FORT WAYNE INTEGRATIVE MEDICINE

FORT WAYNE PRIMARY CARE

Attention Patients

Please print and complete this form and bring it to your next Office Visit. If this is not possible, please arrive 30 minutes prior to your appointment to complete Patient Intake Forms.

New Patient Form

Patient Name:

First_____Last _____

Date of birth: __/____/____

Marital status: _____

Street Address_____City_____

State:_____Zip:_____

Telephone: _____Alternate Phone: _____

Cell Phone: _____

Email address: _____

I consent to email correspondence or appointment text reminders

(Please initial) _____Yes____No

What is your preferred pharmacy and location:

_____

Emergency Contact Information:

First name:_____Last name:_____

Telephone_____Relation to patient: _____

_____

How did you hear about our practice?_____Website_____Doctor referral_____

Family member_____Social media_____Referral_____Other_____

Please rank current and ongoing issues in order of priority

Description of problem	Mild	Moderate	Severe	Prior Treatment	Outcome: Fair	Good	Excellent
(Example: eczema)		x		steroid cream	x		
1							
2							
3							
4							
5							

Date of last physical: _____/_____/_____

How many hours of sleep do you get a night on average? ____

Do you have trouble falling asleep? _____Y_____N

Do you have trouble staying asleep? _____Y_____N

Do you currently exercise? _____Y_____N

If yes, how frequently do you exercise? _____

Are there any problems that limit exercise?__Y_____N

If yes, please explain

_____

_____

Do you follow any special diets or nutritional programs? (Vegan, vegetarian, gluten-free, high protein, etc.?) Circle one.

How many servings of fruit per day (Equivalent to a small apple) _____

How many servings of vegetables per day? (Serving = 1 cup) _____

How many days per week do you consume dairy products? (Milk, cheese, butter, goat or cow) _____

How many days per week do you consume gluten products? (Wheat, barley, rye)

_____

How often do you consume animal proteins? (Eggs, chicken, beef, fish)

_____

How many glasses of water do you drink per day? _____

How many cans of soda/sweet drinks do you drink per day? _____

How many alcoholic drinks per week? _____

Do you currently use tobacco products? ___Yes____No

What kind? _____

Check if you have had any of the following:

Silver mercury filling ___Gold filling_____

Root canal_____Dental implants____Caps/crowns____

Tooth pain_____Bleeding gums_____Gingivitis_____

Have you had any mercury fillings removed? ____Yes____No

When? _____

Are you experiencing any gut issues? ____Yes____No

Circle all that apply: Constipation, nausea, vomiting, diarrhea, indigestion, other_____

Do you currently take any probiotics? _____

Have you had any tick bites or exposure to ticks?_____Yes_____No

If yes, when? _____

Past Hospitalizations/Surgeries:

_____
_____
_____

Health History (Including any ongoing/chronic conditions)

_____
_____
_____

Immediate Family Medical History:

_____
_____
_____

Medications/Supplements (Provide dosage, frequency)

_____
_____
_____

Please list any known allergies (Drug, food/environment)

_____

Any chronic issues you'd like to discuss?

Fort Wayne Primary Care Payment and HIPAA Agreement

(A division of Fort Wayne Integrative Medicine)

Authorization to release medical information and assignment of insurance benefit.

X_____I authorize the release of any medical information necessary to process my insurance claim(s) and assign all medical and/or surgical benefits including major medical benefits, to *Fort Wayne Primary Care***.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. Even though I have provided all of my insurance information, I understand that I may be financially responsible for any balance not covered by my insurance. I agree to provide my most current insurance information and if any bills are not paid by the insurance because of outdated or inaccurate information, I agree to pay my entire bill in full – even though the bill might have been paid by insurance had I provided the correct information. I understand that holistic treatments are not a substitute for medical diagnosis and treatment, and no medical claims are made regarding these treatments.

Financial Agreement

X_____All *Fort Wayne Primary Care* account balances are due at the time of service. I understand and agree that (regardless of insurance coverage), I am ultimately responsible for any professional service rendered. I certify that this information is true & correct to the best of my knowledge. I will notify you of any changes in my insurance coverage, address, or health status. I accept this statement as notice from you that my insurance plan may not pay for any service that you provide to me because the service or procedure may not be covered by the plan or may not be considered medically necessary by the plan. I agree that all services and procedures that I receive from you have been requested by me with full knowledge that my insurance plan may not cover them.

Late Payments

X_____All past-due account balances may be assessed a *late payment fee* equal to 18% per annum on the delinquent balance. A *late payment fee* can be avoided by paying the account balance within 30 days of the mailing of the patient statement. Subject to such limitation as may be imposed by applicable law, if I have not made payment on my account as required, my account may be sent to an attorney or collection agency for collection, I will pay the reasonable fees of such attorney or collection agency, and all court costs to the extent provided by law as well as my total outstanding bill. No waiver by *Fort Wayne Integrative Medicine* or *Fort Wayne Primary Care* or any default hereunder shall constitute a waiver of any other default. The construction and enforcement of this Agreement shall be governed by the State of Indiana. Any provision of this agreement that may be prohibited by law shall be ineffective only to the extent of such prohibition. From time to time, *Fort Wayne Primary Care may* amend this Agreement by giving of such notice, if any, as may be required by applicable law. *Fort Wayne Primary Care* may assign the Agreement, or it's right hereunder, without notice to me.

Payments due at time of service

X_____I understand that, at the time of service, there will be a minimum charge equal to my copay amount

No-show/Cancellation Policy

X_____When you make an appointment, we are reserving time in our clinician's schedule that is no longer available to other patients. If you are unable to keep an appointment, *Fort Wayne Primary Care* requires that you cancel (or re-schedule) your appointment at least *24 hours in advance* (1 business day) excluding weekends and holidays.

If you cancel an appointment with less than a 24-hour notice or fail to appear in a timely fashion for an appointment, *Fort Wayne Primary Care* will charge the patient $25.00. This applies to new patients as well. Failure to show for your appointments (or violation of this cancellation policy) on two or more consecutive occasions can be grounds for discharge from the practice. *Note*: the cancellation fee may be waived in special circumstances, determined on an individual basis (i.e., medical emergency-patients may be asked to provide documentation for the same).

Consent to care

X_____I request and give consent to Dr.Veerula, Nurse Practitioners, Associates and Assistants who may provide my medical care to perform such medical-surgical care, tests, procedures, and other necessary services as well as provide drugs and supplies as they consider necessary or beneficial for my health and well-being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me. In addition, I understand there may be adverse effects or complications from some treatments/procedures/drugs, etc.

Check all that apply I agree to be contacted at: _____Home _____Work _____Cell _____Email

Signature of Responsible Party: _____

Date_____

For Medicare patients only:

Statement to permit payment of Medicare benefits to provider, physicians, and patients.

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by *Fort Wayne Primary Care*, including physician, nursing, or lab services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or benefits for related services.

_____

Signature

___/____/_____

Date

HIPAA Privacy Receipt Acknowledgement

Date

Month _____Day _____Year _____

Fort Wayne Primary Care, LLC's "Notice of Privacy Practices" has been offered to me. It is available from the front desk of the *Fort Wayne Primary Care Office,* LLC as well as on the website (*WWW.FWIMED.COM*) I understand I have the right to review the 'Notice of Privacy Practices' prior to signing this document. By signing this document, *I acknowledge my receipt of an agreement with an understanding of the above-mentioned privacy practices.*

Fort Wayne Primary Care reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

Updated 'Notice of Privacy Practices' is available at the front desk or on the website.

_____

Printed Name of Patient *or* Printed Name of Patient Representative

_____

Signature of Patient *or* Signature of Patient Representative

_____ _____

Patient Date of Birth Description of Personal Reps. Authority

☐ Check if the patient is a minor

I authorize the following individuals to have access to my Protected Health Information (PHI):

Name	Relationship	Date of Birth	Phone Number

Patient Signature: _____

(For authorization to release PHI to the above listed individuals.)

OFFICE USE ONLY

The above-named patient or personal representative of the patient was given *Fort Wayne Integrative Medicine, Fort Wayne Primary Care* & V.Veerula MD, LLC's Notice of Privacy Practices on the date indicated, but either refused to sign the acknowledgement or did not return the acknowledgement.

_____

Signature and Title of Person providing the Patient Notice of Privacy