



# PERFORMANCE MEDICINE CANCELLATION, NO SHOW, AND FEE FOR ADDITIONAL SERVICES POLICY

With the rise in refill request, new prescription request, and paperwork request, as well as cancellations and no-shows we are now implementing an additional service and cancellation policy into place.

## **CANCELLATIONS AND NO-SHOWS:**

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide at least a 24-hour notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With Cancellations made less than 24 hours' notice, we are unable to offer that slot to other people. **Office appointments which are cancelled with less than 24 hours notification will be charged a \$25.00 cancellation fee.**

Patients who do not show up for their appointment without a call to cancel an office appointment will be considered as NO SHOW. Patients who No-show two (2) or more times in a 12-month period, may be dismissed from the practice thus they will be denied any future appointments. **Patients will also be subjected to a \$25.00 fee for office appointment NO Shows.**

The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that a great Physician/Patient relationship is based upon understanding and communication. Questions about cancellation and no-show fees please contact our office.

**Please sign that you have read, understand and agree to this Cancellation and No-Show Policy.**

**Patient Name (print please)** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Practice Representative** \_\_\_\_\_ **Date** \_\_\_\_\_



# MEDICAL HISTORY FORM

Name \_\_\_\_\_ DOB \_\_\_\_\_

General State of Health:

Excellent  Good  Fair  Poor

Occupation/Job: \_\_\_\_\_

Number of Children: \_\_\_\_\_

Do you smoke?  No  Yes \_\_\_\_\_ packs per day  
 \_\_\_\_\_ years smoking

Do you drink alcoholic beverages?  No  Yes

How much? \_\_\_\_\_

Are you on any type of diet? \_\_\_\_\_

Are you happy with your weight? \_\_\_\_\_

Do you exercise?  No  Yes

How much? \_\_\_\_\_

Who is your regular doctor? \_\_\_\_\_

When was your last physical exam? \_\_\_\_\_

Reason for today's visit?

Do you have hormone issues?  No  Yes

If yes, please explain:

Previous Hospitalizations and/or surgery:

Family History	Age	Present Illness	Cause of Death
Mother			
Father			
Sibling(s)			
Sibling(s)			

**Is there a family history of:** (please check if appropriate)

- |  |  |
|--|--|
| <input type="checkbox"/> Alcoholism        | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Alzheimer's       | <input type="checkbox"/> High Cholesterol    |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Lung Cancer         |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Lung Problem        |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Other Cancer        |
| <input type="checkbox"/> Breast Cancer     | <input type="checkbox"/> Overweight          |
| <input type="checkbox"/> Colon Cancer      | <input type="checkbox"/> Psychiatric Illness |
| <input type="checkbox"/> Depression        | <input type="checkbox"/> Stomach Cancer      |
| <input type="checkbox"/> Glaucoma          | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Heart Attack      | <input type="checkbox"/> Sugar Diabetes      |
|  | <input type="checkbox"/> Tuberculosis        |

### Past Medical History:

Have you had any of the following illnesses or disorders?

- |   |  |
|---|--|
| <input type="checkbox"/> Alzheimer's            | <input type="checkbox"/> Overweight        |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> PCOS              |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Seizures          |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Birth Defects          | <input type="checkbox"/> Sugar Diabetes    |
| <input type="checkbox"/> Bleeding Problems      | <input type="checkbox"/> Suicide Attempt   |
| <input type="checkbox"/> Cancers: _____         | <input type="checkbox"/> Thyroid Problem   |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Decreased Hearing      | <input type="checkbox"/> Ulcer             |
| <input type="checkbox"/> Decreased Vision       | <input type="checkbox"/> Urinary Infection |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Urinary Stone     |
| <input type="checkbox"/> Endometriosis          | <input type="checkbox"/> Venereal Disease  |
| <input type="checkbox"/> Glaucoma               | <b>Other Disorders of:</b>                 |
| <input type="checkbox"/> Gout                   | <input type="checkbox"/> Blood Vessels     |
| <input type="checkbox"/> Gut Problems           | <input type="checkbox"/> Bowel             |
| <input type="checkbox"/> Heart Attack           | <input type="checkbox"/> Breast            |
| <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Gallbladder       |
| <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Kidneys           |
| <input type="checkbox"/> High Cholesterol       | <input type="checkbox"/> Pancreas          |
| <input type="checkbox"/> Lung Disorders         | <input type="checkbox"/> Prostate          |
| <input type="checkbox"/> Migraines              | <input type="checkbox"/> Stomach           |

### Female History:

Age of onset of periods? \_\_\_\_\_

Are your periods regular? \_\_\_\_\_

# of Pregnancies \_\_\_\_\_ # of Miscarriages \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_

Are you pregnant?  No  Yes

Form of birth control? \_\_\_\_\_

Age of "Change of Life" \_\_\_\_\_

Do you do self breast exams?  No  Yes

Name of Gynecologist \_\_\_\_\_

Do you receive UTD Mammograms and Paps/Pelvics?

No  Yes



# MEDICAL INFORMATION RELEASE FORM

## HIPAA RELEASE FORM

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

### RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records; examination rendered to me.  
This information may be released to:

- Spouse \_\_\_\_\_
- Children \_\_\_\_\_
- Other \_\_\_\_\_
- Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

### MESSAGES

Please call:  My home \_\_\_\_\_  My work \_\_\_\_\_  My cell \_\_\_\_\_

#### If unable to reach me:

- You may leave a detailed message
- Please leave a message asking me to return your call
- \_\_\_\_\_

#### The best time to reach me is

Day \_\_\_\_\_ between (time) \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_



# MEDICATIONS AND ALLERGY

Name \_\_\_\_\_ DOB \_\_\_\_\_

## Medications

Name of Medication (indicate form: pills, ointment, drops, etc.)	Dose each time?	How Often?	Medical condition associated with medication	UTD	Initials	Date

## Allergies

Please list any allergies or adverse reactions you have had	What kind of reaction did you experience?	When did this reaction first occur?

# PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

**Signed this** \_\_\_\_\_ **day of** \_\_\_\_\_ **20** \_\_\_\_\_ .

**Print Patient Name** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_



# PATIENT INFORMATION

Mr.     Miss  
 Mrs.    Ms.

Full Name \_\_\_\_\_

LAST

FIRST

MIDDLE

Male    Female    **Marital Status**    Married    Divorced    Separated    Widowed

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Email \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Social Security No. \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Employer Phone No. \_\_\_\_\_

### Chose clinic because/Referred to clinic by (please check one box):

Doctor    Family    Friend    Close to home/work    Social Media    Podcast  
 Facebook Live    Google/Website    Other \_\_\_\_\_

### Other family members seen here:

\_\_\_\_\_

### Medication Allergies:

\_\_\_\_\_

### IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address) \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**PAYMENT IS EXPECTED AT THE TIME OF SERVICE:** Payment can be made with cash, check, credit card, HSA account or Care Credit. **WE DO NOT FILE ANY INSURANCE.** If you desire we will provide you with an itemized receipt to file with your insurance. **YOU CAN NOT FILE MEDICARE, AS I AM NOT A MEDICARE PROVIDER.**

### CURRENT CLINIC POLICES

- We do not take care of hospitalized patients.
- We do not take calls outside of office hours. If you feel that you need medical attention when our office is closed, we recommend that you use the ER at one of the local hospitals.
- **WE DO NOT TREAT CHRONIC PAIN THAT REQUIRES NARCOTIC PAIN MEDICATIONS.**
- This is not a primary care office. We do not follow chronic, ongoing care, so the patient understands and is encouraged to have a primary care physician. We take no responsibility for any other medical condition known or unknown you might have and **you are responsible for seeing your primary health care provider for complete medical care.**
- Aesthetic procedures may not always have the desired outcome and patient assumes risk of any adverse side effects.
- The weight loss program doesn't work for everyone. Diet and Exercise play a big part in weight loss and our medical team makes no guarantees or claims that treatments will be successful. The weight loss shot is not FDA approved nor is it required to be as with this or any injection. There could be a reaction and patient agrees to assume any risk of injury or loss. All the ingredients of the catalog of weight loss injections offered are obtained from an FDA approved facility.

**INFORMED CONSENT: I am giving my consent for the physician and Performance Medicine to evaluate and treat the patient named above. I understand that I am responsible for paying my bills at the time of services.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

