



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

*"We Treat Mind Body and Spirit"*

## Late Arrival Policy

To provide the highest quality care and remain respectful of all patients' time, we have established the following policy regarding late arrivals:

### **1. Appointment Timing**

Patients are expected to arrive on time for their scheduled appointments. We recommend arriving 10–15 minutes early to allow time for check-in and any necessary paperwork.

### **2. Grace Period**

A grace period of up to **10 minutes** may be allowed for late arrivals. Patients arriving within this window will be seen at the provider's discretion and may receive a shortened appointment.

### **3. Arrivals Beyond 10 Minutes**

Patients arriving more than 10 minutes late may be asked to reschedule their appointment. This helps prevent delays for other patients and ensures adequate time for proper care.

### **4. Notification of Late Arrival**

If you anticipate being late, please contact our office as soon as possible. We will do our best to accommodate you, though adjustments may be necessary.

### **5. Missed Appointments**

If a patient does not arrive and does not notify the office, the appointment will be considered a no-show and will be subject to our No-Show Fee Policy.

### **6. Repeat Late Arrivals**

Repeated late arrivals may result in restrictions on scheduling future appointments until the late fee of \$25 has been paid or other administrative actions.

We appreciate your understanding and cooperation in helping us maintain a timely and efficient schedule for all patients.

**Thank you for your cooperation.**

*Medical Healing Center*



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







# 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:**

Irregular menstrual cycles?	Yes	No
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:**

Problems attaining/maintaining an erection	Yes	No
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 conditions: \_\_\_\_\_  
 Siblings' ages and medical conditions: \_\_\_\_\_  
 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.*

<b>Symptoms and Ailments: Please circle one or all that apply on each line:</b>	<b>YES</b>	<b>NO</b>
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 <i>really</i> 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

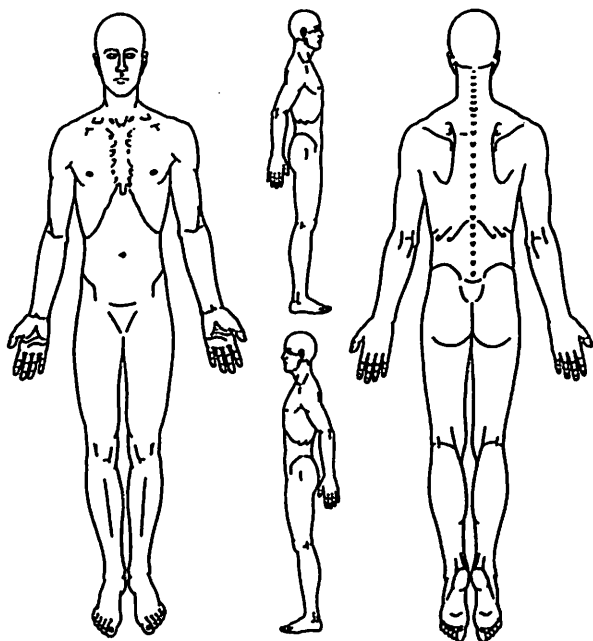
\_\_\_\_\_  
Date

## 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 conducive 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 "crawl space" or an unfinished basement in your home?		
Do you feel better after you leave your home or office for an 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