Integrative Family Medicine
7468 N. LA CHOLLA BLVD., TUCSON, AZ 85741
PHONE (520) 297-9664 FAX (520) 297-9633

PATIENT'S NAME	DATE OF BIRTH	OCCUPATION
ADDRESS	MARRIED ☐ SINGLE ☐ MALE ☐ FEMALE ☐	EMPLOYER
CITY STATE ZIP	SOCIAL SECURITY #	EMERGENCY CONTACT
HOME PHONE CELL PHONE	PRIMARY PHYSICIAN	EMERGENCY CONTACT PHONE
WORK PHONE	PRIMARY PHYSICIAN'S PHONE #	THERAPIES BEING USED
E-MAIL	HOW DID YOU HEAR OF US	

INSURANCE INFORMATION

We are a fee for service facility. Payment is due at the time services are rendered. We are able to send a courtesy claim to your insurance if you choose. There is no guarantee of benefits. Payment will be credited to your account. However, Dr. Sadilek is **not** a Medicare participant. **Medicare will not cover any services or labs** for this office.

NAME OF INSURANCE	WOULD YOU LIKE US TO SUBMIT ☐ YES ☐ NO
ID #	Group #

RELEASE OF INFORMATION AUTHORIZATION

Please list contacts that have your consent to receive your medical information.

Myself by: ☐Home ☐Work ☐Cell ☐Answering Machine

Contact_____phone#_____
Contact_____phone#_____
Contact_____phone#_____

FINANCIAL ARRANGEMENTS AND TREATMENT POLICY

We feel that everyone benefits when there is a definite and clear understanding of our treatment and financial policies prior to treatment. They are intended to allow us to be fair to our entire family of patients and help control the administrative cost.

Medical Consent

By seeking services from Integrative Medical Associates, you authorize the doctor and practice staff to perform necessary services for the patient named above, any treatment, which is deemed advisable by the doctor. You also agree that all disputes concerning the Medical Consent and the treatment shall be resolved by arbitration, which shall be final and binding, held in Pima County, Arizona according to A.R.S. Title 12, Chapter 9, Article 1, as may be amended from time to time.

Appointments

We have exclusively reserved the doctor, nurse, or staff and facilities for your personal health care. We ask our patients to give us a 24 hour notice if you need to cancel or reschedule. If you do not come in for your appointment, or break your appointment without sufficient notice, a $50.00 per hour broken appointment fee will be applied to your account and you will be required to pre-pay for your next appointment.

For IVs and injections, the fee will be the cost of the IV or injection, unless there is an available time slot for the patient to be rescheduled within 48 hours.

If you are scheduled for multiple appointments for the same day, and you do not come in for your appointment, or break your appointment without sufficient notice, a $50.00 per hour broken appointment fee will be applied to your account per each appointment missed and you will be required to pre-pay for your next appointment.

Fees

The fees for quality health care are based on the treatment rendered and the time needed to complete the treatment. Our office believes that the fees are a fair representation of the standard of care we provided and in-step with the industry standard.

Payments

All fees are due at the time of service. We accept Cash, Personal Check, Visa and MasterCard.

Insurance

While Integrative Medicine is growing in popularity among healthcare consumers, many insurance companies do not provide coverage for these services. At this time due to insurance limitations, the consultation will remain on a fee for service basis. We do however offer a courtesy insurance billing, provided we have current and accurate benefit coverage information. We will submit your visit to your insurance company

CONTINUE ON OTHER SIDE

for possible reimbursement, depending on your insurance guidelines. However, we will not get involved in any dispute between you and your insurance company.

Please understand that your health benefit program is a contract between you, your employer and the insurance company. We do not have a contract with your insurance company and we do not know the details of what your insurance plan covers. You hold the contract. Therefore, you are responsible to know what your plan covers. In the event that your insurance company pays Integrative Medical Associates, we will gladly apply it to your account, so you would be able to use it towards future visits or purchases. If you would prefer, just ask and we would also be willing to send you a refund check.

If you have authorized us to provide you courtesy insurance billing, then you are agreeing to the following:

- You authorize the insurance company(s), attorney and any third party payers to pay directly to Integrative Medical Associates for any and all services rendered to me or minor who I am responsible that were provided by Integrative Medical Associates.
- You acknowledge that insurance is billed as a courtesy; and you are ultimately responsible for the bill.
- You agreed that Integrative Medical Associates may deliver and release medical records, consultations, depositions and court appearances to any insurance company, adjuster, attorney or legal service bureau.
- You also grant Integrative Medical Associates full power of attorney to endorse and/or sign your name on any and all checks for payment of any debt owed to this office.

Medicare

Medicare does not cover Integrative Medicine. Integrative Medical Associates is not a Medicare participant. We do not submit any claims to Medicare.

Medicare will not pay for integrative services done in this office and will not cover any labs ordered by any of our doctors. If any of our doctors request labs to be done, you have several options, 1) you may take the request to your participating Medicare physician and ask them to process those labs. 2) Have the lab tests done and prepay for your labs here at this office at a discounted rate. 3) Decline to have the tests done.

Finance Charges

Even though we encourage patients to maintain a zero-balance account, in the event your account is not paid in full, a service fee will be incurred on any unpaid balance that is older than 45 days. The service fee will be a minimum of two dollars or 1 ½ % per month (18% annually) of the unpaid balance which ever is greater. In the event that collection efforts become necessary to collect on your account, you are responsible to pay all costs including collection fees and returned check fees.

Returned Checks

There is a minimum of $30.00 fee for any returned check.

Request for Records, Health Savings Letters and Other Forms

Medical Records: It is the policy of Integrative Medical Associates to charge for the processing of medical records relating to purposes other than continuing care, along with requiring pre-payment of these fees. This is in accordance with ARS 12.2295, A., which states that except as otherwise provided by law, a health care provider or contractor may charge a person who requests copies of medical records a reasonable fee for the production of the records and may require the payment of any fees in advance. Our fees are set at $25.00 professional fee plus $1.00 per page up to 20 pages, and $.25 per page thereafter.

Letters and Forms: When a patient requests a letter or form to be filled out by the doctor or other staff member, a fee will occur when it is not for a medical necessity. There will be a charge for Health Saving Account forms or letters, disability forms, insurance forms, etc.

Termination of Treatment

You play an important role in your own health care. Just as a patient can choose to discontinue care at any time, Integrative Medical Associates reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans and/or financial policies.

Our office would like to thank you for your time, cooperation and trust in us to deliver comfortable, safe and quality care to you, your family and friends. We also appreciate your understanding in the necessity of the aforementioned guidelines and procedures.

I am the patient, parent, guardian, or personal representative of the person listed on page one of the Financial Arrangement and Treatment policy. There are no court orders in effect that prohibit me from signing this consent. **I have read, understand and will abide by the information concerning these office policies.**

_____ _____

Responsible Party Signature Date

WOMEN'S HEALTH HISTORY

Name _____ Today's Date_____

Age _____ Birthdate _____ Date of Last Physical Examination _____

Current Major Health Concern(s)_____

Medication Allergies _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the last year.

GENERAL

☐ Chills
☐ Depression
☐ Dizziness
☐ Fainting
☐ Fever
☐ Forgetfulness
☐ Headache
☐ Loss of sleep
☐ Loss of weight
☐ Nervousness
☐ Numbness
☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

☐ Arms ☐ Hips
☐ Back ☐ Legs
☐ Feet ☐ Neck
☐ Hands ☐ Shoulders

CARDIOVASCULAR

☐ Chest pain
☐ High blood pressure
☐ Irregular heart beat
☐ Low blood pressure
☐ Poor circulation
☐ Rapid heart beat
☐ Swelling of ankles
☐ Varicose veins

SKIN

☐ Bruise easily
☐ Hives
☐ Itching
☐ Change in moles
☐ Rash
☐ Scars
☐ Sore that won't heal
☐ Skin tags
☐ Skin discoloration

GASTROINTESTINAL

☐ Appetite poor
☐ Bloating
☐ Bowel changes
☐ Constipation
☐ Diarrhea
☐ Excessive hunger
☐ Excessive thirst
☐ Gas
☐ Hemorrhoids
☐ Indigestion
☐ Nausea
☐ Rectal bleeding
☐ Stomach pain
☐ Vomiting

GENITO-URINARY

☐ Blood in urine
☐ Frequent urination
☐ Lack of bladder control
☐ Painful urination

EYE, EAR, NOSE, THROAT

☐ Blurred vision
☐ Crossed eyes
☐ Double vision
☐ Vision – flashes
☐ Vision – halos
☐ Earache
☐ Ear discharge
☐ Loss of hearing
☐ Ringing in ears
☐ Nosebleeds
☐ Sinus problems
☐ Hay fever
☐ Hoarseness
☐ Difficulty swallowing
☐ Persistent cough
☐ Bleeding gums

GYNECOLOGICAL HISTORY

	Date	Results
Last Pap Smear		
Last Mammogram		
Last Menstrual Cycle		Length
Interval between cycles		
Any recent changes in normal menstrual flow		
Forms of Birth Control		
# of Children	# of Pregnancies	
# of C-Section	Surgical menopause, date	

CONDITIONS Check (✓) any conditions you have or have had in the past.

	Comments
☐ AIDS / HIV Positive	
☐ Alcoholism	
☐ Anemia	
☐ Anorexia / Bulimia	
☐ Appendicitis	
☐ Arthritis	
☐ Asthma	
☐ Bleeding Disorders	
☐ Breast Lump	
☐ Bronchitis	
☐ Cancer	Type:
☐ Cataracts	
☐ Chemical Dependency	
☐ Chicken Pox	
☐ Diabetes	
☐ Emphysema	
☐ Epilepsy	
☐ Glaucoma	
☐ Goiter	
☐ Gout	
☐ Heart Disease	
☐ Hepatitis	
☐ Hernia	
☐ High Cholesterol	
☐ Kidney Disease	
☐ Liver Disease	
☐ Measles	
☐ Migraine Headaches	
☐ Miscarriage	
☐ Mononucleosis	
☐ Multiple Sclerosis	
☐ Mumps	
☐ Pacemaker	
☐ Pneumonia	
☐ Polio	
☐ Psychiatric Care	
☐ Rheumatic Fever	
☐ Scarlet Fever	
☐ STDs	Type:
☐ Stroke	
☐ Suicide Attempt	
☐ Thyroid Problems	
☐ Tonsillitis	
☐ Tuberculosis	
☐ Ulcers	
☐ Vaginal Infections	
☐ Valley Fever	

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				
Grand Parents				

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

DATE	SERIOUS ILLNESS/INJURIES	OUTCOME

MEDICATION INFORMATION

Medication	Dosage / Directions	Doctor	Date Started

LIFESTYLE

Stress level on a scale of 1 to 10 (1 being the lowest) _____
Identify the major stress causes _____
Exercise daily? _____ Times per week _____
Type of exercise _____
☐ Use tobacco / smoke cigarettes How many a day _____
☐ Exposed to secondhand smoke

DIET Check (✓) any that apply

☐ Sweets, soda, ice cream ☐ Chocolate
☐ Whole grains, legume, cereals ☐ Skip meals
☐ Fried foods ☐ Diet frequently
☐ Fruits / Vegetables ☐ Dine out regularly
☐ Drink coffee ☐ Decaffeinated # cups per day _____
☐ Alcoholic beverages # servings per day/week _____

MENSES Check (✓) the symptoms you experience regularly

One to two week(s) before your period

☐ Anxiety
☐ Irritability
☐ Nervous Tension
☐ Aggressive or hostile
☐ Weight gain
☐ Water retention
☐ Abdominal bloating
☐ Tender, swollen and/or painful breasts
☐ Breast lumps increased in size and tenderness.
☐ Discharge from nipples
☐ Craving for sweets
☐ Increased appetite
☐ Fatigue
☐ Headaches
☐ Insomnia / difficulty sleeping
☐ Heart palpitations
☐ Shaky or clumsy
☐ Withdrawn
☐ Confused
☐ Forgetful

During your period

☐ Cramping in lower abdomen or pelvic area
☐ Sharp intermittent pain
☐ Dull aching pain
☐ Upset stomach
☐ Diarrhea
☐ Nausea or vomiting
☐ Low back aches
☐ Headaches
☐ Unusual fatigue (take naps)
☐ Weight gain
☐ Painful and/or swollen breasts
☐ Irritability
☐ Depression
☐ Painful intercourse
☐ Difficulty concentrating
☐ Mood swings
☐ Accident prone
☐ Decreased productivity

Throughout the month

☐ Decline of vital energy and sense of well being
☐ Hot Flashes / Night Sweats
☐ Spontaneous sweating
☐ Chills
☐ Depressed
☐ Anxiety
☐ Anger
☐ Headaches
☐ Difficulty concentrating
☐ Difficulty sleeping
☐ Urinary problems
☐ Vaginal problems
☐ Bleeding between periods
☐ Irregular periods
☐ Stopped menstruation
☐ Joint and muscle pain
☐ Change in sexual desire
☐ Difficulty with orgasm
☐ Painful intercourse
☐ Vaginal bleeding after sex
☐ Vaginal discharge

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature Date