BIO FUNCTIONAL MED

PATIENT REGISTRATION FORM

Date: _____

First Name: _____ Last Name: _____ MI: _____

Date of Birth: _____ Sex: M F Marital Status: S M W D SEP

Driver License Number (Required for prescriptions): _____

Mailing Address: _____

Shipping Address (for prescriptions) NO PO BOXES: _____

Home #: _____ Cell #: _____

Email: _____ Employer: _____

Name of your primary physician: _____ Date of last physical: _____

How did you hear about us or did anyone refer you? _____

***I consent to receive calls from BioFunctional MED, PA for my protected healthcare and other services related to the service of my account and appointments at the phone number(s) above, including my cell number provided. Initial here _____**

MEDICATIONS:

Are you currently taking any medications *prescription or over-the-counter*? No____ Yes ____ Please list:

_____

_____

List any allergies to medications: _____

List any current medical conditions: _____

LIFESTYLE:

Height: _____ Weight: _____ Do you smoke? No ____ Yes ____ How many packs per day?_____ Do you drink alcoholic beverages? No ____ Yes ____ How many drinks per week? _____

Do you exercise regularly? No ____Yes ____ How many days per week? _____

What type(s) of exercise do you engage in on a regular basis?

_____

EMERGENCY CONTACT:

Name: _____ Relation: _____ Phone: _____

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GOALS & EXPECTATIONS FOR TREATMENT:

It is important that you take your time and fill this section out with specific answers in order for us to be able to address your goals and our recommendation for reaching them.

Which of the following treatments are you most interested in? Circle all…..
Weight Loss, IV infusions, Hormone Management, Detoxification, General Wellness, LipoLaser, Body Wraps, More energy, Stress Reduction, Male Erectile dysfunction, Better Intimacy, Hair Loss, HCG programs, Supplements, Cellulite, Thyroid dysfunction, Memory and Mood, Neuropathy

What are your top five goals and expectations for treatment? (Please be as specific as possible)

1. _____ 2. _____

3. _____ 4. _____

5. _____

What are your top three hindrances or things standing in between you and your goals?

1. _____ 2. _____

3. _____

How likely are you to follow the necessary treatment and do whatever it takes in order to reach your goals?

• Not Very Likely • Somewhat Likely • Very Likely • Reach for the Stars

What is the most important element in deciding to use our services?
Circle only one.

Effectiveness	*"My results are my top priority."*
Time	*"I want results quickly."*
Service	*"I need extra support along the way through my journey."*
Affordability	*"I need this to be affordable."*

Potential Weight Loss Clients

What do you consider your ideal weight? _____

How much weight do you want to lose? _____

When was the last time you were at your goal weight? _____

How many times a year do you diet? _____

What is stopping you from losing weight on your own?_____

What have you tried in the past that has failed? _____

Do your weight problems make you feel uncomfortable? Yes No Please Describe:

Does your weight issues make you feel physical pain? Yes No Please Describe:

Are you embarrassed by your excessive weight? Yes No Please Describe:

Does being overweight and unhealthy limit your activities? Yes No

Do you binge eat? Yes No

Do you suffer from uncontrollable cravings? Yes No

Do you feel that food controls you? Yes No

Do you eat because of your emotions? Yes No

Do you eat between meals? Yes No

What do you choose to eat between meals? _____

Do you feel that your eating behaviors are normal? Yes No

Briefly describe your daily eating behaviors:

Do you feel tired, run down, or out of energy? Yes No

Is successful weight loss a top priority? Yes No Please explain:

How fast do you want to be slim, trim, and fit? _____

What's more important to you: fast or permanent?

Does your family support your weight loss efforts? Yes No

Is your family excited that you're working with us? Yes No

Can you remember being at your ideal weight? Yes No

What do you remember most about it? _____

INFORMED CONSENT

I, _____, authorize BioFunctional MED, PA. to discuss/disclose information related to my treatment to the individuals listed below. This includes appointment scheduling, test results, current treatment, etc.

If I do not specify anyone, then I understand that no information will be released via phone, email or in person**. If my spouse, or family member contacts BioFunctional MED, PA. by phone or email, and their name(s) is not listed below, they will not receive a return call/reply as this would verify that I am a client.** I understand that this is for my privacy and protection.

We may call to remind you of your appointment or notify you of your test results. I agree to allow the doctor or office employees to identify themselves, as well as myself, to notify me of my appointment or tell me that test results are back. We will not leave test results on your answering machine.

Name(s) of individual(s) that we are authorized to discuss/disclose your information related to your therapy:

_____

_____

_____

_____

_____

X_____ _____

Patient or Representative Signature Date

If this consent is signed by a personal representative of the patient, complete the following:

Representative's Name: _____

Relationship to Patient: _____

BIO FUNCTIONAL MED

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth: _____

This practice's Notice of Privacy Practices is available to me and I understand it written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual right and the practice's legal duties with respect to my protected health information. This includes, but is not limited to:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide me a revised Notice of Privacy Practices upon request.

X_____ _____

Patient or Representative Signature Date

OFFICE POLICIES

We take great pride in the quality of care that we deliver. In effort to maintain this high-level of care, we have the following appointment policies in place. Compliance with these policies will allow all patients to receive treatment in a timely and efficient manner.

- Cancellation or Changes of an Appointment: In order to be respectful of the needs of other patients, please be courteous and call our office if you are unable keep your appointment. If it is necessary to cancel or change your appointment, we require that you notify us 24 hours in advance. Your early cancellation will allow us to provide that time to another patient in need.

- Late Arrivals: I understand if I am late for my appointment, BioFunctional MED, PA. reserves the right to reschedule my appointment. We do our best to be prompt with our appointments so that our patients have very little wait time. If you are late to your appointment, we will do our best to work you in, but often our schedule does not allow for it.

- Missed Appointments: Cancellations without proper notice or missed appointments may be subject to fees. We realize that emergencies can come up; however, giving us as much notice as possible helps us better serve you and our other patients. It is vital to your treatment and health that you attend all your scheduled appointments. FAILURE TO PROVIDE PROPER NOTICE WILL BE MARKED AS A MISSED APPOINTMENT.

****Please note: Any deposit paid cannot be refunded or used towards future appointments if changes are not made within the 24 hour time frame.**

I have read and understand all of the office policies above. I understand that BioFunctional MED, PA. reserves the right to discharge a client who exhibits non-compliance with the treatment as prescribed; is uncooperative; does not follow medical advice; does not keep appointments; does not pay any balance due; or is disruptive or unpleasant to the staff.

X_____ _____

Patient Signature Date

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Female **Initial Symptom Form**

Name: _____ Date: _____

Are you currently using any method of Birth Control? If so, what method? _____
Have you had a hysterectomy? YES NO
Do you have irregular menstrual periods? YES NO N/A (Hysterectomy/Post-Menopausal)
When was your last menstrual period? _____ N/A (Hysterectomy/Post-Menopausal)

Symptom (please check mark)	**Never**	**Mild**	**Moderate**	**Severe**
Depressive mood				
Fatigue				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes/Night sweats				
Joint Pain				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Acne				

FOR OFFICE USE ONLY:

_____

BIO FUNCTIONAL MED

Reviewed by: _____ Date: _____

Male **Initial Symptom Form**

Name: _____ Date: _____

If you are currently on testosterone, when did you take your last testosterone dose: _____

Symptom ***(please check mark)***	**Never**	**Mild**	**Moderate**	**Severe**
Decline in general well being				
Fatigue				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

FOR OFFICE USE ONLY:

_____

Reviewed by: _____ Date: _____