Patient Information Form

Name: (Last) ___________________________________ (First)_____________________(MI) _______________

Name you prefer to be called: ____

Patient Address for shipping: (No PO Boxes) ____

City: ____ State: ____________ Zip: _____________________

Phone: ____________________ Cell: ____________________ E-mail: __________________________________

Birthdate: ___________________ SS #: _____________________________ Age: _________ Sex: M F

How did you hear about us? (Circle)

Sign Internet Coupon Referral Event Direct Mail TV Other: _________________________

Employment Information:

Patient Employer: __________________________ Occupation: ________________ Phone: _________________

Employer Address: ____

City: ____ State: ______________ Zip: ____________________

In Case of Emergency:

Name: ______________________________(Relationship)_____________ Phone: _________________________

Patient's Spouse: ____ Phone: _________________________

Family Physician: ____ Phone: _________________________

Financial Policy Agreement:

Thank you for selecting Atlanta Medical Institute (AMI) for your health care needs. We are pleased to be of service to you and your family. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard, American Express and checks.

By signing this Financial Policy Agreement, I agree:

1. Should this account be referred to an agency or an attorney for collection that I will be responsible for all collection costs, attorney's fees and court costs.
2. AMI weight loss program is non-refundable! If I choose to cancel my enrollment in this program anytime before the end of the enrollment period, I will be given a credit towards any additional services the clinic provides.
3. In the unlikely event that our medical provider determines that you are not a good candidate for prescription medicines described in your program, a natural substitute will be supplied. A 30% administrative fee will be applied to any approved refunds, decided at the sole discretion of our medical director.
4. The cost of prescription medications includes the scripting/processing fee. I have read and understand all of the above and have agreed to these statements.

Signature: ____ Date: ___________________________

AMI Survey

Are You Interested in Improving Your Overall Wellness?

Do you have an interest in? (Please Circle)

- **Hormone replacement therapy:** **Yes / No**
  - Do you want to feel more energized? **Yes / No**
  - Do you want to improve your sex life? **Yes / No**
  - Do you want to sleep better? **Yes / No**
  - Do you want to feel less anxious; less depressed? **Yes / No**

- **Weight Loss:** **Yes / No**
  - How much weight would you like to lose? _______
  - Is there an event in the next 90 days you would like to lose weight by? **Yes / No**
  - Are you ready to commit to a weight loss plan? **Yes / No**

- **Nutrition:**
  - Do you take a multi-vitamin, supplements or fish oil daily? **Yes / No**
  - Are you interested in Freshly Prepared Meals? **Yes / No**

- **Stress Reduction:** **Yes / No**
  - What kind of stress bothers you the most? (Work, family, money, etc.) _______
  - On a scale of 1-10, how much does this stress interfere with you life? _______

- **Detoxification:**
  - Are you interested in cleansing toxins from your system? **Yes / No**
  - Do you experience constipation (slow bowel elimination)? **Yes / No**
  - Do you have joint pain, headaches? **Yes / No**

- **Spinal Health (Chiropractic and Massage):** **Yes / No**
  - Do you have pain in your upper or lower back? **Yes / No**
  - Rate the severity of your pain on a scale from 1-10 _______
  - Do you have insurance that you would like us to verify for future visits? **Yes / No**
  - Have you had a Spinal X-Ray? **Yes / No**

- **Would you like more information on additional testing?**
  - Food Sensitivity? **Yes / No**
  - Allergy Testing? **Yes / No**
  - Adrenal Fatigue? **Yes / No**

- **Aesthetics: (Botox, Fillers, Cosmetic Surgery, Facials)** **Yes / No**
  - Are you concerned about fine lines and wrinkles? **Yes / No**
  - Are you interested in mole removal? **Yes / No**
  - Do you want to improve the look of your jawline? **Yes / No**

PT Name: ____ DOB: ___________________________

PATIENT CONSENT FOR USE AND DISCOLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Atlanta Medical Institute (AMI) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to AMI's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices (NPP) prior to signing this consent. AMI reserves the right to revise its NPP at any time. A revised NPP may be obtained by forwarding a written request to AMI. With my consent, AMI may:

- call my home (or other location) and leave a message on voice mail or in person in reference to any item(s) that assist the practice in carrying out TPO, such as:
    - appointment reminders
    - insurance items
    - calls pertaining to my clinical care (including laboratory results among others)
- mail to my home (or other location) any items that assist the practice in carrying out TPO, such as:
    - appointment reminder cards
    - patient statements as long as they are marked Personal and Confidential
- email to my home (or other location) any items that assist the practice in carrying out TPO, such as:
    - appointment reminder cards and patient statements

By signing this form, I am consenting to AMI's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, AMI may decline to provide treatment to me.

I have been offered and have had the opportunity to review the HIPAA disclosure form: ____

____
Signature of Patient

____ Date ____
Patient Name

REQUEST TO RELEASE MEDICAL RECORDS

I request the release of my medical records from Atlanta Medical Institute (AMI) to ____. I release WCOA, its managers, physicians, and contractors from any and all claims resulting from this release, as I realize these constitute their permanent records. I authorize each physician, doctor, nurse, clinic, or and other health care provider to provide any and all information or records as to diagnosis, treatment or prognosis concerning my past, present or future physical or mental history or condition for Date: 2016.

I acknowledge and understand that I may revoke this authorization at any time by notifying AMI of my revocation in writing and delivering my revocation by mail or personal delivery. I further understand that, as a result of this Authorization, any of my medical information disclosed by any Authorized Discloser on my behalf may be disclosed and may no longer be protected by the HIPPA Privacy Regulations. I certify I am executing and delivering this authorization freely and unilaterally as of the date written below and that all information contained in this authorization is true and correct. I request these medical records be forwarded as follows:

Fax: ____ Email: ____

____ ______________________________________ ________________________

Patient Signature Name (Print) Date

Medical History Form

Family Physician: ____ Phone: __________________________

Y	N	Question	Details
Y	N	Are you in good health at the present time?	
Y	N	Are you under a doctor's care?	For what: Last Checkup:
Y	N	Are you taking any medications?	What (dosage): What (dosage):
Y	N	Any allergies to any medications?	List: List:
Y	N	History of high blood pressure?	
Y	N	History of diabetes?	At what age:
Y	N	History of heart attack or chest pain?	
Y	N	History of swelling feet?	
Y	N	History of frequent headaches?	Migraines:
Y	N	History of constipation?	
Y	N	History of glaucoma?	
Y	N	Serious Injuries?	Specify (date): Specify (date) :
Y	N	Any surgeries?	Specify (date): Specify (date): Specify (date):

Gynecologic History: (Women Only)

Y	N	Item	Details	
Y	N	Pregnancies	Number:	Dates:
Y	N	Menstruation	Onset: Regular: Y N	Duration: Painful: Y N
Y	N	Hormone Replacement Therapy	What:	
Y	N	Birth Control Pills	Type:	

Personal Health History:

Y	N	Condition		Y	N	Condition
Y	N	Cancer: Type _________________________________		Y	N	Liver or Gallbladder Disease
Y	N	Blood Clots		Y	N	Insulin Resistance/Diabetes
Y	N	Neurological Disorder: Epilepsy, seizure, stroke		Y	N	Thyroid Disease
Y	N	Heart Disease		Y	N	Arthritis or Joint Problems
Y	N	Peptic Ulcer		Y	N	Musculoskeletal Problems
Y	N	Irritable Bowel/Chrohn's Disease				

PT Name: ____ DOB: ___________________________

PLEASE CHECK ALL SYMPTOMS THAT APPLY WITH THE APPROPRIATE SEVERITY:

ICD-9	SYMPTOM	Mild	Moderate	Severe
	Endocrine Concerns			
R68.82	Low Libido/Sexual Interest			
F52.8	Inability to Orgasm			
N95.1	Female: Hot Flashes			
R61	Female: Night Sweats			
N64.4	Female: Breast Tenderness			
N94.89	Female: Vaginal Dryness			
N94.3	Female: PMS			
N94.6	Female: Menstrual Cramps			
N92.5	Female: Irregular Periods			
N93.8	Female: Bleeding between periods			
F52.4	Male: Inability/premature ejaculation			
N52.9	Male: Erectile dysfunction			
	Physical Concerns			
I97.3	Elevated/Decreased B/P			
G43.119	Migraine Headaches			
R52	Body Aches			
F48.8	Fatigue			
R60.0	Occasional Swelling			
I10	High Blood Pressure			
E785	High Lipids (Cholesterol/Triglycerides)			
Z79.899	Long Term Use of Medications			
R7301	Elevated Glucose			
E55.9	Low Vitamin D			
R00.2	Palpitations			
R32	Urine Leakage			
J01.10	Sinus Congestion			
B37.9	Chronic/Recurrent Yeast			
	Neurological Concerns			
R41.3	Memory Loss/Forgetfulness			
G47.09	Insomnia			
F41.1	Racing Thoughts @ night			
R41.840	Brain Fog/Focus Difficulty			
	Emotional Concerns			
F32.9	Depression			
F41.1	Anxiety			
R45.4	Irritability			
F41.0	Panic Attacks			
F06.30	Mood Swings			
L65.9	Thinning Hair			
F60.6	Low Self Esteem			
	Esthetic Concerns			
L94.2	Thinning Skin			
L11.9	Wrinkles			
R20.8	Creepy/Crawly Skin			
L70.8	Dry/Oily Skin			
L71.0	Acne			

PT Name: ____ DOB: ________________________

I understand that Atlanta Medical Institute (AMI) does not submit billing to my insurance company. However, Quest Labs or Lab Corp, located on the premises of AMI, will submit an insurance claim with my insurance company (where applicable,) on my behalf, to cover my lab fees. If my insurance company does not pay for the cost of the labs performed and I receive a bill from Quest, I will be able to submit a copy of my bill to AMI for rebilling at a discounted rate and will only be responsible for reimbursing AMI at the clinic's cash rate (between $250-$350). In the event that the insurance company pays Quest a partial payment, the balance bill may be my responsibility and may not be able to be transferred to AMI for further discounting.

I have read and understand all of the above and have agreed to these statements.

Signature: _______________________________________ Date: ______________________

I, the undersigned Patient, accept, understand, and agree to the following terms, provisions and conditions:

Independent Contractors of AMI

Independent contractors and medical organizations that may provide medical services, physician services, laboratory services, pharmacy services, other services, prescription drugs and products to Patient on behalf of AMI include, but are not limited to the following:

- Physicians and medical organizations that conduct Patient's physical examination, evaluate Patient's physical exam results, medical history, medical complaint, and prescribe medication or medical treatment to Patient;
- Diagnostic medical testing laboratories.
- Pharmacies that dispense prescribed medication directly to Patient.

Medical Service and Products Provided: Physical Examination, Prescribing or Treatment, Dispensing Pharmacy and Supervision of Patient Medical Treatment

- The physician conducting the physical examination of Patient, or other physician within the medical organization who is employing the examining physician (Physician), shall be responsible for supervising medical treatments prescribed to Patient.
- Patient agrees to undergo a medical laboratory urine or blood test if required for the AMI treatment program purchased.
- Physician shall evaluate the physical exam report, medical history report, any laboratory test report and the medical complaint of Patient in determining whether or not to issue a prescription for a medical treatment requested by Patient.

Physician Conducts a Physical Examination and Evaluates Patient's Medical History and Medical Complaint Before Prescribing any Medical Treatment

- Patient understands that AMI do not anticipate any adverse effect to arise as a result of any medical program provided to Patient. Patient also understands that the practice of medicine is not an exact science and that no specific outcome from treatment can be assured to Patient.
- **Patient is freely seeking medical services offered by AMI with an understanding that the Physician will conduct the physical examination of Patient and supervise Patient's medical treatment**. Patient is also aware that all medical programs offered by AMI require that the Physician prescribe any medical program offered by AMI.
- Patient has examined and requested a medical program offered by AMI and understands the nature and risks inherent in the medical program purchased from AMI.
- Patient represents that all information provided to Physician and AMI by Patient is complete, correct and accurately reflects Patient's known medical condition.

Patient Agrees to Provide Accurate and Complete Information to Physician and AMI

- Physician shall obtain Patient information, draw conclusions and make decisions based upon Patient's honest responses to questions presented to Patient.
- Patient represents that all responses to questions regarding Patient's medical condition shall be truthful, accurate and complete.
- Patient understands that failure to provide truthful, accurate and complete information to Physician or AMI on any data collection form could cause Physician to unknowingly make an inappropriate treatment decision affecting the physical or mental health of Patient.

PT Name: ____ DOB: ___________________________

Physician is an Independent Contractor of AMI. Patient understands that AMI does not practice medicine and functions as a medical administration organization coordinating the services and products of medical organizations for AMI.

- Unless otherwise communicated by AMI to Patient in writing, the Physician is an independent contractor of AMI and is not an agent or employee of AMI. AMI does not direct, control or influence the treatment decisions made by Physician with respect to Patient care or any Patient request for specified treatment.
- AMI compensates Physician the same amount for professional services rendered regardless of whether or not a prescription is issued for treatment sought by Patient.
- Patient understands and agrees that Patient medical records become the property of AMI: and that, in addition, AMI will have continuing access to and the right to copy and retain any and all portions of Patient medical records.
- Patient understands and agrees that a duplicate copy of Patient medical records become the property of the medical organization or physician that conducts Patient's physical examination; and that, in addition, said medical organization and examining physician shall have continuing access to and the right to copy and retain any and all portions of Patient's medical records.

Miscellaneous Provisions

- Patient understands that prescription medications cannot be returned to the dispensing pharmacy, AMI or any other individual or entity after the medication has been dispensed to Patient.
- This Agreement represents the complete and entire agreement between the parties. No prior written or electronic agreement, verbal communication or verbal agreement may be offered or used to alter any terms or condition of this Agreement.
- Patient agrees that a delivery receipt for a shipment from AMI, its contractors, any independent pharmacy, or any delivery service signed by a person at the Patient's shipping address shall constitute conclusive evidence of the delivery and receipt of the prescription drug and full performance of the obligations of AMI to Patient.
- Patient irrevocably agrees and instructs Visa, MasterCard, or other credit card provider or processor, and Patient's bank to withdraw any credit card dispute submitted should independent evidence of delivery of the shipment to Patient's address be provided by AMI.
- Federal Express or other delivery services report of delivery to the Patient's shipping address on the Federal Express or delivery service's website shall constitute delivery to Patient. Federal Express's or other delivery service's reported delivery to the Patient's shipping address on the Federal Express or other delivery service's website with a reported wavier of signature on file with Federal Express or other delivery service for deliveries to Patient's shipping address shall also constitute delivery of the prescription drug and its receipt by Patient. The reported delivery of the prescription medicine shipment by the United States Postal Service to the Patient's address on its website shall also constitute delivery to Patient and conclusive evidence of the full performance of this Agreement by AMI.
- AMI shall use its best efforts in good faith to assure a high level of service to Patient, including the timely delivery of all prescription medicine dispensed by the responsible pharmacy.

Patient's Representations and Assurances

- Patient is over 18 years of age.
- Patient agrees that any claim or action brought by Patient against AMI, its agents, officers, directors, owners, shareholders, contractors and affiliated companies shall be brought in Fulton County, Georgia, which is granted exclusive jurisdiction and venue of claims brought by Patient, or any assignee, against said parties, arising from any transaction or occurrence involving Patient and said parties.
- Patient unconditionally and expressly waives all claims and defenses that might be brought or asserted by Patient in any such action against said parties. Patient agrees that this agreement is voluntary, and that it is binding to any individual or entity claiming by or through Patient or on behalf of Patient.
- Patient further agrees to pay all attorneys fees and costs incurred by AMI as they are incurred in the event Patient brings any action or claim against AMI in violation of this provision; or in violation of any term, condition or provision of this Agreement; or brings an action against AMI, or any of its officers, directors, employees, agents or contractors inconsistent with Patient's waiver of all claims and defenses as set forth in this Agreement.
- Patient is aware of potential side effects associated with medication requested by Patient and personally accepts all risks involved in taking such medication; and Patient agrees not to seek any indemnification, damages of any kind, or any other liability from AMI, its officers, directors, employees, parent, subsidiaries, affiliates, contractors, agents, or any medical organization or pharmacy that provides Patient with medical services or products at the request of AMI in the event Patient experiences any of the adverse side effects of prescribed medication.
- Patient understands that AMI, its employees, agents, contractors, contracting physicians, nurses, sales personnel, administrative personnel and other entities and organizations and their employees who provide medical services or products to Patient at the request of AMI cannot guarantee that the prescription medication or treatment sought by Patient will provide the results sought by Patient.
- Patient has obtained and consulted with Patient's primary care physician or pharmacist and Patient is not taking any medication or combination of medications that will make the medication requested from AMI inadvisable to take (contraindicated).

- Patient agrees to advise Patient's primary care physician of any medications obtained through AMI before commencing use of such medication.

- Patient agrees that this Agreement shall serve as Patient's authorization for AMI to release or disclose Patient's medical information to medical organizations rendering medical services to Patient at the request of AMI
- This consent does not give AMI the right to sell Patient's name or information to any third party.

Waiver

- PATIENT UNCONDITIONALLY AND EXPRESSLY WAIVES ANY AND ALL CLAIMS AND DEFENSES AGAINST WCOA IT'S SHAREHOLDERS, DIRECTORS, OFFICERS, EMPLOYEES, AGENTS, CONTRACTING PHYSICIANS, AND ANY AND ALL ORGANIZATIONS AND THEIR EMPLOYEES PROVIDING SERVICES OR PRODUCTS TO PATIENT ON BEHALF OF AMI FOR ANY CLAIM RELATING DIRECTLY OR INDIRECTLY TO ANY SERVICE OR PRODUCT PURCHASED BY PATIENT FROM AMI.
- THIS WAIVER INCLUDES, BUT IS NOT LIMITED TO, ANY ILLNESS, BODILY INJURY OR OTHER ADVERSE PHYSICAL, MENTAL OR MEDICAL CONDITION SUSTAINED BY PATIENT AS A RESULT OF A SERVICE OR PRODUCT PURCHASED FROM AMI BY PATIENT OR PROVIDED TO PATIENT BY ANY MEDICAL ORGANIZATION OR CONTRACTING PHYSICIAN OF AMI.
- PATIENT EXPRESSLY WAIVES ANY AND ALL DEFENSES IN ANY ACTION BROUGHT BY PATIENT AGAINST WCOA OR ANY OF ITS CONTRACTORS. PATIENT UNDERSTANDS THE NATURE OF THIS WAIVER OF CLAIMS AND DEFENSES AND VOLUNTARILY AGREES TO THIS WAIVER OF CLAIMS AND DEFENSES.
- THIS WAIVER OF CLAIMS AND DEFENSES IS BINDING TO ANY INDIVIDUAL OR ENTITY CLAIMING BY, OR THROUGH, OR ON BEHALF OF PATIENT. PATIENT HOLDS WCOA, ITS AGENTS, SHAREHOLDERS, DIRECTORS, OFFICERS, EMPLOYEES AND CONTRACTORS HARMLESS AND INDEMNIFIES EACH FOR ANY LIABILITY ARISING IN CONNECTION WITH THE TREATMENT PROGRAM PURCHASED FROM AMI BY PATIENT.

Authorization

- I hereby grant AMI permission to use my photograph in any and all publications, including web site entries, without payment or any other consideration in perpetuity.
- I hereby authorize AMI to edit, alter, copy, exhibit publish or distribute this folder. I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my photo appears. Additionally, I waive the right to royalties or other compensation arising or related to the use of the photography.
- I hereby hold harmless and release and forever discharge AMI from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf of my estate which may have or may have or may have by reason of this authorization.
- I am 18 years of age or older and am competent to contract in my own name. I have read this release, and fully understand the contents, meanings, and impact of this release.
- If any provision in this agreement is found to be unenforceable, such finding does not invalidate the entire agreement, but only that particular provision.
- The cost of prescription medications includes the scripting and processing fee.
- I understand I can have my prescription filled at any pharmacy of my choice.

Signature: ____ Date: __________________________________

PT Name: ____ DOB: ____________________________