Advanced Metabolic Care + Research
PATIENT HISTORY

Patient Name: ______________________________ Date of Birth:_____________ Age:_______

Medication Allergies: ____

Hospitalizations and Operations:

YEAR	REASON	LOCATION

Date of Last:

Flu Shot:__________________ Eye Exam:________________ by Dr.:____________________

Pneumonia Shot:_________ Foot Exam:______________ by Dr.:____________________

EKG:____________________ Physical Exam:____________ by Dr.:____________________

Family History: Are you adopted? YES / NO

	Alive	Deceased	Age
Mother	_____	__________	____
Father	_____	__________	____

	How many?	Alive	Deceased	Age
Brother(s)	____________	____	__________	____
Sister(s)	____________	____	__________	____
Children	____________	____	__________	____

Family Members with the following diseases:

	Mother	Father	Siblings	Others
Diabetes				
Thyroid Disease				
Cancer (type)_______				
Epilepsy				
Strokes				
Heart Disease				
Hypertension				
Kidney Disease				
Anemia				
Bleeding Disorder				
Gout				
Tuberculosis				

Social History

Birthplace: _____________ Education: _____________ Occupation: ________________

Marital Status: Married Widowed Divorced Single Separated Other ____________________

Alcohol?: Y / N ____years _____per day/week Type: ____________Stopped ______ years.

Do you smoke?: Y / N ____years _____Packs/Day________Stopped _______years.

Caffeine (What and how much) Coffee / Tea / Soda _____ per day_____ per week.

Drug Use History: ____

Advanced Metabolic Care + Research

Your Symptom Review

Name: ________________________________ Date of Birth __________________ MR#: __________________

Date:

Endocrine / Diabetes

			Explain
Excess Urination	Yes❐	No❐	____________
At night (Number ____)	Yes❐	No❐	____________
Blurred Vision	Yes❐	No❐	____________
Dry Mouth	Yes❐	No❐	____________
Tingling of toes /fingers	Yes❐	No❐	____________
Fatigue	Yes❐	No❐	____________
Cold Intolerance	Yes❐	No❐	____________
Dry skin/hair/nails	Yes❐	No❐	____________
Palpitations	Yes❐	No❐	____________
Tremors	Yes❐	No❐	____________
Weight loss/gain (lbs._____)	Yes❐	No❐	____________
Excess sweating	Yes❐	No❐	____________
Double Vision	Yes❐	No❐	____________
Dizziness/loss of consciousness	Yes❐	No❐	____________
Depression	Yes❐	No❐	____________
Mental fatigue/mood swings	Yes❐	No❐	____________
Low Bone Density/Osteoporosis	Yes❐	No❐	____________
Fracture	Yes❐	No❐	____________
Do you take Calcium	Yes❐	No❐	How much_______

Urinary

Burning while urinating	Yes❐	No❐	____________
Loss of bladder control	Yes❐	No❐	____________
Blood in urine	Yes❐	No❐	____________
Trouble starting to urinate	Yes❐	No❐	____________
Passed a kidney stone	Yes❐	No❐	____________

Hematology

Anemia	Yes❐	No❐	____________
Bruising	Yes❐	No❐	____________
Transfusion	Yes❐	No❐	____________

Cardiovascular/Pulmonary

Chest pain/tightness	Yes❐	No❐	_______
Shortness of breath	Yes❐	No❐	_______
Chronic cough	Yes❐	No❐	_______
Wheezing	Yes❐	No❐	_______
Coughing up blood	Yes❐	No❐	_______
Pain in calves when walking	Yes❐	No❐	_______
Leg Cramps at night	Yes❐	No❐	_______
Swelling in the ankles	Yes❐	No❐	_______
High Cholesterol	Yes❐	No❐	_______

Gastrointestinal

Abdominal (stomach) pain	Yes❐	No❐	_______
Loss of appetite	Yes❐	No❐	_______
Nausea/vomiting	Yes❐	No❐	_______
Difficulty swallowing	Yes❐	No❐	_______
Change in bowel habits	Yes❐	No❐	_______
Blood in stools	Yes❐	No❐	_______
Black tarry stools	Yes❐	No❐	_______

Neurological

Ever had a convulsion	Yes❐	No❐	_______
Have you had a stroke	Yes❐	No❐	_______
Headaches	Yes❐	No❐	_______
Fainting spells	Yes❐	No❐	_______
Ringing in ears	Yes❐	No❐	_______
Spells of weakness of arm/leg	Yes❐	No❐	_______

Rheumatology

Arthritis	Yes❐	No❐	_______
Gout	Yes❐	No❐	_______

For Men Only

Loss of sexual interest	Yes❐	No❐	____________
No or incomplete erections	Yes❐	No❐	____________
Prostate trouble	Yes❐	No❐	____________
Hernia (rupture)	Yes❐	No❐	____________

For Women Only

Age of first menses _______
Duration of flow _______
Heavy periods _______
Bleeding in between periods _______
Date of last period _______
Age of menopause _______

Total pregnancies _______
Live births _______
Birth weight of babies___________
Miscarriages _______
Any gestational diabetes Yes❐ No❐

Date of last PAP _______
Date of last mammogram _________
Do you have discharge from nipples Yes___No___
Dryness of vagina Yes❐No❐
Loss of sexual interest Yes❐No❐

SIGNATURE:____ DATE:____________________

Advanced Metabolic Care + Research

Medication List

Today's Date ______________________

Patient's Name
____

Help us care for you better by telling us what prescriptions and over-the-counter medications you take.

Prescriptions						
Name of medicine	**Dose** (total milligrams)	**How many times per day?**	**When do take it?** (Morning and night? After meals?)	**Who prescribed it for you?** (Physician's last name)	**Why do you take it?**	**Do have any side-effects? Describe them.**
Over-the-counter medications, herbal remedies, vitamins						

PATIENT FINANCIAL AGREEMENT

Deductible/Co-Insurance: All applicable co-insurance and deductibles are due at the time of service. An estimate will be provided and payment is required before services are rendered. This does not constitute final payment and any additional balance due after the insurance claim is adjudicated will be due upon receipt of a bill. We accept cash, personal checks, and credit cards (Visa, Mastercard, Discover). For any questions regarding billing, please call (760)466-1548 or email billing@amcrclinic.com.

Co-Payments: Your insurance company requires us to collect co-payments at the time of service. Due to state and federal laws, co-payments will not be waived.

Payment Options: If you do not have insurance: payment is expected on the day treatment is rendered. If you do have insurance: you are responsible for any deductibles, coinsurance, and any out of pocket portions on the day that treatment is rendered.

Checks: Returned checks may be subject to a $30.00 fee.

Missed Appointments: Please note a $75.00 fee may be charged for a missed appointment or failure to cancel an appointment within 24 hours prior to scheduled appointment time. This fee will be billed directly to you.

Claims Submission: As a courtesy, Advanced Metabolic Care + Research will bill your insurance and one other insurance. A quote of benefits is not a guarantee of payment. We will submit your claims and assist you until your claim is resolved. Payment from your insurance company is expected within 30 days. After 30 days, we will look to you for full payment. You are responsible for all non-covered services according to your insurance company's guidelines. If we receive notification that you are not eligible for coverage or we are not contracted with your insurance, you will be responsible for all charges incurred and payment is due upon receipt of the bill. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request in a timely manner. You are responsible to provide a copy of your most recent insurance cards for all applicable health plans. All outstanding balances will be subject to a statement fee of $10.00. Additional statement fees will accrue for each subsequent thirty (30) day period of nonpayment. Accounts that are 90 days past due may be referred to a collection agency. Should the account be referred to an outside agency for collection or to an attorney, the undersigned shall pay reasonable collection expenses.

Form Fees: Any forms (DMV $65.00, Disability Forms $65.00, Unemployment Forms $65.00, School Forms $0.00-$30.00) that require a physician to review your chart and require an MD signature will have an applicable form fee charge.

Prescription Refills: If you have not been seen within the last 6 months, a follow up appointment will need to be scheduled to ensure proper treatment. Please contact your pharmacy for prescription refills.

Assignment of Benefits: Authorization is hereby granted to release information as may be necessary (in compliance with HIPAA guidelines) to process and complete my insurance claim and payment of medical benefit is to be paid directly to Advanced Metabolic Care + Research for all services rendered.

I have read and understand the above statements.

I agree to comply with the financial policies of Advanced Metabolic Care + Research and, I understand that I am financially responsible for payment of all medical services or treatment(s) administered with my account.

Patient Name (please print): ____ Date of Birth: __________________

Patient or Guardian Signature: _____________________________________ Date: ______________________________

ADVANCED METABOLIC CARE + RESEARCH

PATIENT REGISTRATION INFORMATION

Patient Information

Patient Name: ____ Sex: Male_______ Female _______
(Last) (First) (MI)
Street Address: ______________________________ City/State: ____________________ Zip: _________

Home Phone: ________________________ Work Phone: _____________________ Cell Phone:_____________________

Date of Birth: _______/_______/_______ Age: ________ Social Security #: __________________________
Month Day Year

Marital Status (Check One): Married _______ Single ______ Divorced ______ Widow(er) _______ Child ______

Employment Status (Check One): Employed _____ Retired _____ Student (Full Time) _____ (Part Time) _____ Not Employed: ______

Employer Name: ______________________ Address: ________________________ City/State___________ Zip________

Primary Care Doctor:________________________ Phone:____________________ Fax:_________________________

E-MAIL Address:____

Responsible Party (IF PATIENT IS A MINOR)

Name: ____ Sex: Male_______ Female _______
(Last) (First) (MI)
Street Address: ______________________________ City/State: ____________________ Zip: _________

Home Phone: ________________________ Work Phone: _____________________ Cell Phone:_____________________

Date of Birth: _______/_______/_______ Age: ________ Social Security #: __________________________
Month Day Year

Marital Status (Check One): Married _______ Single ______ Divorced ______ Widow(er) _______ Child ______

Employment Status (Check One): Employed _____ Retired _____ Student (Full Time) _____ (Part Time) _____ Not Employed: ______

Employer Name: ______________________ Address: ________________________ City/State___________ Zip________

Insurance Information (Please present your insurance card to be photo copied for billing)

Primary Insurance: ____________________________ ID# ______________________ Group# ____________________

Name of Subscriber: ____________________________ Date of Birth ____/ ____/____ Relationship to patient: _______________

Secondary Insurance: ____________________________ ID# ______________________ Group# ____________________

Name of Subscriber: ____________________________ Date of Birth ____/ ____/____ Relationship to patient: _______________

Emergency Contact

Name: ____ Relationship ______________________

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: _________________________

Address: ____ City/State_________________________ Zip________

May we email you appointment reminders, upcoming seminars, research opportunities, general health information and updated news on the practice? YES________ NO_________

I understand that I as the patient will be responsible to inform AMCR of any changes with insurance and will provide AMCR with all necessary information. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ____ Date: ___________________________

Advanced Metabolic Care + Research

Notice of Privacy Practices & Acknowledgement

Today's Date ____________________

Patient's Name ____

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review carefully!

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, patients of this practice are entitled to the greatest degree of privacy possible. This office will use and communicate your health information only to provide treatment, obtain payment and for authorization purposes, as agreed to by the patient.

Patients are advised that they have a right to review their medical files upon 5 days written notice to the practice and during normal business hours. A copying fee of $0.25 per chart page and a $10.50 flat fee plus postage is payable in advance of this review.
You have the right to request that we change your medical information. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change. We may deny your request if we did not create the information you want changed, if the information is not part of our records or if the records are determined to be accurate and complete. If we deny your request, we will provide you a written explanation.
For further information, contact our HIPAA coordinator Evelyn Becerril at (760) 743- 1431. All complaints will be addressed without reprisal to the complainant.

You have the right to obtain a copy of the Notice of Privacy Practices & Acknowledgement form our office at any time. Stop by or call us and we will mail or make you a copy.

____ ____________________

Signature Date

Patient Consent to Treat & HIPAA Notice Form

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) & CALIFORNIA CONFIDENTIALITY OF MEDICAL INFORMATION ACT (CMIA) CONSENT AND AUTHORIZATION.

Today's Date: ______________________ Social Security Number: ______________________________

PATIENT Name: _________________ Date of Birth: ______________________________________

I am the Patient named above:

This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. § 1320d and 45 C.F.R. § 160-164, and/or information governed by the California Confidentiality of Medical Information Act ("CMIA") Cal. Civ. Code §§ 56-56.37. Specifically, this release authority complies with the valid authorization requirements of 45 C.F.R. § 164.508(c). Pursuant to HIPAA and/or CMIA, I authorize and direct any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services, to give, disclose, and release, without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition, to include all information relating to the diagnosis and treatment of sexually transmitted diseases, mental illness, and drug or alcohol abuse.

Advanced Metabolic Care + Research is a Covered Entity as defined by HIPAA and may use or disclose protected health information for treatment, payment, and healthcare operations. Under this definition, use and disclosure of protected health information is permitted without mine or my personal legal authorized representative's consent, authorization, or agreement.

Authorization is required to use protected health information for purposes **other than** treatment, payment, or healthcare operation.

If there is a specific individual, entity or circumstance that we cannot disclose your protected health information too, please list below:

____
____
____
____
____

Expiration date of the restriction: ____

I understand that, with certain exceptions, I have the right to revoke this Authorization at any time. If I want to revoke this Authorization, I must do so in writing. The procedure for how I may revoke this Authorization, as well as the exceptions to my right to revoke, will be performed in accordance with applicable federal law and as stated in the Notice of Privacy Rights of my health care provider, a copy of which has been given to me.

Patient Consent form continued:

When providing information to me, information may be transmitted to me by any or all of the following means (initial all that apply):

Telephone messages on an answering machine ___________________ (initial)
Message to following family members or friends __________________(initial)
____
E-mail to the following address ________________ (initial)
____
____
____

Special message restrictions if any:
____
____
____

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to the physician's privacy notice and that I have had the opportunity to place special restriction upon the consent hereby given.

This consent is valid from the date of executed until revoked in writing by the patient.

Date: ____________________ Patient Signature: _______________________________________

<u>If Applicable:</u>

Date: _____________________ Signature of Authorized Representative: ________________________

Please print name: ____

Please explain Representative's authority to act on behalf of the Patient:
____
____

Advanced Metabolic Care + Research

Authorization for Release and/or Disclosure of Medical Information

This authorization allows this medical practice (AMCR) to release and receive all confidential medical information and records, including but not limited to medical history, illness or injury, consultation, prescription, treatment, diagnoses or prognosis, including x -rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

Patient name: ________________________________ Date of Birth: ______________

Patient's address:

____

As required by the Health Information Portability and Accountability act of 1996 (HIPPA) and California law, the practice may not use or disclose your individually identifiable health information except as provided in our Patient Consent and Notice of Privacy Practices and Acknowledgement Forms. Your completion of this form means that you are giving us permission to receive, use and disclose your confidential medical information. Please review and complete this form.

I hereby authorize this medical practice to receive, use and/or disclose my personal health information to:

____

____

I understand that I may revoke this authorization at any time notifying this medical practice in writing. I understand that although federal law does not protect health information disclosed to someone other than a health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. I understand that I have a right to receive a copy of this authorization. Please furnish any and/or all information concerning my past and present medical history and condition to:

Advanced Metabolic Care + Research
625 W Citracado Pkwy Suite 108
Escondido, Ca 92025
Tel # 760-743-1431 Fax # 760-743-6455

Patient Signature: ____ Date: __________

Witness (if applicable):____ Date: _________

Advanced Metabolic Care + Research

Consent to Discuss my Personal Health Information

I, ____, (Print Name) consent for Dr. Bailey/Dr. Varma and his staff at AMCR, to verbally disclose and discuss my protected health information (PHI) to the person(s) listed below. I understand that I reserve the right at any time in the future to remove or add a person(s) to the list. I do understand that it is my personal responsibility to inform the office of any changes to the "consent to discuss personal health Information list'.

This is for your protection and is in compliance with federal privacy guidelines.

_____________________________________ _____________________

Patient Signature **Date**

Approved person(s):

1) ____
Name of person Relationship

2) ____
Name of person Relationship

3) ____
Name of person Relationship

4) ____
Name of person Relationship

STOP BANG

Screening for: OBSTRUCTIVE SLEEP APNEA

Patient Name: ______________________ Date: ________

Dear Patient,

Please answer the following questions to find out if you are at risk for Obstructive Sleep apnea.

STOP

S (snore)	Have you been told that you snore?	YES / NO
T (tired)	Are you often tired during the day?	YES / NO
O (obstruction)	Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep?	YES / NO
P (pressure)	Do you have high blood pressure or on medication to control high blood pressure?	YES / NO

If you answered YES to two or more questions on the STOP portion you are at risk for Obstructive Sleep Apnea. It is recommended that you contact your primary care provider to discuss a possible sleep disorder.

To find out if you are at moderate to severe risk of Obstructive Sleep Apnea, complete the BANG questions below.

BANG

B (BMI)	Is your body mass index greater than 28?	YES / NO
A (age)	Are you 50 years old or older?	YES / NO
N (neck)	Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches.	YES / NO
G (gender)	Are you a male?	YES / NO

The more questions you answer YES to on the BANG portion, the greater your risk of having moderate to severe Obstructive Sleep Apnea.