The Medical Healing Center
225 Office Plaza Drive
Tallahassee, FL 32301

Patient Registration Form

Patient Name: _____
(Same as it appears on insurance card)

Address: _____
Street City State Zip

Date of Birth: _____ **Social Security #:** _____

Phone: _____
Home Work Mobile

Email: _____ **Contact Preference:** __Phone __Text __E-mail

Sex (circle one): Male Female **Ethnicity:** _____ **Race:** _____

Marital Status (circle one): Married Divorced Single Widowed **Primary Language:** _____

Responsible Party: _____
Name Phone Relationship to Patient

_____
Address (If different from Patient)

Referred by: _____

Primary Insurance Company

Name/Address: _____
Policy #: _____ **Group #:** _____
Primary Policy Holder: _____

Additional Insurance

Name/Address: _____
Policy #: _____ **Group #:** _____

I hereby authorize the release of any medical records or information necessary to process a claim to Medicare, BlueCross or any other private insurance carrier. I also authorize payment of medical benefits to Angela Myers, ARNP, for services rendered. Although medical insurance claims will be filed upon my behalf, I understand that payment for all services provided by this office is the responsibility of the patient/guarantor. I generally authorize treatment and have received information about the practice.

_____ _____
Patient or Legal Guardian Signature Date

Please provide a copy of your ID and insurance card(s)

The Medical Healing Center
225 Office Plaza Drive
Tallahassee, FL 32301

HIPPA New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, _____ understand that as part of my healthcare, **THE MEDICAL HEALING CENTER, LLC** originates and maintains paper and/or electronic records describing my health history symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health 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, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that **THE MEDICAL HEALING CENTER, LLC** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.520 of The Code of Federal Regulations.

I further understand that **THE MEDICAL HEALING CENTER, LLC** reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of The Code of Regulations. Should **THE MEDICAL HEALING CENTER, LLC** change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. Mail or, if I agree email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I further understand that once a service or visit has been provided, there will be no refunds for such unless it is because of an overpayment.
I fully understand and accept the terms of this consent.

_____ _____

Patient and or Legal Guardian Signature **Date**

The Medical Healing Center
225 Office Plaza Drive
Tallahassee, FL 32301

General Release of All Claims Against Supervising Physician of Angela Myers, APRN

This instrument is executed by _____ (insert name of Releasor) of _____ (Address) on the date indicated below in Leon County, Florida, herein called "Releasor".

Whereas, Angela Myers, APRN operates at the Medical Healing Center, LLC, located at 225 Office Plaza Drive, Tallahassee, Florida 32301;
Whereas, Angela Myers, APRN, practices at the center as required by law under a licensed supervising physician, Louis Bolen, MD;

NOW, THEREFORE, in consideration of the Releasors acceptance of professional services by Angela Myers, APRN of (The Medical Healing Center, LLC) and other good and valuable consideration, receipt of which is hereby acknowledged, the Releasor agrees as follows:

1. The above named Releasor, on behalf of the undersigned and the undersigned's heirs, executors, administrator, and assigns hereby fully releases and discharges Dr. Bolen, the supervising physician of Angela Myers and her heirs, executors, administrators, from all rights, claims, and actions. Which the undersigned Releasor and above-mentioned successors now have or may have after the signing of this agreement against the Releasee, Dr. Bolen, and his above-mentioned successors arising out of the any professional services rendered by Angela Myers, APRN.

2. This Release is intended by the parties to release Dr. Bolen, for the claims for injury, damages, or losses to the undersigned Releasor and the undersigned's personal property, real or personal, whether known, or unknown, foreseen or unforeseen, patent or latent, which the Releasor may have against Dr. Bolen. The Releasor and that this releases Dr. Bolen from claims for his own negligence or medical negligence or malpractice. The undersigned Releasor understands and acknowledges the significance and consequence of such specific intention to release all claims, and hereby assumes full responsibility for any injuries, damages, or losses that the undersigned may incur with regards to the supervising physician, Dr. Bolen.

3. This release is freely and voluntary executed by the undersigned Releasor after having been apprised of all relevant information, data, and all other information relevant to such release. The Releasor in executing this release does not rely of any inducements, promises, or representations made by the Released or her above mentioned representatives.

4. The Releasor has read this release and understands the terms used herein, and the consequences thereof.

_____ _____
Releasor/Patient or Legal Guardian **Date**

_____ _____
Witness **Date**

The Medical Healing Center
225 Office Plaza Drive
Tallahassee, FL 32301

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO
If YES, please name the members allowed and if there is any medical information you do NOT want released (if member may have all related information please list "ALL"):

_____

_____

This consent was signed by: _____
(Patient or Legal Guardian Print Name)

Signature: _____ Date: _____

Witness: _____ Date: _____

The Medical Healing Center
225 Office Plaza Drive
Tallahassee, FL 32301

48 Hour Cancellation & "No Show" Fee Policy

Recognizing that everyone's time is valuable and the appointment time is limited, we ask that you provide a 48 hour notice if you are unable to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, The Medical Healing Center reserves the right to charge for each missed appointment (No Show), which is, absent for a compelling reason, and is not cancelled within a 48 hour advance notice. Missed appointment charges are as follows:

- $25.00 for each missed practitioner appointment
- $50.00 for each missed IV appointment
- $50.00 for each missed SCIO and/or Dolphin Neurostimulator appointment

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "No Shows" in any 12 month period will result in termination from our practice. Thank you for you anticipated cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy:

_____

Patient or Legal Guardian Printed Name

_____

Signature

_____

Date

The Medical Healing Center
225 Office Plaza Drive
Tallahassee, FL 32301

Fragrance-Free Policy

A fragrance-free environment helps create a safe and healthy workplace/clinic. Fragrances from personal care products, air fresheners, candles and cleaning products have been associated with adversely affecting a person's health including headaches, upper respiratory symptoms, shortness of breath, and difficulty with concentration. People with allergies and asthma report that certain odors, even in small amounts, can cause asthma symptoms. The Medical Healing recognizes the hazards caused by exposure to scented products and we have a policy to provide a fragrance-free environment for all employees and visitors to keep a safe and healthy environment for all.

When you are visiting our office please adhere to our request to keep our facility fragrance-free and refrain from using any type of scented products.

Thank You,
The Medical Healing Center

Medication Log

Patient_____Birthdate_____

Home Phone_____WorkPhone_____Occupation_____

Pharmacy_____ Pharmacy Phone_____

Medical/Allergy Alerts:

Date RX	Medication	Dosage	QTY.	FREQ.	Refills (Date and Initial)				Stop Date

Notes:_____ARE YOU DIABETIC?_____

_____

_____

_____

_____

_____

_____

Problem List

Date Onset	Problem	Date Resolved

Medical History

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

What is the main problem 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's 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:

	Yes	No
Irregular menstrual cycles?		
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:

	Yes	No
Problems attaining/maintaining an erection		
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 condtions: _____

Siblings' ages and medical condtions: _____

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

PRIMARY COMPLAINT(s): _____

_____

Appx. date of onset: _____ **Symptoms began:** __ **Gradually:** __ **Suddenly**

Symptom and Ailments Questionnaire #1

Please check the appropriate box for each question.

Symptoms – Please Circle One or all that apply on each line:	**Frequently**	**Occasionally**	**Rarely**	**Never**
Cold hands, feet, low body temperature				
Fatigue/ tiredness				
Inability to lose weight despite dieting				
Poor memory				
Poor concentration				
Constipation				
Diarrhea				
Hair loss				
Depression				
Anxiety/ nervousness				
Irregular heart beats				
Trouble sleeping				
Muscle weakness				
Muscle aches				
Joint pain				
Headaches				
Early morning stiffness				
Easy fatigue from exercising				
Sleepiness in the afternoon				
Dizzy/ lightheaded				
Sugar cravings				
Loss of voice / hoarseness				
Shaky or irritable when hungry				
Thyroid disease				
Sense of fullness during and after meals				
Belching/ burping/ bloating/ gas				
Rectal itching/ nasal itching				
Toe fungus, jock itch, or athlete's foot				
High sensitivity to smells				
Chronic or long term hives				
Bad breath				
Sinus or breathing problems				
Easy bruising				
Slow wound healing				
Average bowel movements per day?	(1)	(2)	(3)	(4+)

_____ _____ _____ _____

Patient/Authorized Person Initials Date Physician's Initials Date

Symptom and Ailments Questionnaire #2

Please check the appropriate box for each question.

Symptoms – Please Circle One or all that apply on each line:	**Frequently**	**Occasionally**	**Rarely**	**Never**
Vaginal burning, itching or discharge				
Prostatitis or prostate cancer				
Mood swings				
Endometriosis or infertility				
Cramps or menstrual irregularities				
Attacks of anxiety or crying				
Bladder / kidney infections				
Drowsiness				
Irritability				
Eczema or psoriasis				
Itchy skin or eyes				
Chronic hives (urticaria)				
Indigestion or heartburn				
Decreased body hair				
Sensitivity to milk, wheat or foods				
Decreased sex drive				
Dry mouth or throat				
Bad breath				
White tongue				
Excessive foot, hair or body odor				
PMS pre-menstrual syndrome				
Frequent sore throats				
Laryngitis, loss of voice				
Recurring bronchitis				
Pain or tightness in the chest				
Shortness of breath				
Spots in front of eyes				
Burning or tearing eyes				
Recurring infections in eyes				
Ear pain or ringing				
Salt Cravings				
Other symptoms needing consideration:				

Patient/Authorized Person Initials _____ Date _____ Physician's Initials _____ Date _____

Symptom and Ailments Questionnaire #3

Please check the appropriate box for each question.

Symptoms and Ailments: Please circle one or all that apply on each line:	***YES***	***NO***
Have you taken multiple courses of a broad-spectrum antibiotic drug—even in a single dose?		
Have you, at any time in your life, been bothered by persistent prostatitis, vaginitis or other problems affecting your reproductive organs?		
Are you bothered by memory or concentration problems e.g. do you sometimes feel 'spaced out'?		
Do you feel 'sick all over' yet, in spite of visits to many different physicians, no cause has been found?		
Have you been pregnant?		
Have you taken birth control pills longer than 2 years?		
Have you taken steroids orally, by injection or inhalation?		
Does exposure to perfumes, insecticides, fabric shop odors and other chemicals provoke symptoms?		
Does tobacco smoke *really* bother you?		
Are your symptoms worse on damp, muggy days or in moldy places?		
Have you had athlete's foot, ring worm, 'jock itch' or other chronic fungus infections of the skin or nails?		
Do you crave sugar?		
Do you have high blood pressure?		
Have you ever had angina or a heart attack?		
Have you ever had a stroke?		
Do you have diabetes?		
Do you have swelling that is not known to be the result of another health issue?		
Do you smoke?		
Do you have high cholesterol? If yes, what is your cholesterol number? _____		
Have you ever had coronary bypass surgery?		
Is there history of heart disease in your family?		
Have you been diagnosed with sleep apnea?		

24 hr Food Intake:

When did you last eat? _____ hrs ago

What did you have for breakfast today: _____

Lunch (yesterday or today):_____

Dinner (yesterday):_____

Snacks (past 24 hours):_____

Beverages (past 24 hours):_____

_____ _____ _____ _____

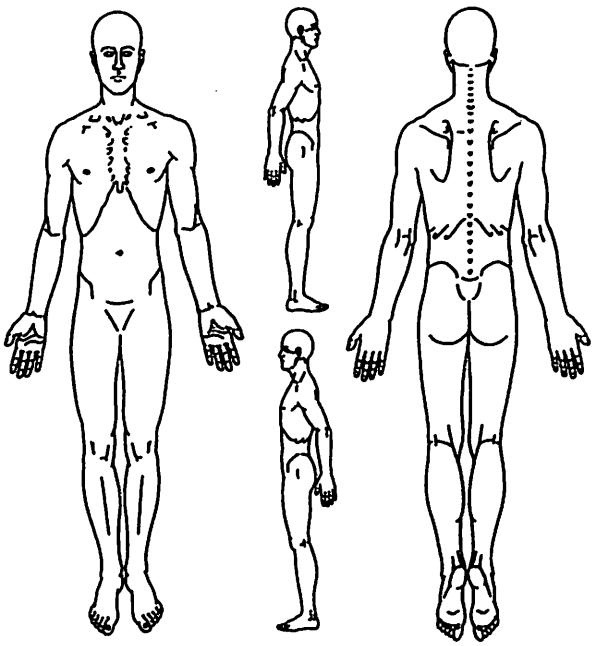
Patient/Authorized Person Initials Date Physician's Initials Date

Pain Symptoms Questionnaire

Please check the appropriate box for each question.

Using the diagram below, indicate any areas you are feeling pain by marking a

PPP = Pain NNN= Numbness TTT = Tingling BBB = Burning CCC= Cramping XXX = Other



On a scale of 1-10, with 10 being the worst possible pain, what is your level of pain?

1 2 3 4 5 6 7 8 9 10

Please indicate any other symptoms that you have experienced:

_ Dizziness _ Memory Loss _ Numb Feet/ Toes
_ Irritability _ Ears Ringing _ Back Pain
_ Difficulty Sleeping_ Fatigue _ Jaw Problems _ Chest Pain
_ Arm/ Shoulder Pain_ Leg Pain _ Back Stiffness
_ Blurred Vision _Numb Hand/ Fingers _ Tension
_ Low Back Pain _ Neck Stiffness _Shortness of Breath
_ Nausea _ Buzzing in Ear _ Neck Pain _ Upset Stomach_

Other: _____

_____

Circle Quality of Pain:

Stabbing Shooting Dull Constant Intermittent Better /Worse with heat Better/Worse with ice
Better/Worse with movement Better/Worse sitting Better/Worse standing Better/Worse lying down

If yes,
How many days a week do you exercise? _____ How long? _____

What type of exercise (s)? _____

Have you ever seen a pain management specialist? NO__ YES__

If yes, what treatments are you currently receiving on a regular basis? (Acupuncture, physical therapy, medication…)_____

_____ _____ _____ _____
Patient/Authorized Person Initials Date Physician's Initials Date

Environmental Profile

According to the World Health Organization as much as 65% of all illnesses can be caused or made worse by the indoor environment. Numerous chronic diseases, which were once rare, are becoming commonplace as the levels of toxins present in our environment continue to escalate. Many times medical treatments are rendered ineffective if the environment in which a patient lives is not conductive to the healing process. During the course of your medical treatment the physician obtains a complete profile of your living environment. This will enable Progressive Medical Centers of America to determine if your illness is caused or worsened by your living or working environment and to specifically individualize a treatment program for optimal results.

Please circle one or all that apply on each line and answer the following questions by checking YES or NO:

Question	Yes	No
Are pesticides in your home or office?		
Do you use natural cleaning and laundry products?		
Is the construction of your house less than 15 years old?		
Have you had plumbing leakage, wet carpets or other water damage anywhere in your home?		
Do you have animals live indoors?		
Do you or your neighbors use lawn chemicals?		
Do you have moldy odors, mildew or visible molds anywhere in your home?		
When turning on your heating or air conditioning system(s) do you smell foul or moldy odors?		
Does the dust in your home reappear shortly after dusting?		
Do you have "blown-in" insulation in your attic?		
Are you, or is anyone in your home, experiencing any chronic ailments such as asthma, allergies, sinus infections, respiratory problems, or frequent cold or flu-like symptoms?		
Have you ever had bird, rat, mouse or any rodent infestation in your home?		
Do you have a "crawlspace" or an unfinished basement in your home?		
Do you feel better after you leave your home or office for a extended period of time?		
Do you use only natural products for your skin?		
Do you have moldy odors or visible molds in your workplace?		
Has there ever been water stains on the ceiling tiles, chemical odors, dirty air vents or excessive dust intrusion in your home or workplace?		
Do you frequently feel tired or run-down at the end of a workday?		
Do your family members and co-workers frequently complain of headaches, colds or flu-like symptoms?		
Is smoking permitted in your workplace or home?		
Do you have carpeting in your home or office?		
Do you use a filter for all drinking, cooking and shower/bath water?		
Do you have an air filter in your home or work place?		

What is your current occupation? _____

If less than one year, what was your prior occupation? _____

_____ _____ _____ _____

Patient/Authorized Person Initials Date Physician's Initials Date