MEDICAL QUESTIONNAIRE

Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

Today's Date _____

First Name: _____Middle Name: _____Last Name: _____

Address:_____ City: _____ State: _____ ZIP: _____

Home: (_____) _____-_____ Cell: (_____) _____-_____

Work Phone: (_____) _____-_____ Birth Date: _____/_____/_____ Age: _____

Email: _____ Place of Birth: _____

(City or town & Country if not US)

Referred by: _____

Height: ___' ____" Weight: _____ Sex: _____

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

DESCRIBE THE TOP 3 HEALTH ISSUES	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
1.			
2.			
3.			

2. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
   Example: Wendy, age 7, sister
   _____
   _____
   _____

3. 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

4. Have you lived or traveled outside of the United States? Yes____ No____
   If so, when and where? _____
   _____
   Did you become ill during this(these) trips?_____

5. Have you or your family recently experienced any major life changes? Yes____ No____
   If yes, please comment: _____
   _____

6. Have you experienced any major losses in life? Yes____ No____
   If so, please comment: _____
   _____

7. Have you experienced any emotional or physical trauma/abuse in your lifetime? Yes____ No____
   _____
   _____
   _____

8. How important is religion or spirituality for you and your family's life?
   a. _____ not at all important b. _____ somewhat important c. _____ extremely important

9. How much time have you lost from work or school in the past year?
   a. _____ 0-2 days b. _____ 3 –14 days c. _____ > 15 days

10. Past Medical and Surgical History:

	ILLNESSES	WHEN	COMMENTS
	Anemia		
	Arthritis		
	Asthma		
	Autoimmune Disorder		
	Breast (Fibrocystic, Calcifications, Densities)		
	Bronchitis/Emphysema/Pneumonia		
	Cancer		
	Clotting Defects		
	Childhood Illness (i.e. rheumatic fever, chickenpox, mumps, measles, etc.)		
	Chronic Fatigue Syndrome		
.	Crohn's Disease or Ulcerative Colitis		
	Dental Issues		
	Depression/Anxiety		
	Diabetes (Type 1, Type 2)		
	Eating Disorder (Anorexia, Bulimia)		
	Epilepsy, convulsions, or seizures		
	Fibromyalgia		

Gallstones		
Gout		
Heart Disease, Attack/Angina/Failure		
High blood fats (cholesterol, triglycerides)		
High blood pressure (hypertension)		
Irritable bowel		
Kidney stones		
Liver Disease (Hepatitis, Fatty, Other)		
Osteoporosis/Osteopenia		
Sinusitis		
Sleep apnea		
Stroke		
Thyroid disease		
Other (describe)		
INJURIES	**WHEN**	**COMMENTS**
Back injury		
Fracture / Right or Left		
Head injury		
Neck injury		
Other (describe)		
DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
Barium Enema		
Bone Scan		
CAT Scan (Location)		
Chest X-ray		
Colonoscopy/Sigmoidoscopy		
EKG		
MRI		
Thermogram		
Upper GI Series		
Other (describe)		

OPERATIONS	WHEN	COMMENTS
Appendectomy		
Cosmetic Surgery (Location)		
Dental Surgery		
Gall Bladder		
Hernia		
Hysterectomy (Partial or Total)		
Tonsillectomy		
Tubal Ligation		
Vasectomy		
Other (describe)		

11. Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON
a.		
b.		
c.		
d.		
e.		

12. How often have you have taken antibiotics?

	< 5 times	> 5 times
Infancy/ Childhood		
Teen		
Adulthood		

13. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

	< 5 times	> 5 times
Infancy/ Childhood		
Teen		
Adulthood		

14. Are you allergic to any medications or vaccines? Yes _____ No _____
If yes, please list with reactions:
_____
_____
_____
_____
_____

15. Doctors you are currently seeing:
_____
_____

16. What medications are you taking now? Include non-prescription drugs.

Medication Name/Dose	Date started	Tolerance/Side Effects
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

17. 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.

Supplement Name, Dose and Brand	Date started	Effective?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

18. Childhood:

Question	Yes	No	Don't Know	Comment
1. Were you a full term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				
2. As a child did you eat a lot of sugar and/or candy?				

19. As a child, were there any foods that you had to avoid because they gave you symptoms?
Yes____ No____
If yes, please: name the food and symptom (Example: milk – gas and diarrhea)
_____
_____
_____
_____

20. Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

	Usual Breakfast	√		Usual Lunch	√		Usual Dinner	√
a.	None		a.	None		a.	None	
b.	Bacon/Sausage		b.	Butter		b.	Beans (legumes)	
c.	Bagel		c.	Coffee		c.	Brown rice	
d.	Butter		d.	Eat in a cafeteria		d.	Butter	
e.	Cereal		e.	Eat in restaurant		e.	Carrots	
f.	Coffee		f.	Fish sandwich		f.	Coffee	
g.	Donut		g.	Juice		g.	Fish	
h.	Eggs		h.	Leftovers		h.	Green vegetables	
i.	Fruit		i.	Lettuce		i.	Juice	
j.	Juice		j.	Margarine		j.	Margarine	
k.	Margarine		k.	Mayo		k.	Milk	
l.	Milk		l.	Meat sandwich		l.	Pasta	
m.	Oat bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Poultry	
o.	Sweet roll		o.	Salad dressing		o.	Red meat	
p.	Sweetener		p.	Soda		p.	Rice	
q.	Tea		q.	Soup		q.	Salad	
r.	Toast		r.	Sugar		r.	Salad dressing	
s.	Water		s.	Sweetener		s.	Soda	
t.	Wheat bran		t.	Tea		t.	Sugar	
u.	Yogurt		u.	Tomato		u.	Sweetener	
v.	Other: (List below)		v.	Water		v.	Tea	
			w.	Yogurt		w.	Water	
			x.	Other: (List below)		x.	Yellow vegetables	
						y.	Other: (List below)	

21. How much of the following do you consume each week?

a.	Candy	
b.	Cheese	
c.	Chocolate	
d.	Cups of coffee containing caffeine	
e.	Cups of decaffeinated coffee or tea	
f.	Cups of hot chocolate	
g.	Cups of tea containing caffeine	
h.	Diet sodas	
i.	Ice cream	
j.	Salty foods	
k.	Slices of white bread (rolls/bagels)	
l.	Sodas with caffeine	
m.	Sodas without caffeine	

22. Are you on a special diet? Yes____ No____

_____ GFCF _____ vegetarian _____ other (describe):
_____ Diabetic _____ vegan _____
_____ Dairy restricted _____ blood type diet _____

23. Is there anything special about your diet that we should know? Yes____ No____
If yes, please explain:
_____

24. a. Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc.?
Yes____ No____
b. If yes, are these symptoms associated with any particular food or supplement(s)?
Yes____ No____
c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.
_____
_____

25. Do you feel you have <u>delayed</u> 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____

26. Do you feel much **worse** when you eat a lot of :

_____high fat foods _____refined sugar (junk food)
_____high protein foods _____fried foods
_____high carbohydrate foods _____1 or 2 alcoholic drinks
(breads, pastas, potatoes) _____other _____

27. Do you feel much **better** when you eat a lot of :

_____high fat foods _____refined sugar (junk food)
_____high protein foods _____fried foods
_____high carbohydrate foods _____1 or 2 alcoholic drinks
(breads, pastas, potatoes) _____other _____

28. Does skipping a meal greatly affect your symptoms? Yes____ No____

29. Have you ever had a food that you craved or really "binged" on over a period of time? (Food craving may be an indicator that you may be allergic to that food.) Yes____ No____

    If yes, what food(s)? _____
    _____

30. Do you have an aversion to certain foods? Yes____ No____
    If yes, what foods? _____

31. Please fill in the chart below with information about your bowel movements:

a. Frequency	√	b. Color	√
More than 3x/day		Medium brown consistently	
1-3x/day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible.	
1 or fewer x/week		Varies a lot.	
		Dark brown consistently	
b. Consistency		Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often float			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

32. Intestinal gas:
    _____Daily
    _____Occasionally
    _____Excessive
    _____ Present with pain
    _____ Foul smelling
    _____ Little odor

33. a. Have you ever used alcohol? Yes____ No____
    b. If yes, how often do you now drink alcohol?
    ___ No longer drinking alcohol
    ___ Average 1-3 drinks per week
    ___ Average 4-6 drinks per week
    ___ Average 7-10 drinks per week
    ___ Average >10 drinks per week

    c. Have you ever had a problem with alcohol? Yes____ No____
    If yes, please indicate time period (month/year): from _____ to _____.

34. Have you ever used recreational drugs? Yes____ No____
    Describe which ones and how long used
_____

35. Have you ever used tobacco? Yes____ No____
    If yes, number of years as a nicotine user _____. Amount per day _____. Year quit _____.
    If yes, what type of nicotine have you used? _____Cigarette _____ Smokeless
    _____Cigar _____Pipe _____Patch/Gum

36. Are you exposed to second hand smoke regularly? Yes____ No____

37. Do you have mercury amalgam fillings? Yes____ No____
    How many? _____ Are any of them bothering you?
_____

38. Do you have any root canals? Yes_____ No_____
    How Many? _____ Are any of them bothering you?
_____

39. Have your wisdom teeth or any other teeth been removed? Yes_____ No_____
    Any dry sockets or infections?
    _____

40. Have you ever worn braces? Yes_____ No_____
    Did you tolerate them without excessive mouth ulcers? Yes_____ No_____

41. Do you have any artificial joints or implants (include dental)? Yes____ No____

42. Do you feel worse at certain times of the year? Yes____ No____
    If yes, when? _____spring _____fall
    _____summer _____winter

43. Have you, to your knowledge, been exposed to toxic metals in your job or at home? Yes____ No____
    If yes, which one(s)? _____ lead _____cadmium
    _____arsenic _____mercury
    _____aluminum

44. Do or have you drank or bathed in well water? Yes____ No____
    How long? _____

45. Do odors affect you? Yes____ No____
    How?
    _____

46. Do you live or work in a damp, musty environment? Yes____ No_____

47. Any known water problems, mold/mildew in home or at work?
    _____
    _____

48. 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					

49. Have you ever had psychotherapy or counseling? Yes____ No____
Currently? _____ Previously? _____ If previously, from _____ to _____.
What kind? _____
Comments: _____

50. Are you currently, or have you ever been, married? Yes____ No____
If so, when were you married? _____ Spouse's occupation _____
When were you separated? _____ Never _____
When were you divorced? _____ Never _____
When were you remarried? _____ Never _____ Spouse's occupation _____
Comments: _____

51. Hobbies and leisure activities: _____
_____

52. Do you exercise regularly? Yes____ No____

If so, how many times a week?
1._____1x
2._____2x
3._____3x
4._____4x or more

When you exercise, how long is each session?
1._____ ≤15 min
2._____ 16-30 min
3._____ 31-45 min
4._____ > 45 min

What type of exercise is it?
_____Jogging/walking
_____Basketball
_____Home aerobics
_____tennis
_____water sports
_____other _____

50. FAMILY HISTORY: For each member of your family, follow the grey or white line across the page and check the boxes for:
1. Their present state of health, and
2. Any illnesses they have had.

*(Note: Except for **spouse**, Family refers to **blood** or **natural** relatives.)* **PRINT NAME/AGE BELOW**	Good Health	Poor Health	Deceased/ Cause	Alcoholism	Allergies or Asthma	Alzheimer's or Dementia	Anemia	Blood Clotting Problems	Diabetes	Cancer or Tumor	Epilepsy	Genetic Disease	Heart Trouble	High Blood Pressure	Kidney or Bladder Dis.	Nervous Breakdown	Rheumatism or Arthritis	Other
Father																		
Mother:																		
Brothers/Sisters:																		
Spouse:																		
Child:																		
Child:																		
Child:																		
Child:																		
Paternal relatives (in each box, write in how many affected with condition):																		
Maternal relatives (in each box, write in how many affected with condition):																		

53. Any other family history we should know about? Yes____ No____
If so, please comment: _____

54. What is the attitude of those close to you about your illness?
_____Supportive
_____Non-supportive

FOR WOMEN ONLY (questions 52-62):

55. Have you ever been pregnant? (If no, skip to question 57.) Yes____ No____
    Age at first pregnancy _____

    Number of miscarriages _____ Number of abortions _____ Number of preemies _____

    Number of term births _____ Birth weight of largest baby _____ Smallest baby _____

    Did you develop toxemia (high blood pressure)? Yes____ No____

56. Have you had other problems with pregnancy or in trying to conceive? Yes____ No____
    If so, please comment: _____

    _____

57. Age at first period _____ Date of last Pap Smear _____ Date of last Mammogram_____
    Pap Smear: ___ Normal ___Abnormal Mammogram: ___ Normal ___ Abnormal

58. Menstruation
    Length of menstrual cycle _____ Number of days of flow _____
    Heaviness of flow_____
    Premenstrual symptoms? Yes____ No_____
    Starting and ending when _____
    Bleeding between periods? Yes____ No_____ Any pelvic pain, pressure or fullness? Yes____ No_____
    Any unusual vaginal discharge or itching? Yes____ No_____

59. In the last 2 weeks of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes____ No____ Not applicable _____
60. Are you sexually active or would you like to be? Yes____ No____

61. Have you ever used birth control pills? Yes____ No____ If yes, when/How long _____
    Are you taking the pill now? Yes____ No____
    Did/does taking the pill agree with you? Yes____ No____

62. Do you currently use contraception? Yes____ No____
    If yes, what type of contraception do you use? _____

63. Are you in menopause? No _____ Yes _____ If yes**, age at last period**_____
    Do you take synthetic hormones: Premarin? ___ Provera? ___ Other (specify) _____
    Do you take bioidentical hormones: Progesterone? ___ Estrogen? ___ Other (specify) _____
    _____

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

65. Age mother in menopause? _____

66. Please check if these symptoms occur presently or have occurred in the past 6 months. Note location where applicable.

GENERAL:	Mild	Mod-erate	Severe
Cold hands & feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Fatigue (AM/PM/Constant)			
Fever			
Flushing			
Heat intolerance			
Insomnia			
Nightmares			
No dream recall			
Weight Gain/Loss			
HEAD, EYES & EARS:			
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear noises			
Ear pain			
Ear ringing/buzzing			
Eye dryness/crusting			
Eye pain			
Eyelid margin redness			
Headache (Migraine or Tension)			
Hearing loss			
Hearing problems			
Migraine			
Sensitivity to loud noises			
Vision problems			

MUSCULOSKELETAL:	Mild	Mod-erate	Severe
Back muscle spasm			
Calf cramps			
Chest tightness			
Foot cramps			
Joint deformity			
Joint pain / redness			
Joint stiffness			
Muscle pain			
Muscle spasms			
Muscle stiffness			
Muscle twitches: Around eyes			
Arms or legs			
Muscle weakness			
Tendonitis			
Tension headache			
TMJ problems			
MOOD/NERVES:			
Agoraphobia			
Anxiety / panic attacks			
Auditory hallucinations			
Black-out			
Depression / Low Mood			
Difficulty: Concentrating			
With balance			
With thinking			
With judgment			
With speech			
With memory			
Dizziness (spinning)			
Fainting			
Fearfulness			
Irritability			
Light-headed			

MOOD/NERVES, Cont'd:	Mild	Mod-erate	Severe
Mood swings			
Numbness /Tingling			
Obsessive / compulsive			
Other Phobias			
Paranoia			
Seizures			
Suicidal thoughts/Plan			
Tremor/trembling			
Visual hallucinations			
EATING:			
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Carbohydrate craving			
Carbohydrate intolerance			
Poor appetite			
DIGESTION:			
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating			
Blood in stools			
Burping / belching			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lips			
Dentures w/poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			
Feels full too long after meal			
Farting			

DIGESTION, Cont'd:	Mild	Mod-erate	Severe
Fissures			
Heartburn/Reflux			
Hemorrhoids			
Intolerance to: Lactose			
All milk products			
Intolerance to: Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/jaundice (yellow eyes or skin)			
Lower abdominal pain			
Mucus in stools			
Nausea			
Periodontal disease			
Sore tongue			
Stomach pain			
Strong stool odor			
Undigested food in stools			
Upper abdominal pain			
Vomiting			
SKIN PROBLEMS:			
Acne on back			
Acne on chest			
Acne on face			
Acne on shoulders			
Athlete's foot			
Bumps on back of upper arms			
Cellulite			
Dark circles under eyes			
Ears get red			
Easy bruising			

SKIN PROBLEMS, Cont'd:	Mild	Mod-erate	Severe
Eczema			
Hair Loss			
Herpes - genital			
Hives			
Jock itch			
Lackluster skin			
Mole w color/size change			
Oily skin			
Pale skin			
Patchy dullness			
Psoriasis			
Rash			
Red face			
Sensitive to bites			
Sensitive to poison ivy/oak			
Shingles			
Skin cancer			
Skin darkening			
Strong body odor			
Thick calluses			
Vitiligo			
SKIN, ITCHING:			
Anus			
Arms			
Ear canals			
Eyes			
Feet			
Hands			
Legs			
Nipples			
Nose			
Penis			
Roof of mouth			
Scalp			
Skin in general			
Throat			
Wheezing			

SKIN, DRYNESS OF:	Mild	Mod-erate	Severe
Feet cracking /peeling			
Hair dry/loss			
Hands cracking /peeling			
Mouth/throat			
Scalp dandruff			
Other			
LYMPH NODES:			
Neck enlarged/tender			
Other enlarged/tender lymph nodes			
NAILS:			
Bitten			
Brittle / soft			
Curve up / frayed			
Fungus - fingers / toes			
Pitting / ridges			
Ragged cuticles			
Thickening of: Finger nails / toenails			
White spots/lines			

RESPIRATORY:	Mild	Mod-erate	Severe
Bad breath			
Bad odor in nose			
Cough - dry / productive			
Hay fever: Season_____			
Hoarseness			
Nasal / Sinus stuffiness			
Nose bleeds			
Post nasal drip			
Shortness of breath			
Sinus infection			
Snoring			
Sore throat			

CARDIOVASCULAR:			
Angina/chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High/low blood pressure			
Mitral valve prolapse			
Palpitations/Irregular Pulse			
Phlebitis			
Rapid Heart Rate /Tachycardia			
Swollen ankles/feet /hands			
Varicose veins			

URINARY:	**Mild**	**Mod-erate**	**Severe**
Bed wetting			
Blood in urine			
Hesitancy /urgency			
Bladder Infection			
Kidney disease / stones			
Leaking/incontinence			
Nocturia (# times per night _____)			
Pain/burning			
Prostate enlargement			
Prostate infection			
PSA Level Normal?			
MALE REPRODUCTIVE:			
Discharge from penis			
Ejaculation problem			
Genital pain			
Erectile dysfunction /maintaining erections			
AM Erections?			
Infection			
Lumps in testicles			
Poor libido (sex drive)			

FEMALE REPRODUCTIVE:			
Breast cysts / lumps			
Breast tenderness			
Ovarian cyst			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Hot Flashes/Night Sweats			
Infertility			
Nipple discharge			
Painful intercourse			
Vaginal discharge			
Vaginal dryness			
Vaginal odor / itch			
Vaginal pain			
<u>Premenstrual:</u> Bloating			
Breast tenderness			
Carbohydrate craving			
Chocolate craving			
Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Irritability			
<u>Menstrual</u>: Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			

Prevention & Healing of Iowa, LLC

____ Initials Informed Consent

I, _____, have sought medical care at Prevention & Healing of Iowa (PHI). I do this of my own free will, because I believe that the functional, holistic approach to medicine that is practiced at PHI is more in keeping with my own philosophy of health and well-being.

The nurse practitioner (NP) at PHI is board-certified, licensed in the State of Iowa, and can employ standard, orthodox drug therapy for medical management as well as refer you to physician specialists when indicated.

____ Initials Office Policies and Procedures for Nurse Practitioner

1. We must have this **signed/initialed** "Informed Consent and Office Policies and Procedures for Nurse Practitioner" form returned with your completed Health History form in order to schedule the initial visit.

2. There must be a VISA, Master Card, or Discover number on file to hold your first visit. **If you do not use a credit/debit card, you will need to send a check for the initial consult fee along with this signed policy prior to reserving your first appointment.**

3. You will receive a courtesy reminder phone call in advance of your appointment(s).

____ Initials Fee Structure

Initial Consult with Carolyn Walker	90 minutes If > 90 minutes--------→	**$350 for 1st 90 minutes (to hold appointment time & due day of initial consult);** **$100 / each 30 minutes that extend beyond the Initial 90 minutes, due day of consult/service**
Follow Up Visit with Carolyn Walker (may be a phone consult if distance/weather a factor)	**1st follow-up is usually 90 minutes or longer depending on lab results/questions**; other consults vary on client needs.	**$200 / hour** **or** **$100 / each 30 minutes due day of consult/service**
Time for Phone Consult / Email / Documentation / Orders / Scripts	$3.00 / minute	Depends on # of minutes; **not billable to insurance**
Correspondence / Letters to Insurance / Transferring Records	$3.00 / minute; minimum $45	Depends on # of minutes; often we need to refer back to patient chart, etc.
Copying	$0.25 per sheet	Depends on # of copies
Returning Test Kits	$25 per kit	To compensate for time in kit preparation for you

1. **On average, 90 minute appointments are reserved for a new patient's initial TWO visits** with the NP. Depending on one's need, often other NP visits necessitate one hour or more.

____ Initials Child Care

We ask that another adult come with parent(s) of young infants/children seen in our clinic. This allows us to provide optimal treatment and communication with the parent(s). There may be follow-up consults where it is not necessary to have the child/client along.

____ Initials Telephone Consults/Questions to the Practitioner

1. Since the practitioner is not in the office every day, it is possible you may not have a return call or voice mail response that same day.

2. Due to the volume of phone calls and each individual's differing degree of severity of health care needs, a reserved telephone appointment with the practitioner may be necessary at the above rate.

    a. **These telephone/Email/Documentation/Orders/Script fees are customary to most phone consults and will be billed to your credit card account at the time of phone consult.**

____ Initials Cancellation Policy

A cancellation on the day of your appointment is inconvenient to other patients waiting for an appointment and costly to PHI. If you need to cancel or reschedule, kindly do so **24 hours in advance** or you will be charged for that appointment as indicated below.

Name as it appears on credit card (print): _____

Credit Card #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Type of credit card: VISA / Master Card / Discover/Debit

Date of Expiration: _____ **Card Verification Code (CVC2 Code)** ___ ___ ___

I agree to allow Prevention & Healing of Iowa to debit the above credit/debit card account the amount of the initial consult fee in the event I do not show up for my prescheduled initial appointment and neglect to give 24 hours advance notice. In addition, I agree to allow Prevention & Healing of Iowa to debit the above credit card account $150.00 in the event I do not show up for my prescheduled follow-up appointment(s) without giving 24 hour advance notice.

____ Initials Insurance Payment/Reimbursement of Services

Although Prevention & Healing of Iowa's NP does not contract with health insurance carriers or submit claims, we do provide the following to assist you in filing for reimbursement with your particular carrier:

1. A statement itemizing payment of services.
2. A medical claim form (delineating services provided, by whom, with diagnostic and procedure codes) and cover letter directing your insurance provider to direct reimbursement to you, not PHI.
3. Should your insurance ultimately deny reimbursing you for our services, one can always submit these to their Medical Savings account at a general pretax savings of about 70¢ on each dollar spent.

I agree with the above informed consent, child care, cancellation / scheduling / fee structure / telephone / payment / reimbursement of services / email / records transfer / copying policy.

Please Sign Here: _____ **Date:** _____

OFFICE USE ONLY: Date Received: Appt. Date: Time:	☐ HIPPA ☐ Demographic Form ☐ Health HistoryForm