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/nurses/medical scribes to obtain a more detailed history. One of our licensed attending physicians, either Viktor Bouquette, M.D., Joanne Donaldson, M.D., Joan Ifarinde, MD, Benjamin Johnston, Sr., M.D., DeAndra McDuffie, DNP, Kayla Keenan, FNP-C, Melanie Wardle, ARNP, or Julie Abrahamson, PA-C, who 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 $170.**

__________________________
Patient/Authorized Person Signature Date

This paperwork is essential to your visit. To maximize your time with the physician, please initial that you understand this entire packet needs to be completed 30 min. prior to your appointment time. If your paperwork is not completed prior to your appointment time, your visit may need to be rescheduled. In an effort to maximize the time of our patients, this intake paperwork is also available online via the Healow app.

_____ (Initial)

We do require you to cancel or reschedule your appointment within 48hrs of your scheduled appointment date & time. In order to reschedule or cancel your appointment, please call our office and speak with our New Patient Coordinator (770-676-6000, option 2). Cancellations after this time and no-shows are subject to the $50 cancellation fee.

_____ (Initial)

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 Center 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 Center is not members of any In Network Managed Care, Medicare/ Medicaid, or HMO programs.

To avoid any inconvenience for our patients, Progressive Medical Center has developed procedures for payment arrangements when necessary. The mission and purpose of Progressive Medical Center 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 Center are out of network providers for most insurance carriers and that my own insurance carrier can change throughout the year. I acknowledge it is my responsibility to notify the billing department of any insurance updates.

_________________________  ____________________
Patient/Authorized Person Signature          Date

Notice to Patients

Jenna Davis, ND            Mallory Howe, ND            Marcia Williams, ND
Megan Borreson, ND

This notice is provided to you pursuant of law. We have other physicians on staff this does not apply to. 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
NOTIFICATION TO PATIENTS

Disclosure of Lab services:

You have the right to choose where you receive medical and laboratory services. Your physician/advanced practitioner may order specialty lab testing when they deem it is medically necessary. Physicians and Advanced Practitioners have no financial relationship with any reference laboratories including but not limited to the following: LabCorp of America, Quest Diagnostics, Dunwoody Labs, Doctor’s Data, Precision Analysis Labs, or Vibrant Laboratory.

The Medical Management Company (which is not owned by your physician) reserves the right to develop a business relationship with Labs. You have the right to choose where you receive laboratory services including an entity in which the Medical Management Company may have a business relationship with.

You will not be treated differently by your physician if you choose to use a different laboratory. If desired, your physician can provide information about alternative laboratories, if one is available for your specific tests.

Acknowledgment of Disclosure

By signing this Acknowledgment of Disclosure, you acknowledge that you have read and understand the foregoing Notification to Patients regarding physician ownership.

_________________________________________   _______________________________
Signature of Patient                              Date

______________________________
Type or Print Name of Patient
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.

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AN APPOINTMENT AND/OR DESIGNATION AS AN ERISA/PPACA REPRESENTATIVE

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Progressive Medical Center (Progressive Health Care and Diagnostic, LLC; Precision Medical Center; PMC Medical Care and Diagnostics, LLC; and/or Regenerative Medical Center, PC), as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as “Healthcare Provider”) the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for medical/healthcare services that have or will be rendered and for any supplies, tests, or medications provided.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan, ERISA plan, PPACA plan, or insurance contract rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). This document includes, but is not limited to, a designation that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. This assignment and/or designation will remain in effect unless revoked in writing, and a photocopy or scan is to be considered as valid and enforceable as the original.

Signed this ______ day of _____________________ 20____.

X_______________________________________ X____________________

Patient Signature Signature of Guardian if applicable

________________________________________ ______________________
Authorization for Disclosure of Health Information

Protected health information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment, or health care operations (TPO) and as otherwise required by law.

Examples of some instances in which we are required to disclose your PHI include:
Public health activities; information regarding victims of abuse, neglect, or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donations purposes; research purposes under certain circumstances; national security and intelligence; correctional institutions; and Worker’s Compensation.
Progressive Medical Center will only use or disclose PHI, except as noted above, consistent with the terms of the authorization.

A patient may revoke his authorization to use or disclose PHI at any time but actions taken prior to the revocation are excluded. If authorization is a condition of obtaining insurance coverage, and the authorization is revoked, the insurer may contest a claim under the policy.

Authorizations must be properly executed by the patient or his personal representative. It should include, the date signed, specific PHI to be released or used, to whom this use or release relates, and an expiration date for the authorization.

Patient Name: ___________________________________________________________ Date: __________________
Signature: __________________________________________________________________________________________
Guardian/ Parent name: ___________________________________________ Signature: _____________________________

My health information may be disclosed to and used by the following individual:

Name: ___________________________________________________________ Relationship to patient: ______________________
Address: __________________________________________________________________________________________
City: ___________________________________________ State: ___________ Zip: __________________

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact: Progressive Medical Center.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_________________________ __________________________
Signature of patient or legal representative Date

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, part II.
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:**

| Medications |  |
|-------------|-
|             |  |
|             |  |
|             |  |

**Current Supplements:**

| Supplements |  |
|-------------|-
|             |  |
|             |  |
|             |  |

**Allergies:**

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Foods</th>
<th>Environmental (e.g. pollen)</th>
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<tr>
<td>Tested Y / N</td>
<td>Tested Y / N</td>
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</tbody>
</table>

**Past Medical History:**

Have you had any of the following medical issues?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Current treatment</th>
<th>Date Began</th>
<th>Date Resolved</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADD/ADHD</td>
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<tr>
<td>Alcoholism/Drug addiction</td>
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<tr>
<td>Allergies</td>
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<td>Anemia</td>
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<td>Anxiety</td>
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<td>Arthritis</td>
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<td>Asthma</td>
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<td>Autoimmune Disease Type</td>
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<td>Cancer Type:</td>
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<tr>
<td>Chemical Sensitivities</td>
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<tr>
<td>Chronic Fatigue</td>
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<td>Depression</td>
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<td>Diabetes</td>
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<td>Eczema</td>
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<tr>
<td>Fibromyalgia</td>
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<td>GERD/reflux</td>
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<td>Headaches/migraines</td>
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<tr>
<td>Heart Disease</td>
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<tr>
<td>High Blood Pressure</td>
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<td>High Cholesterol</td>
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</table>

**Condition**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Current Treatment</th>
<th>Date Began</th>
<th>Date Resolved</th>
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</thead>
<tbody>
<tr>
<td>Irritable Bowel Syndrome</td>
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<tr>
<td>Lyme Disease</td>
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<tr>
<td>Menopause</td>
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</tbody>
</table>
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 conditions: ____________________________
Siblings’ ages and medical conditions: ____________________________
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