Advanced Metabolic Care + Research
PATIENT HISTORY

Patient Name: _____ Date of Birth:_____ Age:_____

Medication Allergies: _____

Hospitalizations and Operations:

YEAR	REASON	LOCATION

Date of Last:

Flu Shot:_____ Eye Exam:_____ by Dr.:_____
Pneumonia Shot:_____ Foot Exam:_____ by Dr.:_____
EKG:_____ Physical Exam:_____ by Dr.:_____

Family History: **Are you adopted? YES○/ NO⊙**

	Alive	Deceased	Age
Mother			
Father			

	How many?	Alive	Deceased	Age
Brother(s)				
Sister(s)				
Children				

Family Members with the following diseases:

	Mother	Father	Siblings	Others
Diabetes	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Cancer (type)_____	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐
Strokes	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐
Gout	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐

Social History

Birthplace: _____ Education: _____ Occupation: _____

Marital Status: ○ Married ○ Widowed ○ Divorced ○ Single ○ Separated Other _____

Alcohol?: ○ Y / ○ N ____years _____per day/week Type: _____Stopped _____ years.

Do you smoke?: ○ Y / ○ N ____years _____Packs/Day_____Stopped _____years.

Caffeine (What and how much) ○ Coffee / ○ Tea / ○ Soda _____ per day_____ per week.

Drug Use History: _____

Advanced Metabolic Care + Research

Your Symptom Review

Name: _____ Date of Birth _____ MR#: _____

Date: _____

Endocrine / Diabetes

			Explain
Excess Urination	Yes	No	
At night (Number ____)	Yes	No	
Blurred Vision	Yes	No	
Dry Mouth	Yes	No	
Tingling of toes /fingers	Yes	No	
Fatigue	Yes	No	
Cold Intolerance	Yes	No	
Dry skin/hair/nails	Yes	No	
Palpitations	Yes	No	
Tremors	Yes	No	
Weight loss/gain (lbs.____)	Yes	No	
Excess sweating	Yes	No	
Double Vision	Yes	No	
Dizziness/loss of consciousness	Yes	No	
Depression	Yes	No	
Mental fatigue/mood swings	Yes	No	
Low Bone Density/Osteoporosis	Yes	No	
Fracture	Yes	No	
Do you take Calcium	Yes	No	How much

Urinary

Burning while urinating	Yes	No	
Loss of bladder control	Yes	No	
Blood in urine	Yes	No	
Trouble starting to urinate	Yes	No	
Passed a kidney stone	Yes	No	

Hematology

Anemia	Yes	No	
Bruising	Yes	No	
Transfusion	Yes	No	

Cardiovascular/Pulmonary

Chest pain/tightness	Yes	No	
Shortness of breath	Yes	No	
Chronic cough	Yes	No	
Wheezing	Yes	No	
Coughing up blood	Yes	No	
Pain in calves when walking	Yes	No	
Leg Cramps at night	Yes	No	
Swelling in the ankles	Yes	No	
High Cholesterol	Yes	No	

Gastrointestinal

Abdominal (stomach) pain	Yes	No	
Loss of appetite	Yes	No	
Nausea/vomiting	Yes	No	
Difficulty swallowing	Yes	No	
Change in bowel habits	Yes	No	
Blood in stools	Yes	No	
Black tarry stools	Yes	No	

Neurological

Ever had a convulsion	Yes	No	
Have you had a stroke	Yes	No	
Headaches	Yes	No	
Fainting spells	Yes	No	
Ringing in ears	Yes	No	
Spells of weakness of arm/leg	Yes	No	

Rheumatology

Arthritis	Yes	No	
Gout	Yes	No	

For Men Only

Loss of sexual interest	Yes	No	
No or incomplete erections	Yes	No	
Prostate trouble	Yes	No	
Hernia (rupture)	Yes	No	

For Women Only

Age of first menses _____
Duration of flow _____
Heavy periods _____
Bleeding in between periods _____
Date of last period _____
Age of menopause _____

Total pregnancies _____
Live births _____
Birth weight of babies _____
Miscarriages _____
Any gestational diabetes Yes No

Date of last PAP _____
Date of last mammogram _____
Do you have discharge from nipples Yes No
Dryness of vagina Yes No
Loss of sexual interest Yes No

SIGNATURE:_____ DATE:_____

Advanced Metabolic Care + Research

Medication List

Today's Date _____

Patient's Name

_____

Help us care for you better by telling us what prescriptions and over-the-counter medications you take.

Prescriptions						
Name of medicine	**Dose** (total milligrams)	**How many times per day?**	**When do take it?** (Morning and night? After meals?)	**Who prescribed it for you?** (Physician's last name)	**Why do you take it?**	**Do have any side-effects? Describe them.**

Over-the-counter medications, herbal remedies, vitamins						

PATIENT FINANCIAL AGREEMENT

Deductible/Co-Insurance: All applicable co-insurance and deductibles are due at the time of service. An estimate will be provided, and payment is required before services are rendered. This does not constitute final payment and any additional balance due after the insurance claim is adjudicated will be due upon receipt of a bill. We accept cash, personal checks, and credit cards (Visa, Mastercard, Discover). For any questions regarding billing, please call (760)466-1548 or email billing@amcrclinic.com.

Co-Payments: Your insurance company requires us to collect co-payments at the time of service. Due to state and federal laws, co-payments will not be waived.

Payment Options: If you do not have insurance: payment is expected on the day treatment is rendered. If you do have insurance: you are responsible for any deductibles, coinsurance, and any out of pocket portions on the day that treatment is rendered.

Checks: Returned checks may be subject to a $30.00 fee.

Missed Appointments: Please note a $75.00 fee may be charged for a missed appointment or failure to cancel an appointment within 24 business hours prior to scheduled appointment time. This fee will be billed directly to you.

Claims Submission: As a courtesy, Advanced Metabolic Care + Research will bill your insurance and one other insurance. A quote of benefits is not a guarantee of payment. We will submit your claims and assist you until your claim is resolved. Payment from your insurance company is expected within 30 days. After 30 days, we will look to you for full payment. You are responsible for all non-covered services according to your insurance company's guidelines. If we receive notification that you are not eligible for coverage or we are not contracted with your insurance, you will be responsible for all charges incurred and payment is due upon receipt of the bill. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request in a timely manner. You are responsible to provide a copy of your most recent insurance cards for all applicable health plans. All outstanding balances will be subject to a statement fee of $10.00. Additional statement fees will accrue for each subsequent thirty (30) day period of nonpayment. Accounts that are 90 days past due may be referred to a collection agency. Should the account be referred to an outside agency for collection or to an attorney, the undersigned shall pay reasonable collection expenses.

Form Fees: Any forms (DMV $65.00, Disability Forms $65.00, Unemployment Forms $65.00, School Forms $0.00-$30.00) that require a physician to review your chart and require an MD signature will have an applicable form fee charge.

Prescription Refills: If you have not been seen within the last 6 months, a follow up appointment will need to be scheduled to ensure proper treatment. Please contact your pharmacy for prescription refills.

Assignment of Benefits: Authorization is hereby granted to release information as may be necessary (in compliance with HIPAA guidelines) to process and complete my insurance claim and payment of medical benefit is to be paid directly to Advanced Metabolic Care + Research for all services rendered.

I have read and understand the above statements.

I agree to comply with the financial policies of Advanced Metabolic Care + Research and, I understand that I am financially responsible for payment of all medical services or treatment(s) administered with my account.

Patient Name (please print): _____ Date of Birth: _____

Patient or Guardian Signature: _____ Date: _____

ADVANCED METABOLIC CARE + RESEARCH

PATIENT REGISTRATION INFORMATION

Patient Information

Patient Name: _____ Sex: Male_____ Female _____
(Last) (First) (MI)
Street Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Date of Birth: _____/_____/_____ Age: _____ Social Security #: _____
Month Day Year

Marital Status (Check One): Married _____ Single _____ Divorced _____ Widow(er) _____ Child _____

Employment Status (Check One): Employed ____ Retired ____ Student (Full Time) ____ (Part Time) ____ Not Employed: ____

Employer Name: _____ Address: _____ City/State_____ Zip_____

Primary Care Doctor:_____ Phone:_____ Fax:_____

E-MAIL Address:_____

Responsible Party (IF PATIENT IS A MINOR)

Name: _____ Sex: Male_____ Female _____
(Last) (First) (MI)
Street Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Date of Birth: _____/_____/_____ Age: _____ Social Security #: _____
Month Day Year

Marital Status (Check One): Married _____ Single _____ Divorced _____ Widow(er) _____ Child _____

Employment Status (Check One): Employed ____ Retired ____ Student (Full Time) ____ (Part Time) ____ Not Employed: ____

Employer Name: _____ Address: _____ City/State_____ Zip_____

Insurance Information (Please present your insurance card to be photo copied for billing)

Primary Insurance: _____ ID# _____ Group# _____

Name of Subscriber: _____ Date of Birth ____/ ____/____ Relationship to patient: _____

Secondary Insurance: _____ ID# _____ Group# _____

Name of Subscriber: _____ Date of Birth ____/ ____/____ Relationship to patient: _____

Emergency Contact

Name: _____ Relationship _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ City/State_____ Zip_____

May we email you appointment reminders, upcoming seminars, research opportunities, general health information and updated news on the practice? YES___ NO___

I understand that I as the patient will be responsible to inform AMCR of any changes with insurance and will provide AMCR with all necessary information. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date: _____

Advanced Metabolic Care + Research

Notice of Privacy Practices & Acknowledgement

Today's Date _____

Patient's Name _____

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review carefully!

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, patients of this practice are entitled to the greatest degree of privacy possible. This office will use and communicate your health information only to provide treatment, obtain payment and for authorization purposes, as agreed to by the patient.

Patients are advised that they have a right to review their medical files upon 5 days written notice to the practice and during normal business hours. A copying fee of $0.25 per chart page and a $10.50 flat fee plus postage is payable in advance of this review.
You have the right to request that we change your medical information. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change. We may deny your request if we did not create the information you want changed, if the information is not part of our records or if the records are determined to be accurate and complete. If we deny your request, we will provide you a written explanation.
For further information, contact our HIPAA coordinator Jazmin Miller at (760) 743- 1431. All complaints will be addressed without reprisal to the complainant.

You have the right to obtain a copy of the Notice of Privacy Practices & Acknowledgement form our office at any time. Stop by or call us and we will mail or make you a copy.

_____ _____

Signature Date

Patient Consent to Treat & HIPAA Notice Form

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) & CALIFORNIA CONFIDENTIALITY OF MEDICAL INFORMATION ACT (CMIA) CONSENT AND AUTHORIZATION.

Today's Date: _____ Social Security Number: _____

PATIENT Name: _____ Date of Birth: _____

I am the Patient named above:

This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. § 1320d and 45 C.F.R. § 160-164, and/or information governed by the California Confidentiality of Medical Information Act ("CMIA") Cal. Civ. Code §§ 56-56.37. Specifically, this release authority complies with the valid authorization requirements of 45 C.F.R. § 164.508(c). Pursuant to HIPAA and/or CMIA, I authorize and direct any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services, to give, disclose, and release, without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition, to include all information relating to the diagnosis and treatment of sexually transmitted diseases, mental illness, and drug or alcohol abuse.

Advanced Metabolic Care + Research is a Covered Entity as defined by HIPAA and may use or disclose protected health information for treatment, payment, and healthcare operations. Under this definition, use and disclosure of protected health information is permitted without mine or my personal legal authorized representative's consent, authorization, or agreement.

Authorization is required to use protected health information for purposes **other than** treatment, payment, or healthcare operation.

If there is a specific individual, entity or circumstance that we cannot disclose your protected health information too, please list below:

_____
_____
_____
_____
_____

Expiration date of the restriction: _____

I understand that, with certain exceptions, I have the right to revoke this Authorization at any time. If I want to revoke this Authorization, I must do so in writing. The procedure for how I may revoke this Authorization, as well as the exceptions to my right to revoke, will be performed in accordance with applicable federal law and as stated in the Notice of Privacy Rights of my health care provider, a copy of which has been given to me.

Patient Consent form continued:

When providing information to me, information may be transmitted to me by any or all of the following means (initial all that apply):

Telephone messages on an answering machine _____ (initial)
Message to following family members or friends _____(initial)
_____
E-mail to the following address _____ (initial)
_____
_____
_____

Special message restrictions if any:
_____
_____
_____

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to the physician's privacy notice and that I have had the opportunity to place special restriction upon the consent hereby given.

This consent is valid from the date of executed until revoked in writing by the patient.

Date: _____ Patient Signature: _____

If Applicable:

Date: _____ Signature of Authorized Representative: _____

Please print name: _____

Please explain Representative's authority to act on behalf of the Patient:
_____
_____

Advanced Metabolic Care + Research

Authorization for Release and/or Disclosure of Medical Information

This authorization allows this medical practice (AMCR) to release and receive all confidential medical information and records, including but not limited to medical history, illness or injury, consultation, prescription, treatment, diagnoses or prognosis, including x -rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

Patient name: _____ Date of Birth: _____

Patient's address:

_____

As required by the Health Information Portability and Accountability act of 1996 (HIPPA) and California law, the practice may not use or disclose your individually identifiable health information except as provided in our Patient Consent and Notice of Privacy Practices and Acknowledgement Forms. Your completion of this form means that you are giving us permission to receive, use and disclose your confidential medical information. Please review and complete this form.

I hereby authorize this medical practice to receive, use and/or disclose my personal health information to:

_____

_____

I understand that I may revoke this authorization at any time notifying this medical practice in writing. I understand that although federal law does not protect health information disclosed to someone other than a health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. I understand that I have a right to receive a copy of this authorization. Please furnish any and/or all information concerning my past and present medical history and condition to:

Advanced Metabolic Care + Research
625 W Citracado Pkwy Suite 108
Escondido, Ca 92025
Tel # 760-743-1431 Fax # 760-743-6455

Patient Signature: _____ Date: _____

Witness (if applicable):_____ Date: _____

Advanced Metabolic Care + Research

Consent to Discuss my Personal Health Information

I, _____, (Print Name) consent for Dr. Bailey/Dr. Varma and his staff at AMCR, to verbally disclose and discuss my protected health information (PHI) to the person(s) listed below. I understand that I reserve the right at any time in the future to remove or add a person(s) to the list. I do understand that it is my personal responsibility to inform the office of any changes to the "consent to discuss personal health Information list'.

This is for your protection and is in compliance with federal privacy guidelines.

_____ _____

Patient Signature **Date**

Approved person(s):

1) _____

Name of person Relationship

2) _____

Name of person Relationship

3) _____

Name of person Relationship

4) _____

Name of person Relationship

STOP BANG

Screening for: OBSTRUCTIVE SLEEP APNEA

Patient Name: _____ Date: _____

Dear Patient,

Please answer the following questions to find out if you are at risk for Obstructive Sleep apnea.

STOP

S (snore)	Have you been told that you snore?	YES / NO
T (tired)	Are you often tired during the day?	YES / NO
O (obstruction)	Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep?	YES / NO
P (pressure)	Do you have high blood pressure or on medication to control high blood pressure?	YES / NO

If you answered YES to two or more questions on the STOP portion you are at risk for Obstructive Sleep Apnea. It is recommended that you contact your primary care provider to discuss a possible sleep disorder.

To find out if you are at moderate to severe risk of Obstructive Sleep Apnea, complete the BANG questions below.

BANG

B (BMI)	Is your body mass index greater than 28?	YES / NO
A (age)	Are you 50 years old or older?	YES / NO
N (neck)	Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches.	YES / NO
G (gender)	Are you a male?	YES / NO

The more questions you answer YES to on the BANG portion, the greater your risk of having moderate to severe Obstructive Sleep Apnea.