Dr. Jodi Berg
Integrative Family Health Clinic

Dear Integrative Family Health Clinic patient,

Welcome to Integrative Family Health Clinic. Thank you for allowing us the opportunity to assist with your health care needs. We value all our patients and are committed to providing you with high-quality, health care services.

This packet includes all the new patient forms that will need to be completed for us to assist with your care.

1. HIPPA Compliance Patient Consent Form
2. Financial agreement
3. Patient Registration
4. Medical Information



HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information about you. The Notice contains a Patients' Rights section, describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocations shall not affect any disclosures we have already made in reliance on your prior Consent. Integrative Family health Clinic provides this form to comply with Health insurance Portability and Accountability Act of 1996 (HIPPA

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- Integrative Family Health Clinic has a Notice of Privacy Practices, and that the patient has the opportunity to review this notice.
- Integrative Family Health Clinic reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information, but Integrative Family health Clinic does not have to agree to those restrictions.
- The patient may remove this consent in writing at any time, and all future disclosures will then ease.
- Integrative Family Health Clinic may condition receipt of treatment upon the execution of this consent.

This Consent was signed by: _____

Printed Name- Patient or Representative

_____ Date_____

Signature

Relationship to Patient (if other than patient): _____

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Financial Responsibility Agreement

Patient Name: _____ Date of Birth: _____

1. I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits
2. I understand and agree it is my responsibility and not the responsibility of the Physician or Office to know if my insurance will pay for my medical service or visit, preventive exam or physical, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician
3. I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amounts, usual and customary limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment whenever required.
4. I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider is not recognized by insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.
5. I understand and agree it is my responsibility to know if my PCP (primary care physician) choice had been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.
6. I understand that the physician may charge a $150.00 or $300.00 fee if I do not show up for my appointment or cancel without a 24-hour notice.
7. I understand that if I need a copy of my medical records, a printing fee will be charged.
8. I understand that any forms to be filled out by the physicians will have a fee assessed.
9. I understand that I will be required to provide a valid form of payment, either check or credit card which will be run electronically.
10. I understand that peptides, injections, spiritual counseling, and any spa services are not covered by insurance and payment is due at time of service.
11. I understand that I have an 8 minute grace period, after which can result in a cancelled appointment and a fee.

Signature: _____ Date: _____



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Freed Agreement

To provide you with the best care and attention, I am using a service called Freed that transcribes conversations and helps with my notes. Your information is private, and I will review the content for accuracy. You can tell me to stop using it at any time.

Do I have your permission to use this service during our visits?

Signature: _____ **Date:** _____



Patient Registration

Last Name: _____ First Name: _____ Date of birth: _____

Race: _____ Ethnicity: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip _____

Marital Status: _____ Occupation: _____ Employment Status: _____

Phone Numbers: Home: _____ Mobile: _____ Work: _____

Email: _____

Emergency Contact: Last: _____ First: _____

Relationship to patient: _____ Phone: _____

Preferred Pharmacy:

Pharmacy Name: _____ Phone number: _____

Address: _____ City: _____ State: _____ Zip: _____

How did you hear about us? _____

Insurance Information

Person responsible for account: Last name: _____ First name: _____

Relationship to Patient: _____ Date of birth: _____ SSN: _____

Insurance Company: _____

Subscriber #: _____ Group #: _____

Name of Insured on Card: _____

Secondary Insurance

Insurance Company: _____



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Subscriber #: _____ Group #: _____

Name of Insured on Card: _____

REASON FOR VISIT

Please list your present health concerns, problems, or symptoms:

_____
_____
_____
_____
_____
_____
_____

Please list any medical conditions you have currently or have had in the past year.

_____
_____
_____
_____
_____

MEDICAL GOALS

Please list any medical goals, if any:

_____
_____
_____
_____
_____
_____
_____

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Medical History

Current Primary Care Provider _____

Hospital/Clinic of PCP _____

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications and foods

Name of allergen:	Reaction You Had:



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HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Siblings	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	

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MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No

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Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	