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)

- ☐ Alcoholism
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Depression
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Lung Cancer
- ☐ Lung Problem
- ☐ Other Cancer
- ☐ Overweight
- ☐ Psychiatric Illness
- ☐ Stomach Cancer
- ☐ Stroke
- ☐ Sugar Diabetes
- ☐ Tuberculosis

Past Medical History:

Have you had any of the following illnesses or disorders?

- ☐ Alzheimer's
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Birth Defects
- ☐ Bleeding Problems
- ☐ Cancers: __________
- ☐ Cardiovascular Disease
- ☐ Decreased Hearing
- ☐ Decreased Vision
- ☐ Depression
- ☐ Endometriosis
- ☐ Glaucoma
- ☐ Gout
- ☐ Gut Problems
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Lung Disorders
- ☐ Migraines
- ☐ Overweight
- ☐ PCOS
- ☐ Seizures
- ☐ Stroke
- ☐ Sugar Diabetes
- ☐ Suicide Attempt
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary Infection
- ☐ Urinary Stone
- ☐ Venereal Disease

Other Disorders of:

- ☐ Blood Vessels
- ☐ Bowel
- ☐ Breast
- ☐ Gallbladder
- ☐ Kidneys
- ☐ Pancreas
- ☐ Prostate
- ☐ Stomach

Female History:

Age of onset of periods? ________________________

Are your periods regular? ________________________

# of Pregnancies________# of Miscarriages________

Date of last menstral 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 and 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** ________________

VITAMIN AND SUPPLEMENT LIST

VITAMIN/SUPPLEMENT NAME	BRAND	HOW OFTEN DO YOU TAKE IT	REASON FOR TAKING