WELCOME!

To Our Patients:

Thank you for choosing Progressive Medical Center to assist you in determining the source of your personal health issues. We pledge to you a caring, professional and sharing environment dedicated to getting you back on the right track in as natural a manner as possible. Your wellness is our goal!

Your visit to our medical facility will involve a thorough review of your medical history in order to evaluate proper treatment. This questionnaire will assist the physician in determining the appropriate standing orders for testing to assess for the root cause(s) of your medical condition.

You will be initially interviewed by one of our medical assistants/Registered Nurse/Physician Assistant to obtain a more detailed history. One of our licensed attending physicians, either Viktor Bouquette, M.D., Frank Matalone, D.O., N.M.D, or Joanne Donaldson, M.D. then decides which of our extensive array of tests to utilize in diagnosing and adequately assessing your specific condition.

The cost for this initial office visit and examination will be $150 if you choose not to become a patient.

Should a consult with the Oncologist be needed, there is an additional cost of $125. Our film presentation currently states there is no charge for the consult, however we inform of the charge through this letter.

______________________________ __________

Patient/Authorized Person Signature Date

In the course of your visits here, some of the previously ordered tests might indicate the need for further assessment and, therefore, other studies might be ordered. Again, these studies will be explained to you, staying true to our standard of always keeping the patient fully informed. Your participation in all decisions pertinent to your care is a vital part of our integrated treatment process.

At any time in the process, if you desire to speak with our financial counselor for more details on costs, payments, or your insurance coverage, we will be pleased to consult with you. It is our desire that you are comfortable with all of our medical and financial procedures. We want you to feel at ease and confident with all members of the Progressive Medical Center's team.

If you have any other questions, please feel free to ask any of our staff.

Out of Network Insurance Provisions

In the course of diagnosis and treatment, patients at Progressive Medical Centers of America undergo comprehensive laboratory testing and detailed evaluations. In network managed care programs, Medicare/ Medicaid, and HMO's, however, prefer a more simplified approach to testing and evaluations. As a result, Progressive Medical Centers of America are not members of any In Network Managed Care, Medicare/ Medicaid, or HMO programs.

To avoid any inconvenience for our patients, Progressive Medical Centers of America have developed procedures for payment arrangements when necessary. The mission and purpose of Progressive Medical Centers of America is to work in harmony with our patients on all levels to address medical concerns and move toward a healthier state in life.

I, the undersigned, do hereby acknowledge and understand that Progressive Medical Centers of America are out of network providers for my insurance carrier.

_______________________________ ______________

Patient/Authorized Person Signature Date

Notice to Patients

Gez Agolli, PhD, ND — Cheryl Burdette, ND
Michael Gramazio, PhD, ND — Kimberly Williford, ND

This notice is provided to you pursuant of law. The practitioners above are registered Doctors of Naturopathic Medicine, and under the scope of practice for Naturopathy, are not practicing as licensed medical doctors and therefore do not practice "the application of scientific principles to prevent, diagnose and treat physical and mental diseases, disorders, and conditions and to safeguard the life and health of any person." A person registered to practice naturopathy or naturopathic healing under the law may counsel individuals and treat human conditions through the use of "naturally occurring substances."

The underlying causes of disease can be improper diet, unhealthy habits and environmental factors that cause biological imbalance. A classic naturopath specializes in wellness; the teaching of natural lifestyle approaches to facilitate the body's healing and health building potential.

I fully understand that the above named individuals are not medical doctors. This individual may counsel me on nutrition, supplements, and better health practices, but will not diagnose or prescribe remedies for disease. Furthermore, I understand that I will be diagnosed by a licensed medical physician during my visit at this office.

_______________________________ ______________

Patient/Authorized Person Signature Date

Assignment of Benefits Authorization / Release Form

Patient's Full Legal Name: ________________________________ Preferred: ___________Maiden Name: ______________

Date of Birth: ____________ Age: ___ Sex: M / F SSN: _________________ Race: __________ Ethnicity: _________

Marital Status: M / S / D Driver's License State/#: ______________ Primary Language: _________Religion: ___________

Address: ______________________________City: ____________ State: ____ Zip: __________ County: _____________

Home Phone: (____) _____________Work: (____) _____________ Cell: (____) ____________ Use for Primary: Hm / Wk / Cell

Email Address: ____

Employer: ____ Position: ________________________________

Parent or Spouse Name: ___________________________ Insured Party Y / N SSN: ___________ Date of Birth: _________

Work Number: (___) ____________Cell: (____) ____________ Parent or Spouse's Employer: __________________________

Emergency Contact:_____ __________________________Relationship:____________ Home/Cell: (_____) ______________

Pharmacy Name/Phone: 1) _________________________________ 2) ____

Patient's Primary Care Dr: __________________________ Phone Number: ________________ Date Last Seen: __________

How did you hear about us? Radio / Friend / Family / Existing Patient / Internet / Physician / Expo / Other:__________________

ALL FEES PAYABLE AT TIME OF SERVICE UNLESS SPECIAL ARRANGEMENTS ARE MADE.

RELEASE OF MEDICAL RECORDS/LAB/IMAGING: I authorize the release of any and all information/records/x-rays, etc. needed to evaluate my condition. I further request that this and any other pertinent information be forwarded to Progressive Medical Centers of America, 4646 North Shallowford Rd, Suite 100, Atlanta, GA 30338.

REQUEST FOR MEDICAL CARE: I voluntarily consent to examination, lab evaluation, treatment and the rendering of care, including treatments and performance of diagnostic procedures. I grant my consent for treatment of myself, my spouse or my minor children/dependent listed above. I consent to Progressive owning the copyright to any testimonies I release to the internet. I consent to any matter that involves the medical board of Georgia.

RELEASE OF FINANCIAL INFORMATION: I hereby authorize Progressive Medical Centers of America and/or its assigns all rights necessary to obtain financial information on me or my spouse in order to make determinations of my credit worthiness. Additionally I authorize Progressive Medical Centers of America and or its assigns to obtain a pre-approval for credit on services or treatments that I may or may not elect to utilize.

DIRECT PAYMENT AUTHORIZATION WITHOUT ASSIGNMENT OF BENEFITS: By way of original or a copy hereof, I, the undersigned patient hereby direct my insurance carrier to make payment directly to PMC Medical of America, PC, Viktor Bouquette, MD, Joann Donaldson, MD, Frank Matalone, DO for services rendered on my behalf. Additionally, I hereby authorize my insurance carrier to make any and all checks out to PMC Medical of America, PC, Viktor Bouquette, MD, Joann Donaldson, MD, Frank Matalone, DO. This assignment includes, but is not limited to, all rights to collect benefits directly from my insurance company for services and treatment that I receive from Progressive Medical Centers of America et al and all rights to proceed against my insurance company in any action, including legal suit, if for any reason, my insurance company fails to make payment which I am due. I fully agree, understand, that I am responsible for any/all charges not paid by my insurance company. Furthermore, this direct payment authorization with assignment of benefits transfers no right, title or interest in said contract other than the right to receive direct payments and as specified hereinabove. I also authorize Progressive Medical Centers of America et al to initiate a complaint to

the Insurance Commissioner for any reason on my behalf. I further agree that should I directly receive any insurance checks for services rendered by Progressive Medical Centers of America et al, I shall immediately endorse and forward these checks to Progressive Medical Centers of America, as I have no claim to these checks.

_______________________________ Patient/Authorized Person Signature

_______________ Witness

_______________ Date

Medical History

Patient's Name: ________________________________Date of Birth:___________Age: _____ Date: __________

What is the main problem that brought you in today? ____

How long have you been having symptoms? ____

Current Medications:

____
____
____
____
____

Current Supplements:

____
____
____
____
____

Allergies:

Drugs

____
____
____

Foods

____
____
____
Tested Y / N

Environmental (e.g. pollen)

____
____
____
Tested Y / N

Past Medical History:

Have you had any of the following medical issues?

Condition	**Yes**	**No**	**Current treatment**	**Date Began**	**Date Resolved**
ADD/ADHD					
Alcoholism/Drug addiction					
Allergies					
Anemia					
Anxiety					
Arthritis					
Asthma					
Autoimmune Disease Type					
Cancer Type:					
Chemical Sensitivities					
Chronic Fatigue					

Depression					
Diabetes					
Eczema					
Fibromyalgia					
GERD/reflux					
Headaches/migraines					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Condition	**Yes**	**No**	**Current Treatment**	**Date Began**	**Date Resolved**
Irritable Bowel Syndrome					
Lyme's Disease					
Menopause					
Mental Illness					
Mononucleosis					
Obesity					
Ovarian Cysts (PCOS)					
Psoriasis					
Prostate Disease					
Recurrent Strep infections					
Thyroid Disease					
Vaginal Infections					
Other					

Hospitalizations: **Date:** **Issue:** **Age:**

___________ ____ ______
___________ ____ ______
___________ ____ ______

If female: Do you have any of the following:

Irregular menstrual cycles?	Yes	No
Extreme heavy bleeding or cramping with menstrual cycles?		
Extremely light bleeding with cycles?		
Breast tenderness as part of PMS symptoms?		
Sugar cravings or mood swings as part of PMS symptoms?		

Have you been pregnant? Yes No If yes, ages: ______________
If no, have you tried to get pregnant without success? Yes No
When was your last Menstrual Cycle? Date: ___________________
When was your last: Pap ________ Mammogram _______ Bone Density _______
Have you used birth control pills? Yes No If yes, how long ___________

If male: Do you have any of the following:

Problems attaining/maintaining an erection	Yes	No
Difficulty with urination including decreased stream or increased frequency?		

Family Medical History:

Mother's age (at death if deceased): ____________

Any medical conditions: ____________________
Father's age (at death if deceased): ________
Any medical condtions: ____________________
Siblings' ages and medical condtions: ____________________
Other family members with chronic health conditions (e.g-diabetes, heart disease, thyroid disease):
____

Social history:
Please circle those that apply: Single Married Divorced
Please circle any of the following substances that you use regularly: Tobacco / Alcohol / Coffee / Recreational Drugs

Dental history: Please circle those that apply: Mercury filling(s) / Tooth Abscess(es) / Root Canal(s)

____

______________ ______ ______________ ______
Patient/Authorized Person Initials Date Physician's Initials Date

PRIMARY COMPLAINT(s): ____
____

Appx. date of onset: ____________ **Symptoms began: __ Gradually: __ Suddenly**

Symptom and Ailments Questionnaire #1

Please check the appropriate box for each question.

Symptoms – Please Circle One or all that apply on each line:	Frequently	Occasionally	Rarely	Never
Cold hands, feet, low body temperature				
Fatigue/ tiredness				
Inability to lose weight despite dieting				
Poor memory				
Poor concentration				
Constipation				
Diarrhea				
Hair loss				
Depression				
Anxiety/ nervousness				
Irregular heart beats				
Trouble sleeping				
Muscle weakness				
Muscle aches				
Joint pain				
Headaches				
Early morning stiffness				
Easy fatigue from exercising				
Sleepiness in the afternoon				
Dizzy/ lightheaded				
Sugar cravings				

Loss of voice / hoarseness				
Shaky or irritable when hungry				
Thyroid disease				
Sense of fullness during and after meals				
Belching/ burping/ bloating/ gas				
Rectal itching/ nasal itching				
Toe fungus, jock itch, or athlete's foot				
High sensitivity to smells				
Chronic or long term hives				
Bad breath				
Sinus or breathing problems				
Easy bruising				
Slow wound healing				
Average bowel movements per day?	(1)	(2)	(3)	(4+)

______________________________ ___________ _________________________ ______________

Patient/Authorized Person Initials Date Physician's Initials Date

<u>Symptom and Ailments Questionnaire #2</u>

Please check the appropriate box for each question.

Symptoms – Please Circle One or all that apply on each line:	**Frequently**	**Occasionally**	**Rarely**	**Never**
Vaginal burning, itching or discharge				
Prostatitis or prostate cancer				
Mood swings				
Endometriosis or infertility				
Cramps or menstrual irregularities				
Attacks of anxiety or crying				
Bladder / kidney infections				
Drowsiness				
Irritability				
Eczema or psoriasis				
Itchy skin or eyes				
Chronic hives (urticaria)				
Indigestion or heartburn				
Decreased body hair				
Sensitivity to milk, wheat or foods				
Decreased sex drive				
Dry mouth or throat				
Bad breath				
White tongue				
Excessive foot, hair or body odor				
PMS pre-menstrual syndrome				
Frequent sore throats				
Laryngitis, loss of voice				
Recurring bronchitis				
Pain or tightness in the chest				
Shortness of breath				
Spots in front of eyes				
Burning or tearing eyes				
Recurring infections in eyes				
Ear pain or ringing				
Salt Cravings				
Other symptoms needing consideration:				

Patient/Authorized Person Initials ____ Date ____ Physician's Initials ____ Date ____

Symptom and Ailments Questionnaire #3

Please check the appropriate box for each question.

Symptoms and Ailments: Please circle one or all that apply on each line:	*YES*	*NO*
Have you taken multiple courses of a broad-spectrum antibiotic drug—even in a single dose?		
Have you, at any time in your life, been bothered by persistent prostatitis, vaginitis or other problems affecting your reproductive organs?		
Are you bothered by memory or concentration problems e.g. do you sometimes feel 'spaced out'?		
Do you feel 'sick all over' yet, in spite of visits to many different physicians, no cause has been found?		
Have you been pregnant?		
Have you taken birth control pills longer than 2 years?		
Have you taken steroids orally, by injection or inhalation?		
Does exposure to perfumes, insecticides, fabric shop odors and other chemicals provoke symptoms?		
Does tobacco smoke *really* bother you?		
Are your symptoms worse on damp, muggy days or in moldy places?		
Have you had athlete's foot, ring worm, 'jock itch' or other chronic fungus infections of the skin or nails?		
Do you crave sugar?		
Do you have high blood pressure?		
Have you ever had angina or a heart attack?		
Have you ever had a stroke?		
Do you have diabetes?		
Do you have swelling that is not known to be the result of another health issue?		
Do you smoke?		
Do you have high cholesterol? If yes, what is your cholesterol number? __________		
Have you ever had coronary bypass surgery?		
Is there history of heart disease in your family?		
Have you been diagnosed with sleep apnea?		

24 hr Food Intake:

When did you last eat? ______ hrs ago
What did you have for breakfast today: ____
Lunch (yesterday or today):____
Dinner (yesterday):____
Snacks (past 24 hours):____
Beverages (past 24 hours):____

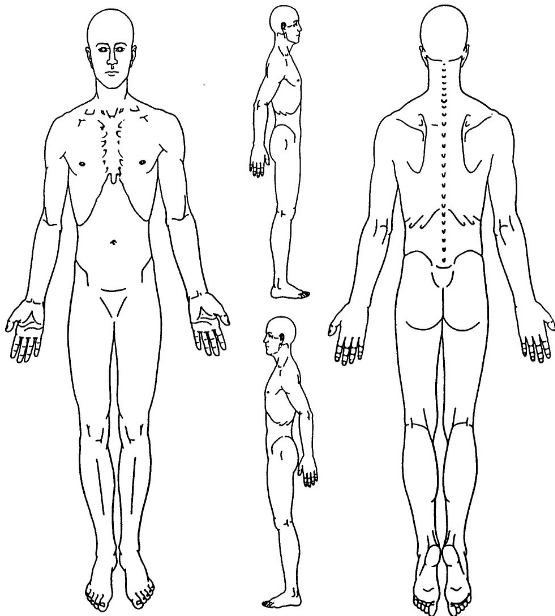
______________________________	__________	_______________________	______________
Patient/Authorized Person Initials	Date	Physician's Initials	Date

Pain Symptoms Questionnaire

Please check the appropriate box for each question.

Using the diagram below, indicate any areas you are feeling pain by marking a

PPP = Pain NNN= Numbness TTT = Tingling BBB = Burning CCC= Cramping XXX = Other



On a scale of 1-10, with 10 being the worst possible pain, what is your level of pain?

1 2 3 4 5 6 7 8 9 10

Please indicate any other symptoms that you have experienced:

_ Dizziness _ Memory Loss _ Numb Feet/ Toes
_ Irritability _ Ears Ringing _ Back Pain
_ Difficulty Sleeping_ Fatigue _ Jaw Problems _ Chest Pain _ Arm/ Shoulder Pain_ Leg Pain _ Back Stiffness
_ Blurred Vision _Numb Hand/ Fingers _ Tension
_ Low Back Pain _ Neck Stiffness _Shortness of Breath
_ Nausea _ Buzzing in Ear _ Neck Pain _ Upset Stomach_

Circle Quality of Pain:

Stabbing Shooting Dull Constant Intermittent Better /Worse with heat Better/Worse with ice
Better/Worse with movement Better/Worse sitting Better/Worse standing Better/Worse lying down

If yes,
How many days a week do you exercise? ______ How long? ________

What type of exercise (s)? ____

Have you ever seen a pain management specialist? NO__ YES__

If yes, what treatments are you currently receiving on a regular basis? (Acupuncture, physical therapy, medication…)____

Patient/Authorized Person Initials	Date	Physician's Initials	Date

Environmental Profile

According to the World Health Organization as much as 65% of all illnesses can be caused or made worse by the indoor environment. Numerous chronic diseases, which were once rare, are becoming commonplace as the levels of toxins present in our environment continue to escalate. Many times medical treatments are rendered ineffective if the environment in which a patient lives is not conductive to the healing process. During the course of your medical treatment the physician obtains a complete profile of your living environment. This will enable Progressive Medical Centers of America to determine if your illness is caused or worsened by your living or working environment and to specifically individualize a treatment program for optimal results.

Please circle one or all that apply on each line and answer the following questions by checking YES or NO:

Question	Yes	No
Are pesticides in your home or office?		
Do you use natural cleaning and laundry products?		
Is the construction of your house less than 15 years old?		
Have you had plumbing leakage, wet carpets or other water damage anywhere in your home?		
Do you have animals live indoors?		
Do you or your neighbors use lawn chemicals?		
Do you have moldy odors, mildew or visible molds anywhere in your home?		
When turning on your heating or air conditioning system(s) do you smell foul or moldy odors?		
Does the dust in your home reappear shortly after dusting?		
Do you have "blown-in" insulation in your attic?		
Are you, or is anyone in your home, experiencing any chronic ailments such as asthma, allergies, sinus infections, respiratory problems, or frequent cold or flu-like symptoms?		
Have you ever had bird, rat, mouse or any rodent infestation in your home?		
Do you have a "crawlspace" or an unfinished basement in your home?		
Do you feel better after you leave your home or office for a extended period of time?		
Do you use only natural products for your skin?		
Do you have moldy odors or visible molds in your workplace?		
Has there ever been water stains on the ceiling tiles, chemical odors, dirty air vents or excessive dust intrusion in your home or workplace?		
Do you frequently feel tired or run-down at the end of a workday?		
Do your family members and co-workers frequently complain of headaches, colds or flu-like symptoms?		

Is smoking permitted in your workplace or home?		
Do you have carpeting in your home or office?		
Do you use a filter for all drinking, cooking and shower/bath water?		
Do you have an air filter in your home or work place?		

What is your current occupation? ____

If less than one year, what was your prior occupation? __________________________

_____________________________ __________ ______________________ ______________
Patient/Authorized Person Initials Date Physician's Initials Date