Performance Medicine Cancellation, NO Show, and Fee for Additional Services Policy

With the rise in refill request, new prescription request, and paperwork request, as well as cancellations and no-shows we are now implementing an additional service and cancellation policy into place.

Cancellations and No-Shows:
We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide at least a 24-hour notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With Cancellations made less than 24 hours' notice, we are unable to offer that slot to other people.
Office appointments which are cancelled with less than 24 hours notification will be charged a $25.00 cancellation fee.
Patients who do not show up for their appointment without a call to cancel an office appointment will be considered as NO SHOW. Patients who No-show two (2) or more times in a 12-month period, may be dismissed from the practice thus they will be denied any future appointments. **Patients will also be subjected to a $25.00 fee for office appointment NO Shows.**
The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.
We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Additional Services:
If anything is needed in between your 6 month follow up appointment like: refill or new prescriptions request, paperwork for school, work, disability and medical records. **These request will come with a $15.00 fee, or the patient can schedule an appointment.** The payment will be taken at the time of the request before it is put on the providers desk or nurses' desk. If a pharmacy requests a prescription request, we will call the patient to see if they want to pay the fee or schedule an appointment with a provider. If you are past due for a follow up appointment, we will only refill your prescription for 1 month and have you set up a follow up appointment. We request that you take care of all your prescription or paperwork needs for the next 6 months at the time of your appointment, for each request we receive it takes up valuable staff time and time away from the patients in our office. We will call in refill request within 3 days of request. Exceptions: Testosterone, Adderall or any controlled substance can not be refilled without and appointment.

Our practice firmly believes that a great Physician/Patient relationship is based upon understanding and communication. Questions about cancellation, no-show fees and additional services please contact our office.

Please sign that you have read, understand and agree to this Cancellation and No-Show Policy.

_____	_____
Patient Name (Print Please)	**Date of Birth**
_____	_____
Patient Signature	**Date**
_____	_____
Practice Representative	**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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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:** ____/____/____

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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

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 _____

PERFORMANCE MEDICINE

109 JACK WHITE DRIVE KINGSPORT TN 37664

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