

Center of Integrative Medicine

Putting the well into being

Contact Information

First Name: _____ Middle: _____ Last: _____

Address: _____ City: _____ State: _____ Zip: _____ Date of Birth: ___/___/___

Home: () _____ Work: () _____ Cell: () _____ Best number to reach you () _____

Occupation: _____ Employer: _____

Place of Birth: _____ Sex: F _____ M _____ Single: _____ Married: _____ Other: _____
City/town and Country

SS # _____ Email address: _____

Insurance Information: Insurance Co. _____ Policy # _____

Name of Insured: _____

Insured's Address: _____ City: _____ State: _____ Zip: _____

Tel.#() _____ Insured's Date of birth: ___/___/___

Emergency Contact/Relationship: _____ Referred by: _____

Please list any and all prior experiences with Integrative /Alternative medicine: _____

Reason for visit: Wellness _____ Specific problem(s) _____

Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/MODERATE/SEVERE	TREATMENT APPROACH	SUCCESS
Example: Post nasal drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			
e.			
f.			

WHAT ARE YOUR EXPECTATIONS FOR COMING TO THE CENTER OF INTEGRATIVE MEDICINE: _____

My permission is granted to *Center of Integrative Medicine, LLC* to obtain necessary medical attention in case of sickness or injury for

(Participant's name)

I, the understood, do hereby release, remiss and forever discharge *Center of Integrative Medicine, LLC*, Yedda Stancil, all employees, contractors, and sponsors from any and all claims, demands, actions, or cause of actions past, present, or future arising out of any damage or injury while participating in Body Age testing, personal training, and/or other services.

Signature: _____ Date: _____



RECORDS RELEASE

Date: _____

1. To: _____

Phone: _____ Fax: _____

2. To: _____

Phone: _____ Fax: _____

I hereby authorize and request you to release the complete medical records, office note, X-Ray reports, MRI / CT reports in your possession to:

DOB: _____

SSN: _____

Signed: _____

Name: _____

*Center of Integrative Medicine
3536 Grove Avenue
Richmond, VA 23221
Phone: 804.353.WELL (9355)
Fax: 804.353.9383*

***PATIENT IS HERE NOW FOR TREATMENT, SO IF YOU
COULD PLEASE FAX THE ABOVE INFORMATION
REQUESTED, IT WOULD BE GREATLY APPRECIATED.***

(Please do not send original films unless indicated)

Notes:

Center of Integrative Medicine, LLC

Putting the Well into Being

MEDICAL SERVICES CONTRACT

I hereby authorize **Center of Integrative Medicine, LLC** to render medical services to me (or child) and to release any information regarding my medical history, diagnosis and treatment of myself (of child, if applicable) to my insurance company regarding my claim for physician services, nutrition education, exercise therapy, and/or behavior modification and to my (or child's) primary care physician. I authorize payment directly to **Center of Integrative Medicine, LLC** for the benefit otherwise payable to me under the terms of my insurance. I understand that **Center of Integrative Medicine, LLC** will file my insurance; however, if the insurance company payments are not timely, it is my responsibility to pay **Center of Integrative Medicine, LLC** and pursue my recovery with the insurance carrier. I understand that I am financially responsible for all charges arising from physician, nutrition, exercise and behavior modification services which are separate services and may have separate co-pays and/or coinsurance. Furthermore, I understand that I am also responsible for court testimony, medical reports, and any other charges arising from said treatment of necessary. I hereby further assign the causes of action I have said to the doctor on any and all proceeds of any medical payment, insurance benefits and (if applicable) on any settlement or judgment arising from the injuries for which I have been treated. If this contract is referred to an attorney or collection agency for collection, I agree to pay all attorney or collection fees in the amount of thirty-three point three percent (33.3%) of total indebtedness and court costs incurred by **Center of Integrative Medicine, LLC**. If this indebtedness is not paid in full within sixty days, I agree to pay a service charge of one and one-half percent (1 ½ %) per month, eighteen percent (18%) per annum.

Patients Name: _____

Responsible Party/Patient's Signature: _____ Date: _____

3536 Grove Avenue, Richmond, Virginia 23221
PHONE: 804-353-WELL (9355) FAX 804-353-9383

Center of Integrative Medicine, LLC

Putting the Well into Being

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

In the course of your care as a patient at the Center of Integrative Medicine, LLC, we may use or disclose personal health related information about you in the following ways:

- Personal health information including clinical records may be disclosed to another health care provider or hospital as a means of communication about and coordination of your care.
- Billing and health care records may be disclosed to another party such as an insurance carrier or your employer, if they are or may be responsible for payment of your services.
- As a means by which a third party can verify that services billed were actually provided.
- As a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.
- Your name, address, phone numbers and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider
- If we provide health care services to you in an emergency
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care
- If we are ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

- I request the following restrictions to the use or disclosure of my health information:
-
-

- I state that my health information can be released to the following family members or persons:
-
-

Center of Integrative Medicine, LLC

Putting the Well into Being

We normally provide information about your health to you in person at the time you receive care from us. We may also mail or email information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice.

If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any changes in our privacy notice will apply for all your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to the Office Manager.

This notice is effective as of _____ . This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (please print)

Signature

Date

If you are a minor, or if you are being represented by another party:

Personal Representative (please print)

Personal Representative Signature

Date

Description of the authority to act on behalf of the patient

No Show/Cancellation Policy

1. If a patient needs to cancel an appointment, at least 24 hours notice should be given.
2. When a patient does not show for treatment without notice, they will be given a verbal review of the no show/cancellation policy. After three consecutive no shows or three consecutive cancelled appointments, the patient will be discharged from the Center of Integrative Medicine.
3. When a patient has a 50% cancel/no show rate for appointments (example 3/6 or 5/10), the office manager or clinical director will discuss the problem with the patient to determine the reason(s). Problem solving will be done to help the patient decrease his/her cancel rate (example: Scheduling a more appropriate time, reminder phone call). If no show or cancel rate continues to be 50% or more after the problem solving, the patient will be discharged from the Center of Integrative Medicine.
4. The officers of the corporation can make exemptions to the above policy after review and discussion of each individual case.
5. Patients will review the above no show/cancellation policy at the first visit.
6. Patient will be responsible for a \$25 fee if he/she no shows or does not give 24 hours notice. This fee will only be waived in emergency situations.

I have read the above no show/cancellation policy of the Center of Integrative Medicine.

I understand that I am responsible for a \$25 fee if I no show or do not give 24 hour notice for my cancellations, with the exception of emergency situations.

Patient Signature

Date

Center of integrative Medicine
3536 Grove Ave.
Richmond, VA 23221
804-353-9355



I understand that at this time I do not have a referral. If for any reason I do not receive one, I am responsible for all services rendered here today.

Patient Signature

Date

Guardian Signature

Date

**3536 Grove Avenue
Richmond, VA 23221
Phone 804-353-WELL (9355)
Fax 804-353-9383**



Treatment and Payment Policies

- § If you do not have health care benefits, you are required, and you agree, to pay at time of service all charges as well as any outstanding balances and delinquent accounts.
- § The Center of Integrative Medicine allows more than the legal and customary amount of time after filing a claim to be reimbursed by insurance companies. If the Center of Integrative Medicine has not received a response within 90 days of having filed a claim for a visit, we will assume that the visit is not covered and is, therefore, your responsibility. At that time, to the extent permitted by law, we will bill you for the visit charges. Questions regarding non-payment by your insurance company should be directed to your insurance company, not to the Center of Integrative Medicine.

- § By signing this document, you agree that you have been advised that your insurance company may determine that the services provided (or to be provided) by the Center of Integrative Medicine during your visit are not covered under your insurance policy and agree that, if your insurance company determines that any services are not covered, you shall be responsible for, and shall pay for, the cost of any such services.
- § In the event that your plan requires approval or referral from your Primary Care Physician or insurer prior to a visit and you did not obtain that approval or referral, you will be responsible for, and agree to pay, any costs of care that your insurance company determines are not covered under your insurance policy and for which you may be held liable by applicable law.

Initial _____

- § You will be billed for all unpaid balances deemed by the Center of Integrative Medicine or your insurance company to be your responsibility. Unless you otherwise request, all bills and other communications from the Center of Integrative Medicine will be sent to your address of record at the Center of Integrative Medicine and will be in the name of the adult family member who initially established your account. You are responsible for notifying us if you wish for a different address or name to be used. You are responsible for paying the bill in full unless special arrangements have been approved in advance by calling the Patient Accounts phone number printed on the billing statement. Late fees of 1 ½ % per month will be charged on balances that are still unpaid starting 30 days after the first statement. There is a fee of \$20 for returned checks. Delinquent accounts will be turned over to a collection agency at which time you will be responsible for collections charges and all associated legal fees in addition to the amount owed. The Center of Integrative Medicine reserves the right to deny non-emergency services if your account is delinquent.

I have read, understand, and agree to the Treatment and Payment Policies described above and understand that the Center of Integrative Medicine may refuse to treat me if I do not remain current in payments for medical services.

Patient or Guarantor Name (Printed) *Patient or Guarantor Signature* *Relationship to Guarantor* *Date*

Minor Patient's Name *Relationship to Guarantor* *Witness Signature* *Date*

*The terms "you" and "your" as used in this document mean the patient's Guarantor. A Guarantor is the individual who accepts financial responsibility for services rendered to the Patient. The Guarantor may be the patient, a family member, or a non-family member. In the event that the patient is a minor or legally dependent person, then the Guarantor must have the authority to take action on the patient's behalf. By signing this form as "Guarantor" on behalf of a minor or legally dependent person, you represent to the Center of Integrative Medicine that you have such authority.

Adult Medical Questionnaire

With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)

Example: Wendy, age7,sister _____

Do you have any pets or farm animals? Yes _____ No _____

If yes, where do they live? 1. _____ indoors 2. _____ outdoors 3. _____ both indoors and outdoors

Have you lived or traveled outside of the United States? Yes _____ No _____

If so, when and where? _____

Have you or your family recently experienced any major life changes? Yes _____ No _____

If yes, please comment: _____

Have you experienced any major losses in life? Yes _____ No _____

If so please comment: _____

How important is religion (or spirituality) for you and your family's life?

- a. _____ not at all important
- b. _____ somewhat important
- c. _____ extremely important

How much time have you lost form work or school in the past year?

- a. _____ 0-2 days
- b. _____ 3-14 days
- c. _____ >15 days

Previous jobs: _____

List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g. calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Supplement Name	Date Started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Are you allergic to any medications Yes _____ No _____

If yes, please list: _____

Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.?

Yes _____ No _____ Symptoms: _____

How well have things been going for you?

	Very Well	Fair	Poorly	Very Poorly	Does not apply
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					
f. With your attitude					
g. With your boyfriend/girlfriend					
h. With your children					
i. With your parents					
j. With your spouse					

Have you ever had psychotherapy or counseling?

Yes _____ No _____

Currently? _____ Previously? _____ If previously, from _____ to _____

What kind? _____

Comments: _____

FOR WOMEN ONLY

1. Have you ever been pregnant? (if no, skip to question 2)

Yes _____ No _____

Number of miscarriages _____ Number or abortions _____

Number of preemies _____

Number of term births _____ Birth weight of largest baby _____

Smallest baby _____

Did you develop toxemia (high blood pressure)?

Yes _____ No _____

Have you had other problems with pregnancy?

Yes _____ No _____

If so, please comment: _____

2. Age at first period _____ Date of last Pap Smear _____ Date of last Mammogram _____

Pap Smear: ___normal ___abnormal

Mammogram: ___normal ___abnormal

3. Have you ever used birth control pills? Yes ___ No ___ If yes, when _____

4. Are you taking the pill now? Yes ___ No ___

5. Did taking the pill agree with you? Yes ___ No ___ Not applicable _____

6. Do you currently use contraception Yes ___ No ___
If yes, what type of contraception do you use? _____

7. Are you in menopause? Yes ___ No ___ If yes, age at last period _____
Do you take: Estrogen? ___ Ogen? ___ Estrace? ___ Premarin? ___ Other (specify) _____
Progesterone? ___ Provera? ___ Other (specify) _____

8. How long have you been on hormone replacement therapy (if applicable)? _____

9. In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)?
Yes ___ No ___ Not applicable _____



Name _____ Date _____ DOB: _____

PERSONAL LIFESTYLE HABITS

Have you ever smoked ? (Circle Appropriate Response)	Yes	No
How many packs / day? _____		
How old were you when you started smoking? _____		
If you stopped, at what age? _____		
How much of the following alcoholic beverages do you drink in the average week?		
Cans / Bottles of Beer: _____		
Glasses of wine: _____		
Shots / Drink of Hard Liquor: _____		
Has anyone ever told you that your drinking is a problem?	Yes	No
Have you ever missed work or been hospitalized because of your drinking?	Yes	No
Do you (or have you) used recreational drugs ? If so, what type and how often?		
Do you have any other habits or activities that might put your health at risk? If so, please describe:		
Do you wear seat belts when in a car?		
	Yes	No
Do you drink caffeinated beverages ? If so, what type and how many per day?		
Do you have any regular form of exercise ? If so, please describe:		
Have you ever had any violence or abuse in your life situation? If so, please describe:		
Traumatic life experiences and dates: _____		
Positive life experiences and dates: _____		
Sleep/rest pattern: Hours/night _____ Nap _____ Difficulty falling asleep _____ Difficulty staying asleep _____		
Waking frequently at night _____ Use of sleep aides _____ if so, which ones?: _____		
Are you single? committed? married? divorced? separated? widowed?		
Who do you live with?		
What is your occupation ?		Where do you work?
What is the highest grade or degree you completed in school?		
What is your religious preference/spiritual practice ?		
Were you ever in the military ? If so, when and what branch?		
Are you a native of the Richmond area ? If not, from where and when did you relocate?		
What would you name as the primary stressors currently in your life?		
What strategies do you use to cope with stressors in your life?		
From the following list, please check all that describe your average diet:		
3 meals / day _____	# of glasses of water / day _____	Fruits and Vegetables _____
Low-Fat intake _____	Moderate-High Fat Intake _____	Low Sugar Intake _____
Red Meats _____	Herbs (Fresh or Prepared) _____	High Salt Intake _____
Whole Grains _____	Fish or Chicken _____	High Sugar Intake _____
"Fast Foods" _____	Daily Fiber / Bran _____	



Patient Name _____

Date _____

NUTRITION HISTORY

Please answer each of the questions below. The information you share will help the Registered Dietitian have a better understanding of your needs.

1. Are you concerned about your weight?

No (Skip to Question 4)

Yes, I want to stop gaining weight. (Skip to Question 4)

Yes, I want to lose weight.

2. What do you think weighing less would do for you?

In the next few months:

In the next year or two:

3. What is your goal weight? _____ lbs.

4. What was your lowest adult weight? _____ Age at this weight?

What was your highest adult weight? _____ Age at this weight?

5. Do you take any vitamin, mineral, herbal or other dietary supplements (for example, protein powders)?

Yes List: _____

No

6. Do you smoke cigarettes?

Yes – How many in a typical day? _____

No

7. Are you currently on a diet or taking prescribed or across-the-counter medication to lose weight or to maintain your current weight?

No

Yes, I am on a diet. Describe the diet.

Yes, I am on these medications.

8. Have you tried to lose weight in the past?

No

(Skip to Question 10)

Yes – check all that apply.

Diet(s) Describe:

Medications List:

Other Describe:

9. If yes to question 8, did you lose weight?

No

Yes _____ lbs. over this period of time:

How much of this weight, if any, did you gain back? _____ lbs.

What worked best for you and why?

10. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or not eating?

No

Yes

Fast Foods _____
Take-out from grocery or restaurant _____

23. Do you have a working stove, oven, and refrigerator where you live?

Yes

No - Explain: _____

24. Were there any days last month when your family didn't have enough to eat or enough money to buy food?

No

Yes

Please check to be sure you have answered all questions. Thank you!



Patient Name _____

Date _____

NUTRITION AND ACTIVITY HABITS

Put a check in the column that best describes your answers to the question below.

Food Choices	0 – 1 Times /Day	2 – 3 Times /Day	4 – 5 Times /Day	6 – 7 Times /Day
How many times a day do you:				
◆ Eat Vegetables (excluding French fries)				
◆ Eat fruit?				
◆ Eat whole grain breads and cereals?				
◆ Eat fried foods?				
◆ Drink sodas or sweetened fruit drinks?				
◆ Drink milk or eat dairy foods (cheese, milkshakes, yogurt)				
◆ What type of milk do you usually drink?				
Meal Patterns	0 – 1 Times / Week	2 – 3 Times / Week	4 – 5 Times / Week	6 – 7 Times / Week
How many times a week do you:				
◆ Eat breakfast?				
◆ Eat lunch?				
◆ Eat supper?				
◆ Eat supper with you family?				
◆ Eat meals away from home?				
Physical Activity	0-1 Times / Week	2- 3 Times / Week	4 – 5 Times / Week	6 – 7 Times / Week
How many times a week do you:				
◆ Participate in physical activity (walk, ride a bike, sports, aerobic exercise) for a combined total of 30 minutes of more?				
◆ Participate in resistance exercise for a combined total of 20 minutes of more?				
How many hour a day do you:	Less than 1 Hour /Day	1 – 2 Hours /Day	3 – 4 Hours /Day	5 or more Hours /Day
◆ Watch TV?				

◆ Use the computer, play video games and talk on the telephone?				
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Thank you for answering these questions!