JULIETAYLOR MD
FUNCTIONAL MEDICINE AND WELLNESS

65 N. Madison Ave Ste 406
Pasadena, CA 91101

tel 626-787-1397

www.julietaylormd.com
info@julietaylormd.com

For office use only

*Blood pressure*_____

Pulse _____

Weight _____

Today's Date: _____

Name: _____ DOB : _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Email address: _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

What are you seeking care for today? _____

_____

How did you hear about us (please circle)? YELP JULIETAYLORMD.COM GOOGLE OTHER _____

REFERRAL? Who can we thank? _____

Please list all medications you are using (including non-prescriptions, aspirin, birth control, vitamins, herbs and supplements), with dosage and frequency:

_____

_____

Are you allergic to any medications (please list)? _____

_____

Which of the following symptoms do you have? (Check all that apply.)

Please note **date of onset** next to the symptom.

❑ Hot Flashes	❑ Fibrocystic Breast	❑ Anxiety	❑ Thin skin
❑ Night sweats	❑ History of Fertility Problems	❑ Irritability	❑ Weight gain
❑ Difficulty falling asleep	❑ Abnormal Pap smear	❑ Foggy thinking	❑ Weight loss
❑ Difficulty staying asleep	❑ Bone loss	❑ Memory lapses	❑ Decreased muscle mass
❑ Morning Fatigue	❑ Fibromyalgia	❑ Tearfulness	❑ Sugar/carb cravings
❑ Evening Fatigue	❑ Increased facial hair	❑ Stress	❑ Hoarseness
❑ Vaginal dryness	❑ Acne	❑ Hair loss	❑ Fluid retention
❑ Painful intercourse	❑ Depression	❑ Migraines/ Headaches	❑ Low blood sugar
❑ Decreased sex drive	❑ Cold body temperature	❑ Dry/Brittle hair	❑ Mood swings
❑ Breast tenderness	❑ Increased heart rate	❑ Dry/Brittle nails	❑ Rapid aging
❑ Heavy Bleeding	❑ Irregular Bleeding	❑ Cramps	❑ Difficulty reaching orgasm

Females only:

Age of onset:____Last Menstrual Period: ____ Still Menstruating? ❑ yes ❑ no

Regular Periods: ❑ yes ❑ no Duration of Periods:___

# of Pregnancies:_____ Are you Pregnant or think you may be? ❑ yes ❑ no

Nursing (breast feeding)? ❑ yes ❑ no

Last Mammogram:_____ Last pap smear:_____

Males only:

Last PSA:_____ Last prostate exam: _____

Personal Medical History: (Please indicate if **YOU** have ever experienced any of the following conditions.)

❑ Heart Disease	❑ Bladder Infections	❑ Blood Clots	❑ Fractures or Injuries	❑ Hepatitis A, B, or C
❑ Thyroid Disease	❑ Kidney Infections	❑ Diabetes	❑ Bladder Disease	❑ Anxiety
❑ Kidney Disease	❑ Gallbladder Disease	❑ Epilepsy	❑ Sexually Transmitted Diseases	❑ Anemia
❑ Skin Disease	❑ Autoimmune Disorder	❑ Liver Disease	❑ PCOS	❑ Eating Disorder
❑ Breast Disease	❑ Head Injuries or Fainting	❑ High Blood Pressure	❑ Cancer	❑ Depression
❑ Breast Cancer	❑ PMS	❑ High Cholesterol	❑ Ulcers	❑ Migraines

List any other medical problems or conditions you feel are relevant, and whether these are currently being treated:

_____

Surgical History: (Please indicate the type of surgery, when, and complications, if any)

_____

_____

Family Medical History: (Please indicate if **a relative** has ever experienced any of the following conditions and note relation.

❑ Family History Unknown	❑ Blood Clots: _____
❑ Breast Cancer: _____	❑ Suicide: _____
❑ Ovarian Cancer: _____	❑ Mental Illness: _____
❑ Uterine Cancer: _____	❑ Thyroid Disease: _____
❑ Colon Disease: _____	❑ Diabetes: _____
❑ High Blood Pressure: _____	❑ Osteoporosis: _____

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Personal Wellness:

Height:_____Weight: _____ Sex (please circle): Male Female

Diet:

Do you consider yourself: ❑ gluten free ❑ dairy free ❑ vegetarian ❑ vegan

Use of artificial sweeteners and/or drink sodas? _____

Please summarize your current exercise regimen: _____

_____

Do you have any specific health goals? _____

I ,_____, certify that all statements regarding my health and medical history provided are true, complete and accurate to the best of my ability.

Signature_____Date _____

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Welcome to Julie Taylor MD, Functional Medicine and Wellness!

Dr. Taylor practices functional medicine, meaning she looks at the whole body and tries to get at the root of the problem, not simply treating the symptoms. The philosophy of functional medicine is on the forefront of medical research and the future of medicine, as we know it.

Conventional medicine tends to search for a disease causing your symptoms. When testing is inconclusive, they treat the symptoms with medication. Functional medicine looks for the source, focusing on optimal range of nutrients and organ function in hopes of increasing good health and preventing disease, and in doing so remedying your symptoms.

It's important to note that within functional medicine, labs are much more extensive and the ranges used to determine which results are normal or abnormal are narrower than conventional ranges. Dr. Taylor will review all your results with you and help you understand these values. At anytime, if your general practitioner has questions about your care under Dr. Taylor, they should always feel free to reach out to her.

I have read and understand the above statement.

Signature_____Date _____

CONSENT FOR BIO-IDENTICAL HORMONE RESTORATION

Initial below:

_____I consent to the administration of hormones (progesterone, estrogen or testosterone) and oral supplements as prescribed by Julie Taylor MD, Inc. I acknowledge that there are no guarantees or assurances made with respect to the benefit of hormone therapy, and as with any medication there is a risk of unintended side effects.

_____I understand that I will be in charge of administering hormones and supplements prescribed to me. I will conform and comply with the recommended doses and methods of administration.

_____I understand that initial tests will be performed to establish my baseline hormone levels. I agree to comply with the requests for ongoing tests to assure proper monitoring of my hormone levels. I agree to report to the physician any adverse reaction or problems that might be related to hormone therapy. I understand that with hormone supplementation there are possible risks and complications if I do not comply with the recommended dosage.

(Female) Bio-identical hormone therapy uses concentrated hormones (progesterone, testosterone, or estrogen), biologically identical to the hormones you make in your own body prior to menopause. Estrogen and testosterone were made in your ovaries and adrenal gland prior to menopause. Bio-identical hormones have the same effects on your body as your own estrogen, progesterone and testosterone did when you were younger, without the monthly fluctuations (ups and downs) of menstrual cycles. You will have similar risks as you had prior to menopause, from the effects of estrogen and androgens, with bio-identical hormone therapy.

Possible risks included hyper sexuality (overactive Libido); lack of effect (from lack of absorption); breast tenderness and swelling (estrogen only); weight gain; increase in hair growth on the face, similar to pre-menopausal patterns; water retention (estrogen only); increased growth of estrogen dependent tumors (endometrial cancer, breast cancer); birth defects in babies exposed to testosterone during their gestation; growth of liver tumors, if already present; change in voice (which is reversible); clitoral enlargement (which is reversible). The estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and can cause bleeding. Testosterone therapy may increase one's hemoglobin and hematocrit, or thicken one's blood. This problem can be diagnosed with a blood test. Thus, a complete blood count (Hemoglobin & Hematocrit) should be done at least annually. This condition can be reversed simply by donating blood periodically.

Patients who are pre-menopausal are advised to continue reliable birth control while participating in hormone replacement therapy. Testosterone is category X (will cause birth defects) and cannot be given to pregnant women.

CONSENT FOR BIO-IDENTICAL HORMONE RESTORATION (continued)

(Male) There is some risk, even with natural testosterone therapy, of enhancing an existing current prostate cancer to grow more rapidly. For this reason, a prostate specific antigen blood test is to be done before starting testosterone therapy and will be conducted each year thereaher. If there is any question about possible prostate cancer, a follow-up with an ultrasound of the prostate gland may be required as well as a referral to a qualified specialist. While urinary symptoms typically improve with testosterone, rarely they may worsen, or worsen before improving. Testosterone therapy may increase one's hemoglobin and hematocrit, or thicken one's blood. This problem can be diagnosed with a blood test. Thus, a complete blood count (Hemoglobin and Hematocrit.) should be done at least annually. This condition can be reversed simply by donating blood periodically.

_____I have been encouraged and have had the opportunity to ask any questions regarding bio-identical hormone therapy. All of my questions have been answered to my satisfaction. I further acknowledge that there may be risks of testosterone and or estrogen therapy that we do not yet know, at this time, and that the risks and benefits of this treatment have been explained to me and I have been informed that I may experience complications, including one or more of those listed above. I accept these risks and benefits and I consent to the use of hormone therapy. Furthermore, I have not been promised or guaranteed any specific benefits from the administration of bio-identical therapy.

_____I understand that based on my levels and what is considered optimal range from a functional medicine perspective, I may be prescribed thyroid hormones and other supplements.

_____I understand that the role of the physician is for functional medicine care. I agree that I am and will be under the care of another physician for all medical conditions and to ensure I am current with radiological exams and tests, i.e. mammograms, pap smears, etc.

_____I have been informed that the insurance carriers and Medicare do not pay for hormone therapy. I therefore agree to pay for all services including laboratory and pharmacy charges, with the understanding that I will not be reimbursed by my insurance company.

_____ I have read and understand the above consent. I fully understand what I am signing and hereby request and consent to treatment using hormone therapy supplementation.

Printed Patient Name _____

Patient Signature_____Date _____

FINANCIAL AGREEMENT and OFFICE CONSENT POLICIES

Payment is due at the time of service. For your convenience we accept cash, check, and all major credit cards.

Initial Consultation: $895 (60 minutes with Dr. Taylor and 60 minutes with our nutritionist Annie)
Follow Up Appointment (phone or in person): $295 (30 minutes)
Out of respect for all our patients, appointments are limited to the allotted time. If your appointment goes over the allotted time, you may incur an additional fee at $750/hour.

If you have any questions about your treatment plan or testing, please call the office for assistance. If you need to speak with Dr. Taylor to discuss changes to your medications, treatment or review test results, you will need to schedule a Follow Up Appointment.

Tests: Cost varies depending on type and quantity. All test costs are the patient's responsibility.

Insurance When using insurance, you are responsible for the full payment of service at the time of service. Julie Taylor MD, Inc. will provide you with a receipt of payment (superbill) per your request, which may be submitted to your insurance provider for reimbursement. Julie Taylor MD, Inc. does not partner with insurance and does not submit superbills on behalf of patients. Reimbursement is NOT guaranteed. It is suggested that you check with your insurance provider prior to your first appointment.
Cancellation/No Show Policy: In order to be respectful of the medical needs of other patients, please be courteous and call Dr. Taylor's office 48 hours in advance if you are unable to make your appointment so the time can be reallocated to someone who is in need of treatment.
If you do not cancel your appointment within 48 hours or fail to show up, you will be charged a J50 late cancel/no show fee.
Medical Records: We will provide a digital or analog copy of your medical records upon request for a twenty-five dollar ($25.00) administrative fee. You will be required to sign a medical record form and pay the medical record fee in full prior to having your medical records copied. Please allow up to one week for this request to be processed.
Lab Policy Per Cal. Bus. & Prof. Code § 650.02, the cash price includes an administrative and interpretation fee on top of the actual costs of the blood work, saliva testing, and gut testing which is paid to the office of Dr. Julie Taylor. Dr. Taylor also must disclose that the patient may choose any clinical laboratory to perform lab work ordered and can also use their insurance versus paying this negotiated cash price when that applies. Julie Taylor, MD Inc. has no other financial interests in Quest Labs, Genova Diagnostics, or ZRT labs.
I have read and understand the financial agreement and oGice consent policies. I understand that all services are my financial responsibility and are due at the time of service.

Printed Patient Name _____

Patient Signature _____ **Date** _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties' consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive EGect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

Patient Initials _____

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____	_____
Physician's Signature	Patient's or Patient Representative's Signature (Date)
Julie Taylor, MD	_____
Name of Physician	Name of Patient

A signed copy of this document is to be given to Patient. Original is to be filed/scanned in Patient's medical records.

HIPAA NOTICE OF PRIVACY POLICIES

We Are Required By Law To:

- Maintain the privacy of protected health information.
- Give you the notice of legal duties and privacy practices regarding your health information.
- Follow the terms of our notice that is currently in effect.

How We May Use and Disclose Health Information:

- We will use and disclose health information only with your written permission.
- You may revoke such permissions at any time by writing to our practice's privacy officer.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations, such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations - and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

Printed Patient Name _____

Patient Signature _____