

# Patient Registration Form

Patient Legal Name: -----/-----/  
Last First MI

DOB-----

Address: -----/ City ----- State -----Zip-----

Phone: Home ( ) ----- Work ( ) ----- Mobile ( ) -----

Marital Status: [ ] M, [ ] S, [ ] D, [ ] W

Occupation: -----

Work address: -----

Name of Emergency Contact: ----- Phone Number ( ) -----

How did you hear about us?

1. Internet
2. Friends and Family Members
3. Yellow Pages
4. Drive by
5. Other \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Name Telephone Address

# Medical History Form

## Health History

List the main problems that you are having, or reason for this appointment:

Any insights to the cause of your symptoms

Any insights to the treatment of your symptoms

### **Past Medical History:**

Major Illnesses:

Accidents or major trauma (Scars –Please give location)

Hospitalizations/Surgeries – please give month/year if possible:

Dental Procedures (root canals, etc.)

Allergies and Sensitivities: Foods, environmental, etc.–Ever tested? Copies of reports?

Occupational Exposures:

**Vaccinations:**

( ) DPT (Diphtheria, Pertussis, Tetanus) Year(s) \_\_\_\_\_

( ) Booster (Usually DT) Year(s) \_\_\_\_\_

( ) Polio injection ( ) Polio oral Year(s) \_\_\_\_\_

( ) MMR (Measles, Mumps, Rubella) Year(s) \_\_\_\_\_

( ) HBV (Hepatitis B Vaccine) Year(s) \_\_\_\_\_

( ) Other (Flu shots, etc.) Year(s) \_\_\_\_\_

**Women:**

Last Pap \_\_\_\_\_ First day of last menstrual period \_\_\_\_\_

Marital history: Years married \_\_\_\_\_ # of children \_\_\_\_\_ Ages \_\_\_\_\_

No. of Pregnancies \_\_\_\_\_ Deliveries \_\_\_\_\_ Complications \_\_\_\_\_

**Lifestyle Factors (Please fill in the approximate amounts):**

Never/ Occasionally /Weekly /Daily

Coffee \_\_\_\_\_

Tobacco \_\_\_\_\_

Alcohol \_\_\_\_\_

**Exercise Activities**

How much and what type? (Explain)

**Nutrition**

How is your diet? Your weight? (Explain)

**Sleep**

Problems falling asleep? Sleeping too much or not enough? (Explain)

## Medications& Supplements

| Medication Name | Dosage & Frequency | Starting Date | Stop Date |
|-----------------|--------------------|---------------|-----------|
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| Herbs, Vitamins & Supplements | Dosage & Frequency | Starting Date | Stop Date |
|-------------------------------|--------------------|---------------|-----------|
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## Consent for Treatment

### ***Release and Authorization***

I understand that Carolina Integrative Clinic (“CI Clinic”) is an integrative treatment center, employing conventional therapies as well as innovative therapies, and that some of these therapies are not FDA approved. I hereby voluntarily request, authorize and consent to the medical care, including diagnostic treatments as deemed appropriate by and delivered by CI Clinic providers, related to health problems for which I have sought the services of CI Clinic. I understand that CI Clinic is not a my primary care clinic and that I am required to maintain an established relationship with a primary care provider (“PCP”) as well as any specialists that may be required. I understand that I will see my PCP for my yearly complete physical exam including applicable procedures such as a prostate exam, breast exam, Pap, mammogram and other x-rays, appropriate laboratory tests, etc. I understand that I will address any health issues, acute illnesses or drug and surgical complications to my PCP or my local emergency room. I further understand that CI Clinic providers are not on call, do not provide walk-in or emergency services, do not keep customary office hours and will be available on an appointment basis only.

I authorize CI Clinic to obtain my medical records, X-ray/Lab reports, or other health-related information deemed necessary to allow CIC providers to appropriately diagnose and/or treat my medical condition(s).

### ***Payment Requirements***

Appointments must be paid for at time of service. We accept Visa, MasterCard, check, cash, or Traveler’s checks. You will be charged a \$25 fee for returned checks.

### ***Health Insurance***

**I understand that CIC does not contract with any insurance company, including Medicare and Medicaid.** I acknowledge that I will be required to pay for all charges that are incurred. I have been given no assurance that I will receive insurance reimbursement for any of the charges incurred at CI Clinic. I understand that I will be given itemized codes for office visit charges at CI Clinic and it will be my responsibility to file with my insurance company for reimbursement. I understand that I may be unable to receive reimbursement from my insurance carrier for consultations, recommended laboratory tests or recommended therapies or supplements. I understand that my ability to receive reimbursement for office visit charges will be dependent on my insurance carrier policies. I understand that Carolina Integrative Clinic has opted out of the Medicare program and Medicare will not reimburse for any fees paid to CI Clinic.

### ***Cancellation/No Show Policy***

In case of cancellation, in order to allow another patient the opportunity to utilize your appointment time, we require that you notify our office no less than 48 business hours in advance. If you fail to give us 48 business hours advanced notification for cancellation of a regularly scheduled office visit or are unable to keep your appointment there will be a \$100.00 fee charged. If you fail to give us 48 business hours advance notification for cancellation of regularly scheduled new-patient evaluation, you will forfeit the \$100 deposit for this appointment and no refunds will be made. We reserve the right to cancel any appointment without a cause in which case the patient will not incur any cost.

I acknowledge that the \$100 deposit reserves my initial appointment time and will be applied to the cost of my initial evaluation. I also acknowledge that I will be responsible for the payment of the remaining balance at the time of service.

**There will be no exceptions to this policy under any circumstances, and we ask that all patients respect our staff and their time.**

### ***Medications and Nutritional Supplements***

I understand that medications and nutritional supplements may be recommended as component of my treatment program. These medications and supplements are for sale at Carolina Compounding Pharmacy, but they may also be purchased elsewhere. I am free to purchase my supplements at Carolina Compounding Pharmacy, or at any other pharmacy or retail store. I do understand that all supplements purchased elsewhere may not be comparable with regards to quality, and benefits and effects may vary depending on

the product. I understand that I am expected to use medications and supplements as directed and to report any side effects to my doctor or pharmacist immediately.

***Requests for Prescriptions***

Patients should always bring ALL of their pharmaceutical prescriptions and current supplements to every office visit so the doctor knows exactly what you are taking, the dosage, and how many refills are remaining. Any change that you like to have made to your medications prescribed by a CI Clinic provider, as well as all requests for refills, should be discussed during your regularly scheduled office visit.

***Copying Medical Records***

There will be a fee of \$.50 per page, with a \$10 minimum charge.

***Letters of Medical Necessity***

Occasionally, patients will request letters of medical necessity to be written by the doctor to assist them in obtaining insurance coverage for certain laboratory tests or therapies recommended by CIC. As a service for our patients, the doctor will perform a chart review and provide a letter reviewing your health history, previous testing and treatment, current laboratory results, treatments provided or planned outcome, and prognosis. **There will be a \$40.00 fee charged for a letter of medical necessity. If you have not been seen within the past year, you will be required to have a follow-up office visit before such a letter can be written.**

I have read and fully understand and acknowledge all of the information contained in this document. I have had the opportunity to ask any questions, and I have asked all questions that I need to ask regarding any of this information. Today, the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Patient (or Patient Guardian) Signature