care received.

If your insurance carrier has not chosen Whole Family Medicine, LLC as one of their participating providers, we will:

- Require payment at the time of service
- Assist the patient in submitting the proper documentation so that they can file the claim: detailed statement summary, proper ICD-9 and CPT codes
- We gladly accept cash and personal checks with proper identification. (Please note: A $25.00 overdraft charge will be added to all returned checks).

Missed appointments: you may be charged a no-show fee of $50.00 for a missed appointment.

When you bill remains unpaid, a collection agency may be chosen to manage delinquent accounts. If your account is placed with a collections agency, the patient will be charged a 30% surcharge. The patient is solely responsible for all costs of collections.

Thank you for choosing Whole Family Medicine, LLC for your entire healthcare needs!

I have read and fully understand my financial responsibilities under this policy.

____   ______________________________
SIGNATURE (printing name is acceptable in lieu of signature)   DATE

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WAIVER OF LIABILITY FOR NON-COVERED SERVICES

Dear Managed-Care Beneficiary:

The managed-care contractor with whom you have been insured (e.g. HMOs, PPOs, etc.) many do not cover some services provided at Whole Family Medicine, LLC. Each insurance carrier has certain criteria on which they base payment decisions. Dr. Owen will do her best to anticipate what services will not be covered, but each company has different rules & policies about such things. By signing this waiver, you are agreeing to pay Whole Family Medicine, LLC, directly for any charges not covered by your insurance company.

I, ____ understand that my insurance carrier may not pay for some services. I understand that it is my responsibility to contact my insurance company to determine if coverage is available. If coverage is not available and I choose to obtain the service, I agree to pay personally for the service(s).

____ ______________________________
SIGNATURE (printing name is acceptable in lieu of signature) DATE

____ ______________________________
SIGNATURE (printing name is acceptable in lieu of signature) DATE

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

- I hereby give my consent for Whole Family Medicine, LLC, to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).
- The Notice of Privacy Practices provided by Whole Family Medicine, LLC, describes such uses and disclosures more completely

I have the right to review the Notice of Privacy Practices prior to signing this consent. Whole Family Medicine, LLC, reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Whole Family Medicine, LLC.

With this consent, Whole Family Medicine, LLC, may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among other.

With this consent, Whole Family Medicine, LLC, may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient health records.

With this consent, Whole Family Medicine, LLC, may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Whole Family Medicine, LLC, restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Whole Family Medicine, LLC, to sue and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Whole Family Medicine, LLC, may decline to provide treatment me.

____

SIGNATURE OF PATIENT or LEGAL GUARDIAN (printing name is acceptable in lieu of signature)

____ ____________________________

PRINT PATIENTS NAME DATE

____

PRINT NAME OF PATIENT or LEGAL GUARDIAN (if applicable)

Names of people with whom my medical conditions and any related to my relationship to Whole Family Medicine, LLC, may be discussed:

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INFORMED CONSENT TO ROUTINE PROCEDURES/TREATMENTS

** DO NOT SIGN THIS FORM WITHOUT READING/UNDERSTANDING ITS CONTENTS**

I understand that Physicians rendering the services at Whole Family Medicine, LLC, are owners, employees or independent professionals engaged in the private practice of medicine.

1. I acknowledge and understand that during the course of my/my child's care and treatment, it is likely that various types of routine diagnostic and treatment procedures ("Procedures") may be utilized, which are considered necessary techniques for the ordinary care and treatment of condition(s).
2. While these types of Procedures are routinely performed in hospitals and doctors' offices without incident, there are certain risks associated with each of these Procedures.
3. The physician or his/her associates or assistants are responsible for providing me with information about the Procedures and for answering all of my questions. It is not possible to enumerate each and every risk for every Procedure utilized in modern health care. However, physicians who practice medicine at Whole Family Medicine, LLC, have attempted to identify the most common Procedures, their associated risks and possible alternatives. If I have further questions or concerns regarding these Procedures, I agree to ask my/my child's physician to provide additional information.

The Procedures referenced herein may include, but are not limited to, the following:

a) Needle sticks, such as shots, injections or intravenous injections (IV's). The risks associated with these types of Procedures include, but are not limited to, nerve damage, causing tingling or burning, infection, swelling, bruising, infiltration (fluid leakage into surrounding tissue), skin sloughing, bleeding, clotting, allergic reactions or paralysis. Alternatives to Needle Sticks (if available) include oral, rectal, nasal or topical medications (each of which may be less effective) or refusal of treatment.
b) Physical test and treatments, such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, rehabilitation procedures, etc. which may be utilized in conjunction with diagnosis and treatment. The risks associated with these types of Procedure include, but are not limited to, reactions to the material(s) used, infection, bleeding, discomfort, muscular-skeletal or internal injuries, nerve damage, paralysis, bruising, worsening of the condition and/or refusal of treatment, no practical alternatives exist.
c) Medications/drug therapy, which may be utilized in the care and treatment of patients. The risks associated with these types of Procedures include, but are not limited to, food-drug-herbal interactions, allergic reactions, adverse reactions, drug dependency and both long and short-term side effects, which vary from medication to medication. Apart from varying the medication prescribed and/or refusal of treatment, no practical alternatives exist.

____ ________________________________

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FUNCTIONAL MEDICINE LABORATORY TESTING INFORMED CONSENT

The purpose of functional medicine laboratory testing in our office is to evaluate nutritional, biochemical or physiological imbalance and to determine any need for medical referral. These lab tests in our office are not intended to diagnose disease. This office utilizes conventional lab tests as well as functional medicine assessment.

Functional medicine assessment is designed to assist our doctors and other healthcare providers in finding the underlying causes of your condition. Functional medicine has evolved through the efforts of scientists and clinicians from the fields of clinical nutrition, molecular biology, biochemistry, physiology, conventional medicine and a wide array of scientific disciplines. Functional medicine evaluates the body as a whole, with special attention to the relationship of one body system to another and the nutrient imbalances and toxic overload that may adversely affect these relationships.

Your medical physician may or may not agree with the necessity for – or our interpretation of – these tests. Please discuss any questions or concerns with our doctors.

I have read and understand the above:

____ ________________________

SIGNATURE (printing name is acceptable in lieu of signature) DATE

____

PRINT NAME

____ ________________________

WITNESS SIGNATURE (to be completed by office staff) DATE

WHOLE FAMILY
MEDICINE

MEDICAL SYMPTOM QUESTIONNAIRE

BASED ON THE PAST 30 DAYS rate each of the following symptoms based upon your typical health profile.

NAME ______________________________ DATE ____________________

Please use the scale shown below to describe the severity of your symptom (please total each section)

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

HEAD

Score	Symptom
____	Headaches
____	Dizziness/Faintness
____	Insomnia
0	**TOTAL (this section)**

EYES

Score	Symptom
____	Watery or itchy eyes
____	Swollen, reddened or sticky eyelids
____	Dark circles under eyes
____	Vision problems (excluding near or farsighted)
0	**TOTAL (this section)**

EARS

Score	Symptom
____	Itchy ears
____	Frequent ear infections
____	Popping of ears
____	Ringing in ears
0	**TOTAL (this section)**

NOSE

Score	Symptom
____	Stuffy nose/Excessive mucus formation
____	Sinus problems
____	Hay fever/Sneezing attacks
____	Nose bleeding
0	**TOTAL (this section)**

MOUTH/

Score	Symptom
____	Gagging, frequent need to clear throat
____	Sore throat, hoarseness, loss of voice
____	Swollen/Discolored tongue, gums, lips
____	Canker sores
0	**TOTAL (this section)**

SKIN

Score	Symptom
____	Acne
____	Hives, rashes, dry skin
____	Hair loss
____	Excessive hair growth
____	Excessive sweating/Body odor
____	Flushing, hot flashes
0	**TOTAL (this section)**

HEART

Score	Symptom
____	Irregular or skipped heartbeat
____	Rapid or pounding heartbeat
____	Chest pain
0	**TOTAL (this section)**

LUNGS

Score	Symptom
____	Chest congestion
____	Asthma, frequent bronchitis
____	Difficulty breathing
____	Frequent coughing
0	**TOTAL (this section)**

DIGESTIVE TRACT

Score	Symptom
____	Nausea, vomiting
____	Diarrhea, loose stools
____	Constipation, hard/infrequent stools
____	Bloated feeling
____	Belching, passing gas, burping
____	Heartburn/acid taste in mouth
____	Intestinal/stomach pain
0	**TOTAL (this section)**

JOINTS / MUSCLE

Score	Symptom
____	Pain or aches in joints/Arthritis
____	Warm, swollen joints
____	Stiffness or limitation of movement
____	Pain or aches in muscles
____	Muscle weakness
0	**TOTAL (this section)**

WEIGHT

Score	Symptom
____	Excessive eating/drinking
____	Strong/Excessive craving certain foods
____	Overweight/Obese
____	Difficulty losing weight
____	Water retention
____	Difficulty gaining weight
0	**TOTAL (this section)**

ENERGY / ACTIVITY

Score	Symptom
____	Fatigue from mental exhaustion
____	Fatigue from emotional exhaustion
____	Hyperactivity (mind or body)
____	Restlessness (mind or body)
0	**TOTAL (this section)**

MIND

Score	Symptom
____	Poor memory
____	Confusion, poor comprehension
____	Poor concentration
____	Poor physical coordination
____	Difficulty making decisions
____	Speech difficulty
____	Learning disabilities
0	**TOTAL (this section)**

EMOTIONS

Score	Symptom
____	Mood swings
____	Anxiety, fear, nervousness
____	Anger, irritability, aggressiveness
____	Depression/Sadness
____	Obsessive, compulsive behaviors
0	**TOTAL (this section)**

OTHER

Score	Symptom
____	Frequent illness
____	Frequent or urgent urination
____	Genital itch or discharge
0	**TOTAL (this section)**

SUM OF ALL SECTIONS ABOVE: 0