# *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 to evaluate proper treatment. This questionnaire will assist the physician in determining the appropriate standing orders for testing to assess the root cause(s) of your medical condition.

You will be initially interviewed by one of our Medical Assistants to obtain a more detailed history. One of our licensed medical doctors: Benjamin Johnston, Sr. M.D, Viktor Bouquette M.D, or one of our Advanced Practice Licensed Providers: Magda Sneddon F.N.P, Diane Spiva N.P, or Kellyn Wingert N.P. who will then decide which of our extensive array of tests to utilize in diagnosing and adequately assesses your specific condition.

***The cost for this new patient consultation and examination will be $170. This consultation fee includes Urine and BIA test ONLY. This fee is payable at check-in.***

_____ _____

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 minutes prior to your appointment time. If your paperwork is not completed prior to your appointment time, your visit may need to be rescheduled. _____ (Initial)

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

During 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 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

During 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 is 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

## Disclosure of Lab 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, LabCorp of America, Quest Diagnostics, American Clinical Labs, Dunwoody Labs, Doctor's Data, Precision Labs or Vibrant Laboratory. **Progressive Medical Center is not responsible for any cost of labs ordered.**

**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

_____

Please Print Name of Patient

# Notice to Patients

Firlande Volcy, ND | Marcia Williams, ND

This notice is provided to you pursuant of the law. We have other physicians on staff this does not apply to. The practitioners above are registered Doctor's 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

## Dear Patient:

Please note that we utilize the services of Physicians Assistants, Nurse Practitioners and Naturopathic doctors in this office. **Please read and initial each of the following:**

_____ I understand that Naturopathic doctors (ND) are not licensed in GA and therefore are not able to prescribe medication or order tests or other treatment modalities.

_____ I understand that I must request lab tests, IVs', Hyperbaric sessions, sauna session and all prescriptions from my medical provider and not the ND.

_____ I understand that prescription refill requests must be made three (3) days in advance. No prescription refills will be handled after business hours or over the weekend.

_____ I understand that all telephone calls will be answered within 24 hours and not same day except urgent requests.

_____ _____

Patient Signature Date

_____

Please Print Patient Name

# 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 Healthcare and Diagnostics, 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

_____ _____

Please print Patient name Please print Guardian name

# 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:**

_____
_____
_____
_____
_____

**Current Supplements:**

_____
_____
_____
_____
_____

**Allergies:**

| Drugs | Foods | Environmental (e.g. pollen) |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| | Tested Y / N | 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 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:**

| | Yes | No |
|---|---|---|
| Irregular menstrual cycles? | | |
| 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:**

| | Yes | No |
|---|---|---|
| Problems attaining/maintaining an erection | | |
| 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): _____**

_____