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 help the physician determine the appropriate standing orders for testing to assess the root cause(s) of your medical condition.

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

The cost for this new patient consultation and examination will be $250. This fee is payable at check-in.

X_____

Patient/Authorized Person Signature Date

This paperwork is essential for 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 **24hrs** 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 relevant 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.

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.

*X*_____ _____

Patient/Authorized Person Signature Date

_____

Please PRINT Patient Name

Notice to Patients

Firlande Volcy, ND. | Marcia Williams, ND.

This notice is provided to you in accordance with the law. The practitioners mentioned above hold the title of Registered Doctor of Naturopathic Medicine. However, they do not practice as licensed medical doctors and therefore do not engage in 'the application of scientific principles to prevent, diagnose, and treat physical and mental diseases, disorders, and conditions, safeguarding the life and health of any person. Instead, they focus on naturopathy, which allows them to counsel individuals and treat human conditions using naturally occurring substances. The underlying causes of disease may include improper diet, unhealthy habits, and environmental factors that cause biological imbalance. A classic naturopath specializes in wellness, teaching natural lifestyle approaches to enhance 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.

X_____ _____

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 48 hours and not same day except urgent requests.

X_____ _____
Patient/Authorized Person Signature Date

_____
Please PRINT Patient Name

Terms of Service

By accessing or using the services at Progressive Medical Center ("PMC," "we," "us," or "our"), you ("Patient" or "Client") agree to be bound by these Terms of Service. These Terms govern all services provided by PMC, including in-clinic visits, telehealth consultations, diagnostic testing, intravenous (IV) therapies, supplement purchases, and health programs.

Cash-Based Practice Disclosure
PMC operates exclusively as a cash-based practice. We do not bill insurance providers on behalf of patients. Payment is due at the time of service. Upon request, we may provide a itemized statement for potential out-of-network reimbursement; however, PMC makes no guarantees regarding reimbursement and assumes no responsibility for insurance claims or denials.

Medical Disclaimer
Our services are focused on functional and integrative medicine principles, which emphasize addressing underlying root causes of illness and supporting overall wellness.
Services are not a substitute for emergency medical care or conventional treatments when indicated. No specific results are promised or guaranteed; outcomes vary by individual. Patients are encouraged to maintain ongoing care with their primary care physician or specialist(s), when appropriate.

Patient Responsibilities
Patients agree to provide complete and accurate health history and medical information, and to inform PMC promptly of any changes to health status or medications. Patients further agree to actively participate in their care by following all medical advice, treatment protocols, and safety guidelines as prescribed by PMC providers.
Because illness and imbalance rarely develop overnight, patients acknowledge that achieving true wellness requires time, sustained effort, and consistency. Accordingly, patients commit to making any and all

recommended dietary, lifestyle, and behavioral changes, and to adhering to prescribed treatment plans. Failure to engage in these commitments may limit the effectiveness of care.

Payment Terms
PMC accepts credit card, debit card, HSA/FSA cards, and cash. Progressive offers financing options for qualified patients. Financing options will be offered to you at your request. Payment is required in full at the time of service, or in advance for packages or programs. Full payment or authorized payment plan is required before initiation of any multi-visit or bundled program.

Refund and Cancellation Policy
Progressive Medical Center maintains a strict no-refund policy for all services, programs, and therapies. Once services are rendered, provider time, staff resources, and clinical expertise cannot be reversed.
Nutritional IV therapies are compounded through 503A pharmacies and ordered exclusively for each patient; federal regulations prohibit reallocation, resale, or refund of these medications. All IV sales are final. For diagnostic testing, once bloodwork is collected, specimens are immediately processed by reference labs and cannot be canceled or refunded.
Unused take-home diagnostic kits may be refunded at PMC's discretion, subject to management approval and a 50% restocking fee. Progressive Medical Center may, at its discretion, reallocate remaining program balances or unused credits toward other eligible services. Patients who discontinue a program mid-course remain subject to this no-refund policy.

Scheduling, Rescheduling, and Missed Appointments
Notice Requirement: A minimum of 24 hours' notice is required to cancel or reschedule appointments. Late Cancellations / No-Shows: Missed appointments or cancellations with less than 24 hours' notice may result in a fee. Repeated missed appointments may result in dismissal from the clinic.

Telehealth
Telemedicine services are provided in compliance with applicable state laws. Patients are responsible for confirming eligibility and state residency requirements. By engaging in telehealth, patients consent to virtual care and acknowledge its limitations.

Privacy and Confidentiality
PMC complies with applicable federal and state privacy regulations, including HIPAA. Patient records are confidential and will not be released without written authorization except as required by law. For more details, refer to our Notice of Privacy Practices.

_____ (Initial)

Assumption of Risk and Informed Consent
Patients acknowledge that all medical treatments carry inherent risks and that PMC has provided sufficient information regarding potential benefits and risks. By proceeding with care, patients voluntarily assume these risks and release PMC and its providers from liability, except in cases of gross negligence or willful misconduct.

Intellectual Property
All educational materials, handouts, website content, and treatment protocols developed by PMC are the intellectual property of the clinic. Unauthorized reproduction, distribution, or use is prohibited.

Dispute Resolution and Governing Law
These Terms are governed by the laws of the State of Georgia. Any disputes shall be resolved through binding arbitration in Dekalb County, Georgia.

Amendments
PMC reserves the right to update or modify these Terms of Service at any time. The most current version will be posted on our website and made available upon request. Continued use of our services constitutes acceptance of the updated terms.

X_____ _____

Patient/Authorized Person Signature Date

_____

Please PRINT Patient Name

Patient Information/Demographics

Patient's Full Legal Name: _____ Preferred: _____Maiden Name: _____

Date of Birth: _____ Age: ____ Sex: M / F 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 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: _____

Authorization to Receive Text Messaging

As a part of ongoing medical care, Progressive Medical Center utilizes text messaging communications. By opting in below, you consent to receive text messages from Progressive Medical Center. These messages may include appointment reminders, important information regarding appointments, instructions on accessing telehealth appointments, and other essential information related to your medical care. You may opt out of receiving these messages at any time by notifying us in writing, updating your communication
preferences in our patient portal, opting out below, or by responding to text messages with the instructions below.

Opt-In Consent:

☐ I agree to receive recurring messages from Progressive Medical Center.

(You may reply STOP to opt out; Reply HELP for help; Message frequency varies; Message and data rates may apply; Carriers are not liable for delayed or undelivered messages.)

Opt-Out Consent:

☐ I do not agree to receive text messages from Progressive Medical Center.

X_____ _____

Patient/Authorized Person Signature Date

_____

Please PRINT Patient 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.

Please PRINT Patient Name: _____ Date: _____

Patient Signature: _____

Guardian/ Parent name: _____ Signature: _____

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

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 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 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.

X_____ _____

Signature of patient or legal representative Date

Medical History

Patient's Name: _____Date of Birth:_____ Age: _____ Date: _____

What is the primary complaint(s) 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:

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