Patient Information – Application for Care

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. (PLEASE PRINT)

Today's Date _____

Name_____Home Phone_____Work Phone_____

Cell Phone_____E-Mail Address _____

Address_____City_____State_____Zip _____

Sex: □Male □Female Age_____ Birth Date_____ Marital Status: S M W D

Your Employer_____Occupation_____Years on Job ____

Employer Address_____City_____State ____Zip_____

Social Security # _____Driver's License # _____Exp: ___/___/___

Name of Spouse or Parent _____Their Birth Date_____

Spouse Employed By _____Occupation_____Years on Job ____

Employer Address _____City_____State_____Zip _____

Office Phone_____

How did you hear about us? _____

If referred by someone, who? _____

How payment will be made: _____Cash _____ Check _____Credit Card

I agree to pay Synergy Medical for services rendered to the above-mentioned patient as the charge is incurred. I understand that I am financially responsible for all charges. I understand that should my account go to collections, I am responsible for all costs associated with collections and any costs charged by the collection company. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the medical provider.

Patient's Signature: _____ **Date:**_____

Patient's Release of the Provider of Service and the Clinic

The undersigned hereby represents that I have disclosed all my pertinent information regarding my health profile to the provider of service during my examination. Patient further represents and guarantees that I have disclosed all medications that I am currently consuming to this provider of service during my examination and from whom, if any, I am obtaining my medications.

I understand that this provider of services makes a determination based on full disclosure from the patient.

I acknowledge that this provider of services reserves the right to limit any patient's medications to an appropriate amount based on the disclosed information from the patient during the examination.

Should information be obtained that in any way suggest false representation were made to this provider of service by the patient, I without reservation waive any and all rights to any claim, of any type or nature whatsoever including but not limited to monetary damages, which I have now or in the future may accrue against the provider of service and this clinic.

I understand that if I lose my medications, which are handed out on a bi-weekly or monthly basis, I will not be able to obtain a new supply until the following office visit whether it be bi-weekly or monthly. As a patient I also understand that if I go to another provider of service during the time frame of treatment at this clinic, I am to notify this clinic and its representatives immediately of any other medications I might be receiving and that said notification must be made in writing by and between this clinic and or its representative and myself. As the patient, I will also receive a copy of this notification after it is awarded.

Please be advised that SYNERGY MEDICAL requires that all patients have a yearly diet panel drawn to give us a thorough perspective of our patient's general health. We also require all new patients and returning patients have a diet panel drawn within the first two weeks of their initial visit, and will not disperse any further medications until this is done. However, extenuating circumstances will be taken into consideration. This is to protect our patients and allow us to provide safe, effective assistance for weight loss and lifestyle change.

As the patient, I have read and understand this release. I also understand that this release constitutes a legal and binding document.

Patient signature: ________________________________ Date: ______________________

Patient Printed name: ____

HIPAA Form

Introduction

At **Synergy Medical**, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective March 31th, 2003 and applies to all protected health information as defined by federal regulation.

Uses and Disclosures

1. We use your health information to document and plan treatment, progress, planning, etc.
2. We use your health information for payment. For instance, we need to send health information including procedures done and diagnoses to your insurance company.
3. We use your health information for regular health operations. For example, our compliance officer regularly chooses medical records for audits. This practice ensures that we are constantly working towards improved quality and effectiveness.
4. There are services provided in our organization through contacts with business associates. Examples include outside labs, x-ray, transcription services.
5. We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care, your location, and general condition.

The following are examples of other purposes for which **Synergy Medical** is permitted or required to disclose confidential information without the individual's written authorization.

1. Uses and disclosures for public health activities;
2. Reporting victims of abuse, neglect, or domestic violence;
3. Disclosures for judicial and administrative proceedings;
4. Disclosures for law enforcement purposes;
5. Uses and disclosures for cadaveric organ, eye or tissue donation purposes;
6. Disclosures to avert a serious threat to health or safety; and
7. Uses and disclosures for specialized government functions.

Separate Statements for Certain Uses or Disclosures **Synergy Medical** may contact patients with appointment reminders, requests for the patient to contact **Synergy Medical** for appointments, notices and letters concerning medical findings. **Synergy Medical** may also contact the patient about treatments alternatives or other health related benefits and services that may be of interest to the individual. Effective Date of this notice is April 1, 2003; Updated April 10, 2008.

Individual Rights

Although your health record is the physical property of **Synergy Medical**, the information belongs to you. You have the right to:

1 The right to request restrictions on certain uses and disclosures of your information;
2 The right to revoke your authorization to use or disclose health information except to the extent that action has already been taken.
3 The right to receive confidential communications;
4 The right to obtain a copy or inspect your health information;
5 The right to amend protected health information;
6 The right to receive an accounting of disclosures of protected health information.

Synergy Medical Center's Rights

1. **Synergy Medical** has 30 days with which to comply with a patient's request to review or copy their health information. **Synergy Medical** is allowed an additional 30 days if the record is off site. **Synergy Medical** may charge a fee for copying the health record.
2. The physicians have the right to review the record and remove any information that they deem to be harmful to either the patient or to another individual;
3. The patient will be supervised by Medical Center staff during any review of the record. Supervision is allowed and required to prevent the removal or altering of the medical record. **Synergy Medical** will charge staff time for this service.

Synergy Medical Center's Duties

1. **Synergy Medical** is required by law to maintain the privacy of confidential information and provide individuals with notice of its legal duties and privacy practices with respect to such information;
2. **Synergy Medical** is required to abide by the terms of this Notice; and
3. **Synergy Medical** reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all confidential information that it maintains. Revisions to this Notice will be posted in the patient waiting area.

Complaints

Individuals may complain to the Office Manager in writing to address above. You may also contact the Secretary of the U.S. Department of Health and Human Services at 200 Independence Ave., S.W.,Rm. 509F, HHH Building, Washington DC 20201.
Further Information-Please contact the SMC administrator at 747-5861 for further information.
I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name:_____ Date of Birth:_____
Signature:_____ Date:_____
Witness Signature (Check In)_____ Date:_____

T ✤·ᐱ·35

New Patient Questionnaire (Health Care Analysis)

Today's Date: _____

First Name: _____ **Last Name:** _____ **Email:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____ **Date of Birth:** _____

Age: _____ **Height:** _____ **Current Weight:** _____ **Gender:** ☐ **Male** ☐ **Female**

How did you hear about us?: _____ **If referred by someone, who?:** _____

Please answer the following questions honestly so we can do our best to help you reach your goals

Who encouraged you to lose weight?: _____

How important to you is it to lose weight?: _____

What important reason, special occasion, or goal date do you have to lose weight?: _____

_____

How many pounds would you like to lose?: _____ How fast do you want lose the weight?: _____

Would you commit to one visit a week?: ☐ Yes ☐ No

Have you ever attended any other weight reduction centers, if so, which ones?: _____

What kinds of diets have you tried on your own?: _____

What is the longest you have been able to stick with a diet?: _____

Does your family support your weight loss efforts?: ☐ Yes ☐ No

Have you been advised by your family physician to lose weight?: ☐ Yes ☐ No

If you answered Yes, what is your doctor's name?: _____

Do you eat because of emotions?: ☐ Yes ☐ No

If you answered yes, please explain: _____

_____

_____

What is most important to you in deciding to use our services? (Please check all that apply):

- ☐ Effectiveness "My results are my top priority."
- ☐ Time "I want results quickly."
- ☐ Service "I need extra support along the way."
- ☐ Ease "I have a difficult time losing weight."

I understand that my patient file will be kept completely confidential unless I give written permission for my information to be released.

_____ _____

Signature: **Date:**

Notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

On average, which of the following reflects your daily eating habits? (Please check all that apply):

- ☐ 3 meals with healthy snacks
- ☐ 3 meals
- ☐ 2 meals or less
- ☐ Skip breakfast or other meals
- ☐ Generally eat on the run
- ☐ No regular eating pattern
- ☐ Often crave sweets/carbs
- ☐ Graze; small, frequent meals
  (How many per day? _____)

Current level of exercise (Please check one that applies):

- ☐ None
- ☐ Light exercise (1-3 times per week, easy pace, stretching, walking, etc.)
- ☐ Moderate exercise (2-3 times per week, moderate pace, some weights, etc.)
- ☐ Heavy exercise: (3-4 times per week, vigorous pace, weights, fast running, etc.)

Health Information

Past or Present Health Conditions (Please check all that apply):

- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Strokes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Hormone Imbalance
- ☐ Hormonal Cancer
- ☐ Thyroid Imbalance
- ☐ Anorexia
- ☐ Bulimia
- ☐ Drug Addiction
- ☐ Currently pregnant or nursing
- ☐ Allergic to sulfur, food or medication
- ☐ History of Melanoma
- ☐ Vegetarian

If you checked any of the above, please explain: _____

_____

Have you ever been hospitalized, under medical care, or checked into rehab for alcohol or drug treatment?: ☐ Yes ☐ No

If you answered yes, please explain: _____

_____

Please list all medications you are currently taking, including doses and reasons for taking

Medication:	Dose:	How often:	Reason:	Prescribing M.D.

Symptom Survey

Please complete the following survey using the key below

☑ ☐ ☐ ☐ = No symptoms (0 points)
☐ ☑ ☐ ☐ = Mild symptoms (1 point)
☐ ☐ ☑ ☐ = Moderate symptoms (2 points)
☐ ☐ ☐ ☑ = Severe symptoms (3 points)

Weight:

- ☐ ☐ ☐ ☐ Inability to lose weight
- ☐ ☐ ☐ ☐ Food cravings
- ☐ ☐ ☐ ☐ Binge eating
- ☐ ☐ ☐ ☐ Nausea or vomiting
- ☐ ☐ ☐ ☐ Water retention

Hormone:

- ☐ ☐ ☐ ☐ Irregular cycle
- ☐ ☐ ☐ ☐ Menopausal symptoms
- ☐ ☐ ☐ ☐ Weight gain
- ☐ ☐ ☐ ☐ Hair loss
- ☐ ☐ ☐ ☐ Depression/ anxiety

☐☐☐☐ Mental fuzziness
☐☐☐☐ Memory problems
☐☐☐☐ Fatigue
☐☐☐☐ Decreased libido
☐☐☐☐ Aggression
☐☐☐☐ Hot flashes and/or night sweats

Head and Ears:

☐☐☐☐ Migraines
☐☐☐☐ Headaches

Emotional and Mental:

☐☐☐☐ Depression
☐☐☐☐ Anxiety
☐☐☐☐ Mood swings
☐☐☐☐ Irritability
☐☐☐☐ Poor concentration

Skin Conditions:

☐☐☐☐ Acne /acne scars
☐☐☐☐ Sagging skin
☐☐☐☐ Fine lines and wrinkles
☐☐☐☐ Loss of volume
☐☐☐☐ Enlarged pores
☐☐☐☐ Lip lines

Hair Conditions:

☐☐☐☐ Hair loss
☐☐☐☐ Thinning hair
☐☐☐☐ Receding hair

Muscle & Joint:

☐☐☐☐ Arthritis
☐☐☐☐ Foot trouble
☐☐☐☐ Low back pain
☐☐☐☐ Neck pain or stiffness
☐☐☐☐ Pain between shoulders
☐☐☐☐ Headaches
Pain or numbness in:
☐☐☐☐ Shoulders
☐☐☐☐ Arms
☐☐☐☐ Elbows
☐☐☐☐ Hips
☐☐☐☐ Legs
☐☐☐☐ Knees
☐☐☐☐ Sciatica

Energy:

☐☐☐☐ Fatigue
☐☐☐☐ Lethargy
☐☐☐☐ Restlessness
☐☐☐☐ Insomnia
☐☐☐☐ Hyperactivity

Other Symptoms:

☐☐☐☐ Irregular heartbeat
☐☐☐☐ Chest pains
☐☐☐☐ Muscle aches

Please list any symptoms you experience that were not previously mentioned: _____

Initial Confidential Patient Case History

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – OCCASIONAL
F – FREQUENT
C – CONSTANT

O	F	C	
			GENERAL
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness/depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors
			MUSCLE & JOINT
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Lumbago
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulders
			Pain or numbness in:
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Painful tail bone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal Curvature
☐	☐	☐	Swollen joints

O	F	C	
			GASTRO-INTESTINAL
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Distension of abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood
			EYES, EARS, NOSE &THROAT
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental Decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noises
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sightedness
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

O	F	C	
			CARDIO-VASCULAR
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heart beat
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles
			RESPIRATORY
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing
			SKIN
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins
			GENITO-URINARY
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Inability to control kidneys
☐	☐	☐	Kidney infection or stones
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine
			FOR WOMEN ONLY
☐	☐	☐	Cramps or backache
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge

☐ Yes ☐ No Are you pregnant?

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism	☐ Chorea	☐ Epilepsy	☐ Malaria	☐ Rheumatic Fever
☐ Anemia	☐ Cold sores	☐ Fever Blisters	☐ Measles	☐ Recreational Drugs
☐ Anorexia	☐ Depression	☐ Goiter	☐ Miscarriage	☐ Scarlet fever
☐ Appendicitis	☐ Diabetes	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Arteriosclerosis	☐ Diphtheria	☐ Heart disease	☐ Mumps	☐ Tuberculosis
☐ Bulimia	☐ Drug Abuse	☐ Hypoglycemia	☐ Pleurisy	☐ Typhoid fever
☐ Cancer	☐ Eczema	☐ Influenza	☐ Pneumonia	☐ Ulcers
☐ Candidacies	☐ Emphysema	☐ Lumbago	☐ Polio	☐ Venereal disease
			☐ Psychiatric Disorder	☐ Whooping cough

If you answered YES to any of the above conditions, please explain: _____

_____

_____

Have you ever been hospitalized or been under medical care for any operation/psychiatric care/alcohol or drug rehab?

☐ Yes ☐ No If yes, please explain: _____

_____

_____

_____

_____

_____

List surgical operation and years:

_____

_____

_____

_____

_____

FAMILY HISTORY: Please specify members of your family including extended family who have these illnesses.

CANCER: _____

HYPOTHYROIDISM: _____ DIABETES: _____

HIGH BLOOD PRESSURE: _____

OBESITY: _____

HEART DISEASE: _____

Current Medications: Prescriptions Only

Medication/Dose/How often	Reason for Taking	Prescribing M.D.