CI Clinic Patient Registration Form

Patient Legal Name: ----------/ ----------/ ----------
Last First MI

DOB----------

Address: ----------/ City ---------- State ----------Zip----------

Phone: Home ( ) ---------- Work ( ) ---------- Mobile ( ) ----------

Email address:----------

Marital Status: [ ] M, [ ] S, [ ] D, [ ] W

Occupation: .....

Name of Emergency Contact: ---------- Phone Number ( ) ----------

How did you hear about us?
1. Internet
2. Friends and Family Members
3. Yellow Pages
4. Other____

Emergency Contact_____

Legal guardian's name:
Legal guardian's telephone number and address: if different than above:

CI Clinic Medical History Form

Health History

List the main problems that you are having, or reason for this appointment:

Past Medical History:

Major Illnesses:

Hospitalizations/Procedures/Surgeries/ Accidents or major trauma:

Allergies and Sensitivities: (Foods, environmental, etc.)

List any medication you are taking including dosage and frequency:

List any supplements you are taking:

CI Clinic Consent for Treatment

Release and Authorization

I understand that Carolina Integrative Clinic ("CI Clinic") is an integrative treatment center, employing conventional therapies as well as innovative therapies, and that some of these therapies are not FDA approved. I hereby voluntarily request, authorize and consent to the medical care, including diagnostic treatments as deemed appropriate by and delivered by CI Clinic providers, related to health problems for which I have sought the services of CI Clinic. I understand that CI Clinic is not a primary care clinic and that I am required to maintain an established relationship with a primary care provider ("PCP") as well as any specialists that may be required. I understand that I will see my PCP for my yearly complete physical exam including applicable procedures such as a prostate exam, breast exam, Pap, mammogram and other x-rays, appropriate laboratory tests, etc. I understand that I will address any health issues, acute illnesses or drug and surgical complications to my PCP or my local emergency room. I further understand that CI Clinic providers are not on call, do not provide walk-in or emergency services, do not keep customary office hours and will be available on an appointment basis only.

I authorize CI Clinic to obtain my medical records, X-ray/Lab reports, or other health-related information deemed necessary to allow CIC providers to appropriately diagnose and/or treat my medical condition(s).

Telehealth

At CI Clinic the health visits are conducted through telehealth. Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format. I understand that telehealth billing information is collected in the same manner as a regular office visit. I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to: It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures. Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network. Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.

I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care. I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records). I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed. I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others. CI Clinic's healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me. I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

I understand that electronic communication cannot be used for emergencies or time- sensitive matters. I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit. I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.). I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.

By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit. I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided. To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.

I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the existing emergency 911 services in my community.

Payment Requirements

Appointments must be paid for at time of service. We accept Visa, MasterCard, check, cash, or Traveler's checks. You will be charged a $25 fee for returned checks.

Health Insurance

I understand that CIC does not contract with any insurance company, including Medicare and Medicaid. I acknowledge that I will be required to pay for all charges that are incurred. I have been given no assurance that I will receive insurance reimbursement for any of the charges incurred at CI Clinic. I understand that I will be given itemized codes for office visit charges at CI Clinic and it will be my responsibility to file with my insurance company for reimbursement. I understand that I may be unable to receive reimbursement from my insurance carrier for consultations, recommended laboratory tests or recommended therapies or supplements. I understand that my ability to receive reimbursement for office visit charges will be dependent on my insurance carrier policies. I understand that Carolina Integrative Clinic has opted out of the Medicare program and Medicare will not reimburse for any fees paid to CI Clinic.

Cancellation/No Show Policy

In case of cancellation, in order to allow another patient the opportunity to utilize your appointment time, we require that you notify our office no less than 48 business hours in advance. If you fail to give us 48 business hours advanced notification for cancellation of a regularly scheduled office visit or are unable to keep your appointment there will be a $100.00 fee charged. We reserve the right to cancel any appointment without a cause in which case the patient will not incur any cost.

Medications and Nutritional Supplements

I understand that medications and nutritional supplements may be recommended as components of my treatment program. These medications and supplements are for sale at Carolina Compounding Pharmacy, but they may also be purchased elsewhere. I am free to purchase my supplements at Carolina Compounding Pharmacy, or at any other pharmacy or retail store.

Requests for Prescriptions

Patients should always bring ALL of their pharmaceutical prescriptions and current supplements to every office visit so the doctor knows exactly what you are taking, the dosage, and how many refills are remaining. Any change that you like to have made to your medications prescribed by a CI Clinic provider, as well as all requests for refills, should be discussed during your regularly scheduled office visit.

Copying Medical Records

There will be a fee of $.50 per page, with a $10 minimum charge.

Letters of Medical Necessity

Occasionally, patients will request letters of medical necessity to be written by the doctor to assist them in obtaining insurance coverage for certain laboratory tests or therapies recommended by CIC. As a service for our patients, the doctor will perform a chart review and provide a letter reviewing your health history, previous testing and treatment, current laboratory results, treatments provided or planned outcome, and prognosis. **There will be a $40.00 fee charged for a letter of medical necessity. If you have not been seen within the past year, you will be required to have a follow-up office visit before such a letter can be written.**

I have read and fully understand and acknowledge all of the information contained in this document. I have had the opportunity to ask any questions, and I have asked all questions that I need to ask regarding any of this information. Today, the _____ day of _____, 20___.

_____ _____

Patient Printed Name Patient (or Patient Guardian) Signature