performance MEDICINE for total health

Medical Information Release Form

HIPAA Release Form

Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me. This information may be released to:

[ ] Spouse _____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ]my cell number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is

(day) _____**between (time)** _____

Signed: _____ **Date:** ____/____/____

Witness: _____ **Date:** ____/____/____

MEDICAL HISTORY FORM

Name _____ DOB _____

General State of Health: Excellent Good Fair Poor

Marital Status: Single Married Widowed Seperated Divorced

Occupation/ Job: _____

Number of Children: _____

Do you smoke? ☐ yes ☐ no
_____ packs per day _____ smoking years

Do you drink alcoholic beverages? ☐ yes ☐ no
How much? _____

Are you on any type of diet? _____

Are you happy with your weight? _____

Do you exercise? ☐ yes ☐ no
How much? _____

Who is your regular doctor? _____

When was your last physical exam? _____

Reason for today's visit?
_____
_____
_____

Do you have hormone issues? ☐ yes ☐ no
If yes, please explain:
_____
_____
_____

Previous Hospitalizations and/or surgery:
_____
_____
_____

Current Medications (include over the counter):
_____
_____
_____
_____
_____
_____
_____
_____

Family History	Age	Present Illness	Cause of Death
Mother			
Father			
Brothers & Sisters			

Is there a FAMILY HISTORY OF: (Please circle if appropriate)

High Blood Pressure	Depression
Sugar Diabetes	Psychiatric Illness
Overweight	Alcoholism
High Cholesterol	Bleeding Disorder
Heart Attack	Anemia
Stroke	Glaucoma
Tuberculosis	Lung Cancer
Lung Problem	Breast Cancer
Asthma	Colon Cancer
Stomach Cancer	Other Cancer

PAST MEDICAL HISORY: Have you had any of the following illnesses or disorders?

Heart Problems	Birth Defects
High Blood Pressure	Arthritis
Sugar Diabetes	Thyroid Problem
Overweight	Gout
Stroke	Anemia
Chronic Bronchitis	High Cholesterol
Emphysema	Bleeding Problems
Asthma	Glaucoma
Tuberculosis	Suicide Attempt
Hepatitis	Depression
Ulcer	*Other disorders of:*
Urinary Stone	Breast
Urinary Infection	Blood Vessels
Seizures	Stomach
Migraines	Bowel
Decreased Vision	Gallbladder
Decreased Hearing	Pancreas
Black Lung	Kidneys
Venereal Disease	Prostate

FEMALE HISTORY:

Age of onset of periods?_____
Are your periods regular? _____
# of Pregnancies _____ # of Miscarriages _____
Date of last menstrual period _____
Are you pregnant? ☐ yes ☐ no
Form of birth control? _____
Age of "Change of Life" _____
Do you do self breast exams? ☐ yes ☐ no

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PATIENT NAME:_____**DOB:**_____

UPDATED MEDICATION AND ALLERGY LIST

Medications

Name of medication, indicate if pills, ointment, drops, etc.	Dose each time?	How often?	For what medical condition is this medication prescribed?	UTD	INITIALS	DATE

Allergies

Please list any allergies or adverse reactions you have had.	What kind of reaction did you experience?	When did this reaction first occur

New Prescription Refill Policy

Currently our office receives a large volume of calls daily for medication refill requests. Our office staff can no longer safely manage this volume of phone requests. As of August 2015, we have a new prescription refill policy. We understand that this is a change for both you and us. We hope to work together to ensure safe and high quality medical care.

1. Before you come to your regular appointment, you should look over your medications to determine if you need to request any new prescriptions at your appointment.
2. We do require office visits on a regular basis for all of our patients taking prescription medication. The interval will vary depending on the type of medication prescribed. Please be sure you have enough medication to last until your next scheduled visit.
3. Please bring all your prescription bottles with you to your appointment. This is important to make sure that you are taking the correct medications and the correct doses. We will continue to take the time to carefully review your medications and write refills at your office visit. We will also ask you to review the new prescriptions to make sure that they are written correctly.
4. As part of our new policy, we offer the following options for prescription refills:

a. We can provide written prescriptions.
b. Prescriptions for attention deficit disorder medication must be printed and picked up at our office.

5. Our new policy will be to call in appropriate requests for prescription refills **within 3 business days**. We have written prescriptions available within 4 business days. Please let our staff know if your request is urgent or if you are out of medication, in which case we will try to provide refills sooner. We certainly strive to complete refill requests as soon as possible.
6. Only prescriptions provided by our office will be refilled. We will not refill medications prescribed by other providers.
7. New symptoms or events require an appointment. Your provider will not diagnose or treat over the phone.
8. It is important to keep your scheduled appointment to ensure that you receive timely refills. All prescriptions require a follow up appointment every 3-6 months.

We understand that there might be a situation when you do have to call us for a prescription. Please look at the list below and see what you can do to avoid incurring a prescription refill fee.

- **Are you changing to a new local pharmacy?** You should call your new pharmacy and request that your prescriptions be transferred from your old pharmacy. We sometimes do not have to write new prescriptions.
- **Are you going on an extended vacation and need to use an out-of-town pharmacy?** You need to call the NEW pharmacy that you will be using and have them contact your hometown pharmacy to have your prescriptions transferred. When you return home, you have to reverse the process.
- **Are you changing to a new mail order pharmacy?** Some pharmacies will transfer your prescriptions to the new pharmacy. If you still have refills on your current prescriptions, please check with your current mail order pharmacy to see if your prescriptions can be transferred.

By signing this form you acknowledge that you have received and read the Prescription Refill Policy for Performance Medicine and that you agree to follow the policy regarding prescriptions provided by our office.

_____
Print Name

_____ _____
Signature Date

PERFORMANCE MEDICINE

(PLEASE PRINT)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	◻ Mr. ◻ Mrs.	◻ Miss ◻ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

EMAIL:	Sex: ◻ M ◻ F	Birth date: / /	Age:	Cell phone: ( )

Street address:	Social Security no.:	Home phone : ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	◻ Dr.	◻ Insurance Plan	◻ Hospital

◻ Family	◻ Friend	◻ Close to home/work	◻ Yellow Pages	◻ Other

Other family members seen here:

Medication Allergies:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

PAYMENT IS EXPECTED AT THE TIME OF SERVICE: Payment can be made with cash, check, credit card, HSA account or Care Credit. **WE DO NOT FILE ANY INSURANCE**. If you desire we will provide you with an itemized receipt to file with your insurance. **YOU CAN NOT FILE MEDICARE, AS I AM NOT A MEDICARE PROVIDER.**

CURRENT CLINIC POLICES:

- We do not take care of hospitalized patients.
- We do not take calls outside of office hours. If you feel that you need medical attention when our office is closed, we recommend that you use the ER at one of the local hospitals.
- **WE DO NOT TREAT CHRONIC PAIN THAT REQUIRES NARCOTIC PAIN MEDICATIONS**.
- This is not a primary care office. I do not follow chronic, ongoing care, so the patient understands and is encouraged to have a primary care physician. We take no responsibility for any other medical condition known or unknown you might have and **you are responsible for seeing your primary health care provider for complete medical care.**
- Aesthetic procedures may not always have the desired outcome and patient assumes risk of any adverse side effects.
- The weight loss program doesn't work for everyone. Diet and exercise play a big part and physician has made no guarantees or claims that treatments will be successful. The weight loss shot is not FDA approved nor is it required to be as with this or any injection. There could be a reaction and patient agrees to assume any risk of injury or loss. All the ingredients of the weight loss shot or obtained from an FDA approved facility.

INFORMED CONSENT: I am giving my consent for the physician and Performance Medicine to evaluate and treat the patient named above. I understand that I am responsible for paying my bills at the time of services.

Patient Signature **Date**

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VITAMIN AND SUPPLEMENT LIST

VITAMIN/SUPPLEMENT NAME	BRAND	HOW OFTEN DO YOU TAKE IT	REASON FOR TAKING

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I Understand that by signing this consent I authorize you to use and disclose my protected health Information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____ 20_____.

Print Patient Name _____

Signature _____

Relationship to Patient _____