



Welcome to the Institute for Specialized Medicine (IFS MED). We are pleased to have you as a patient and we are committed to providing you with exceptional medical care. We are a unique practice, utilizing state-of-the-art diagnostic and treatment protocols as well as a broad spectrum of additional services. In order to best serve you, we want you to be fully informed of our financial policies prior to your first visit. Please read and initial each section below, indicating your understanding and agreement with each statement.

_____ I understand that a co-pay does not cover all expenses incurred during an office visit and that I am responsible for all co-payments, deductibles, and co-insurances. I am also responsible for all charges for services/supplies that are non-covered or deemed experimental, investigational, or not medically necessary. Any services rendered or tests performed may or may not be a covered benefit of my insurance plan and it is my responsibility to verify coverage.

_____ I understand that diagnostic ultrasound is recommended for all new patient appointments and is a procedure that is billed separately from the office visit co-pay, resulting in additional charges. Each joint or body part that is viewed through ultrasound is billed as a separate, additional charge. I understand that in-office diagnostic ultrasound may or may not be a covered benefit on my insurance plan and it is my responsibility to verify coverage.

_____ I understand that IFSMED processes outside lab tests through LabCorp who will bill me separately for their lab services. It is my responsibility to verify if LabCorp is contracted or in-network with my insurance policy. If they are not, I will notify IFSMED if I want my lab work completed at an alternate lab.

_____ I understand that appointments at IFSMED are in high demand. Please contact us 24 hours in advance if you must cancel your appointment. Your first missed appointment will be charged a \$25 no call/no show fee if you choose not to arrive on time or keep your appointment without notification. Two consecutive missed appointments without notification will incur a \$50 fee and three consecutive missed appointments without notification will result in removal from the practice.

_____ I understand that any self pay, fee-based services or products require full payment at the time of service. This includes, but is not limited to, alternative therapies, supplements, and non-covered products and services. This also includes all services rendered to Private Pay patients who do not have insurance.

_____ I understand that if I have not yet met my deductible AND out-of-pocket, IFSMED will collect a deposit of \$600 (in addition to my co-pay) prior to being seen for an initial visit. This deposit will be applied to my account for coinsurance and other charges incurred. In the event that there are funds remaining on my account at the end of the calendar year, IFSMED will provide me a full refund of the remaining balance. I may also request to have that balance carried on to the following year.

_____ I understand that if I have not yet met my deductible, IFSMED will collect a deposit of \$100 (in addition to my co-pay) for any follow up appointment prior to being seen for my visit. This deposit will be applied to my account for coinsurance and other charges incurred. In the event that there are funds remaining on my account at the end of the calendar year, IFSMED will provide me a full refund of the remaining balance. I may also request to have that balance carried on to the following year.

Signed: _____ Date: _____
(patient or responsible party if patient is a minor)

Print name: _____

Patient History Form

Date of first appointment: _____ Date of birth: _____ Age: _____ Sex: _____ SSN: _____

Name: _____
LAST FIRST MIDDLE INITIAL MAIDEN

Address: _____

City: _____ State: _____ Zip: _____

Telephone: Home: _____ Cell: _____

Email: _____
 Needed to create online patient portal for secure access to your health information and secure communication with the practice.

Language Preference: _____
 Refused

Race: White White Hispanic or Latino
 Black or African American American Indian
 Black Hispanic or Latino Alaska Native
 Native Hawaiian Filipino Chinese
 Japanese Korean Other Asian
 Guamanian Samoan Tongan
 Other Pacific Islander Vietnamese Refused

Ethnicity: Hispanic or Latino
 Not Hispanic or Latino Refused

Emergency contact and relationship to you: _____

Emergency contact phone number: _____

Marital status (circle one): Never married Married Divorced Separated Widowed

Education (circle highest level attended): Grade school 7 8 9 10 11 12 College 1 2 3 4 Grad school

Occupation: _____ Number of hours worked/average per week: _____

Who referred you: _____

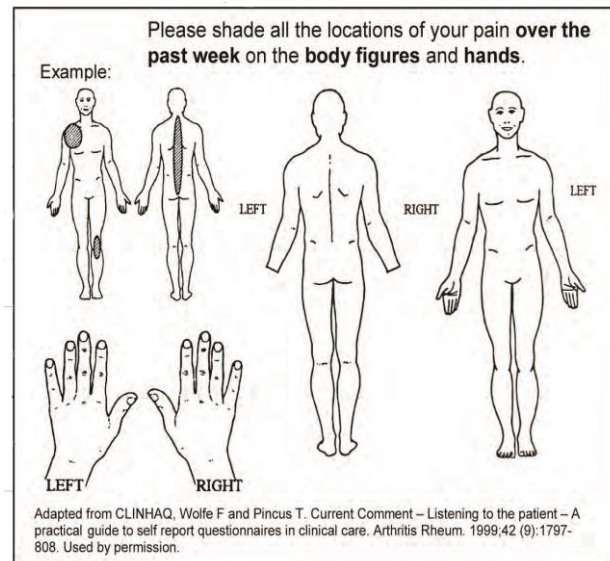
Who is your primary care physician: _____

Date symptoms began (approximate): _____

Diagnosis: _____

Please list the names of other practitioners you have seen for this problem: _____

Briefly describe your present symptoms: _____



Previous treatments for this problem (include physical therapy, surgery and injections; medications will be listed later): _____

Date of last mammogram: _____ Date of last eye exam: _____ Date of last chest x-ray: _____

Date of last Tuberculosis test: _____ Date of last bone densitometry: _____

As you review the following list, please check any problem which as significantly affected you

<p>Constitutional</p> <ul style="list-style-type: none"><input type="checkbox"/> Recent weight gain Amount: _____<input type="checkbox"/> Recent weight loss Amount: _____<input type="checkbox"/> Fatigue<input type="checkbox"/> Weakness<input type="checkbox"/> Fever <p>Eyes</p> <ul style="list-style-type: none"><input type="checkbox"/> Pain<input type="checkbox"/> Redness<input type="checkbox"/> Loss of vision<input type="checkbox"/> Double or blurred vision<input type="checkbox"/> Dryness<input type="checkbox"/> Feels like something in eye<input type="checkbox"/> Itching eyes <p>Ear-Nose-Mouth-Throat</p> <ul style="list-style-type: none"><input type="checkbox"/> Ringing in ears<input type="checkbox"/> Loss of hearing<input type="checkbox"/> Nosebleeds<input type="checkbox"/> Loss of smell<input type="checkbox"/> Dryness in nose<input type="checkbox"/> Runny nose<input type="checkbox"/> Sore tongue<input type="checkbox"/> Bleeding gums<input type="checkbox"/> Sores in mouth<input type="checkbox"/> Loss of taste<input type="checkbox"/> Dryness of mouth<input type="checkbox"/> Frequent sore throats<input type="checkbox"/> Hoarseness<input type="checkbox"/> Difficulty in swallowing <p>Cardiovascular</p> <ul style="list-style-type: none"><input type="checkbox"/> Pain in chest<input type="checkbox"/> Irregular heart beat<input type="checkbox"/> Sudden changes in heart beat<input type="checkbox"/> High blood pressure<input type="checkbox"/> Heart murmurs <p>Respiratory</p> <ul style="list-style-type: none"><input type="checkbox"/> Shortness of breath<input type="checkbox"/> Difficulty in breathing at night<input type="checkbox"/> Swollen legs or feet<input type="checkbox"/> Cough<input type="checkbox"/> Coughing of blood<input type="checkbox"/> Wheezing (asthma)	<p>Gastrointestinal</p> <ul style="list-style-type: none"><input type="checkbox"/> Nausea<input type="checkbox"/> Vomiting of blood or coffee ground material<input type="checkbox"/> Stomach pain relieved by food or milk<input type="checkbox"/> Jaundice<input type="checkbox"/> Increasing constipation<input type="checkbox"/> Persistent diarrhea<input type="checkbox"/> Blood in stools<input type="checkbox"/> Black stools<input type="checkbox"/> Heartburn <p>Genitourinary</p> <ul style="list-style-type: none"><input type="checkbox"/> Difficult urination<input type="checkbox"/> Pain or burning on urination<input type="checkbox"/> Blood in urine<input type="checkbox"/> Cloudy, "smoky" urine<input type="checkbox"/> Pus in urine<input type="checkbox"/> Discharge from penis/vagina<input type="checkbox"/> Getting up at night to pass urine<input type="checkbox"/> Vaginal dryness<input type="checkbox"/> Rash/ulcers<input type="checkbox"/> Sexual difficulties<input type="checkbox"/> Prostate trouble <p><i>For women only:</i> Age when period began: _____ Periods regular? ____yes____no How many days apart? _____ Date of last period: _____ Date of last pap: _____ Bleeding after menopause: ____yes ____no Number of pregnancies? _____ Number of miscarriages? _____</p> <p>Musculoskeletal</p> <ul style="list-style-type: none"><input type="checkbox"/> Morning stiffness. Lasting how long? _____<input type="checkbox"/> Joint pain<input type="checkbox"/> Muscle weakness<input type="checkbox"/> Muscle tenderness<input type="checkbox"/> Joint swelling: list joints affected in the last 6 months _____ _____ _____	<p>Integumentary (skin and/or breast)</p> <ul style="list-style-type: none"><input type="checkbox"/> Easy bruising<input type="checkbox"/> Redness<input type="checkbox"/> Rash<input type="checkbox"/> Hives<input type="checkbox"/> Sun sensitive (sun allergy)<input type="checkbox"/> Tightness<input type="checkbox"/> Nodules/bumps<input type="checkbox"/> Hair loss<input type="checkbox"/> Color changes of hands or feet in the cold <p>Neurological System</p> <ul style="list-style-type: none"><input type="checkbox"/> Headaches<input type="checkbox"/> Dizziness<input type="checkbox"/> Fainting<input type="checkbox"/> Muscle spasm<input type="checkbox"/> Loss of consciousness<input type="checkbox"/> Sensitivity or pain of hands and/or feet<input type="checkbox"/> Memory loss<input type="checkbox"/> Night sweats <p>Psychiatric</p> <ul style="list-style-type: none"><input type="checkbox"/> Excessive worries<input type="checkbox"/> Anxiety<input type="checkbox"/> Easily losing temper<input type="checkbox"/> Depression<input type="checkbox"/> Agitation<input type="checkbox"/> Difficulty falling asleep<input type="checkbox"/> Difficulty staying asleep <p>Endocrine</p> <ul style="list-style-type: none"><input type="checkbox"/> Excessive thirst <p>Hematologic/Lymphatic</p> <ul style="list-style-type: none"><input type="checkbox"/> Swollen glands<input type="checkbox"/> Tender glands<input type="checkbox"/> Anemia<input type="checkbox"/> Bleeding tendency<input type="checkbox"/> Transfusion/when _____ <p>Allergic/Immunologic</p> <ul style="list-style-type: none"><input type="checkbox"/> Frequent sneezing<input type="checkbox"/> Increased susceptibility to infection <p>Any previous fractures? _____ _____ _____ _____</p> <p>Any other serious injuries? _____ _____ _____</p>
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Previous operations: Year: _____ Year: _____

Year: _____ Year: _____

Social History

Do you drink caffeinated beverages? _____

Cups/glasses per day? _____

Do you smoke? ___yes ___no ___

past: how long ago? _____

Do you drink alcohol? ___ yes ___ no how many per week? _____

Has anyone ever told you to cut down on your drinking? ___ yes ___ no

Do you use drugs for reasons that are not medical? ___ yes ___ no If yes, please list: _____

Do you exercise regularly? ___ yes ___ no

Type: _____

Amount per week: _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ___ yes ___ no

Do you wake up feeling rested? ___ yes ___ no

Past Medical History

Do you now or have you ever had: (check if yes)

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Goiter	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Nervous breakdown	<input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Bad headaches	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Colitis
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Anemia	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Tuberculosis

Other significant illness (please list): _____

Natural or alternative therapies (chiropractic, magnets, massage, over-the-counter preparations etc.):

Family History

If Living	Age	Health	If Deceased	Age at Death	Cause
Father					
Mother					

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____ List ages of each _____

Health of children: _____

Do you know any blood relative who has or had: (check and give relationship)

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Leukemia	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Stroke	<input type="checkbox"/> Bleeding tendency	<input type="checkbox"/> Asthma	<input type="checkbox"/> Goiter
<input type="checkbox"/> Colitis	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Psoriasis	

Rheumatologic (Arthritis) History

At any time have you or a blood relative had any of the following? (check if yes)

Yourselves	Relative/Relationship	Yourselves	Relative/Relationship
<input type="checkbox"/> Arthritis (unknown) type		<input type="checkbox"/> Rheumatoid Arthritis	
<input type="checkbox"/> Osteoarthritis		<input type="checkbox"/> Lupus or "SLE"	
<input type="checkbox"/> Gout		<input type="checkbox"/> Ankylosing Spondylitis	
<input type="checkbox"/> Childhood arthritis		<input type="checkbox"/> Osteoporosis	
Other arthritis conditions: _____			

Immunization History (If unsure of the dates, please contact your primary doctor and provide to us at a later date.)

Vaccine	Dates	Vaccine	Dates
Haemophilus influenza type b (Hib)		Pneumococcal 13 (PCV13)	
Hepatitis A		Pneumococcal polysaccharide (PPSV23)	
Hepatitis B		Varicella	
Influenza		Zoster	

Activities of Daily Living

Do you have stairs to climb? ___ yes ___ no If yes, how many? _____

How many people in household? _____

Relationship and age of each: _____

Who does most of the housework? _____

Who does most of the shopping? _____

Who does most of the yardwork? _____

On the scale below, circle a number which best describes your situation. *Most of the time I function....*

1	2	3	4	5
VERY POORLY	POORLY	OK	WELL	VERY WELL

Because of health problems, do you have difficulty: (Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil etc.)			
Walking?			
Climbing stairs?			
Descending stairs?			
Sitting down?			
Getting up from chair?			
Touching your feet while seated?			
Reaching behind your back?			
Reaching behind your head?			
Dressing yourself?			
Going to sleep?			
Staying asleep due to pain?			
Obtaining restful sleep?			
Bathing?			
Eating?			
Working?			
Getting along with family members?			
In your sexual relationship?			
Engaging in leisure time activities?			
With morning stiffness?			
Do you use a cane, crutches as a walker or wheelchair? (circle one)			

What is the hardest thing for you to do? _____

Are you receiving disability? ___ yes ___ no

Are you applying for disability? ___ yes ___ no

Do you have a medically related lawsuit pending? ___ yes ___ no

PATIENT MEDICATION LIST

Patient name: _____ Date of birth: _____

MEDICATION NAME	DOSE/STRENGTH	FREQUENCY	PRESCRIBING PHYSICIAN

PLEASE LIST ANY MEDICATIONS YOU ARE ALLERGIC TO:

HIPAA AND PRIVACY PRACTICES

Please take time to review our **notice of privacy practices** on our website at www.ifsmed.com/new-patients

I hereby acknowledge that I have reviewed the **notice of privacy practices** made available to be my Institute for Specialized Medicine.

Signed: _____
(patient or responsible party if patient is a minor)

Print name: _____

Date: _____

INSURANCE INFORMATION

Please provide your insurance card or cards so we may keep a copy on file. Any time there is a change to your insurance, or new cards are issued, it is your responsibility to provide the updated cards to our office.

Patient name: _____

Primary insurance company: _____ Effective date: _____

Policy holder name: _____ Date of birth: _____

Relationship to patient: SELF SPOUSE CHILD OTHER _____

Secondary insurance company: _____ Effective date: _____

Policy holder name: _____ Date of birth: _____

Relationship to patient: SELF SPOUSE CHILD OTHER _____

If you are **not** the Policy Holder on either of your insurance plans, please complete the following:

I hereby authorize IFSMED to release and discuss my healthcare and/or financial information with the Policy Holder of my insurance plan, named here: _____

Signed: _____

Print name: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS AND CERTIFICATION OF ACCURATE INFORMATION

I hereby authorize Institute for Specialized Medicine to release information which is normally required in the course of my treatment for the sole purpose of processing any insurance claim(s) submitted.

I hereby authorize my insurance company to send payment directly to Institute of Specialized Medicine for any insurance benefits for services rendered. I understand that I am financially responsible for any unmet deductible, co-pays and for any charges of services not covered by my insurance.

I have reviewed the preceding information and I certify that this information is correct. I further understand that I am responsible for any financial loss due to inaccurate or incomplete information provided by me.

Signed: _____
(Patient or responsible party, if patient is a minor)

Print name: _____ Date: _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient name: _____ Date of birth: _____

Previous name: _____ Social Security Number: _____

I authorize Institute for Specialized Medicine to release healthcare information and discuss my treatment with the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This authorization applies to:

- Healthcare information
- Billing information
- Other: _____

Signed: _____

(Patient or responsible party, if patient is a minor)

Print name: _____ Date: _____