

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

PATIENT'S NAME			F BIRTH OCCUPATION			
ADDRESS			ED SINGLE	EMPLOYER		
		MALE	FEMALE			
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			ID YOU HEAR OF US			
INSURANCE INFORMATION			RELEASE OF INFORMATION AUTHORIZATION			
We are a fee for service facility. Payment is due at the time services are rendered. We			Please list contacts that have your consent to receive your medical information.			
are able to send a courtesy claim to your insurance if you choose. There is no guaran of benefits. Payment will be credited to your account. However, Dr. Sadilek is <u>not</u> a		not a	Myself by:   Home   Work   Cell   Answering Machine			
Medicare participant. Medicare will not cover any services or labs for this office.		fice.	Mysen by. Thome Twork Tell Tanswering Machine			
NAME OF INSURANCE WOULD YOU LIKE US TO SUBMIT			Contactphone#			
	☐ YES ☐ NO		Contact	phone#		
ID#	Group #	_	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 <u>fee for service basis</u>. 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

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.

<u>Letters and Forms</u>: 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 Treatmer
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	

# **MEN'S HEALTH HISTORY**

Name		Today's Date			
Age Birthdate Date of Last Physical Examination					
Current Major Health Conce	ern(s)				
Medication Allergies					
SVMDTOMS Chack (4) a	wentens you surrently have or	CONDITIONS Cheek (//) any conditions you have at have had			
have had in the last year.	symptoms you currently have or	<b>CONDITIONS</b> Check (✓) any conditions you have or have had in the past.			
GENERAL	GASTROINTESTINAL	□ AIDS / HIV Positive			
☐ Chills	☐ Appetite poor	☐ Alcoholism			
□ Depression	□ Bloating	□ Anemia ————————————————————————————————————			
☐ Dizziness	☐ Bowel changes	□ Anema ————————————————————————————————————			
☐ Fainting	☐ Constipation	☐ Appendicitis ———————————————————————————————————			
□ Fever	□ Diarrhea	☐ Arthritis ———————————————————————————————————			
☐ Forgetfulness	☐ Excessive hunger	☐ Asthma			
☐ Headache	☐ Excessive thirst	☐ Bleeding Disorders			
□ Loss of sleep	□ Gas	☐ Breast Lump			
☐ Loss of weight	☐ Hemorrhoids	□ Bronchitis			
□ Nervousness	☐ Indigestion	□ Cancer			
□ Numbness	□ Nausea	□ Cataracts			
☐ Sweats	☐ Rectal bleeding	☐ Chemical Dependency			
MUSCLE/JOINT/BONE	☐ Stomach pain	□ Chicken Pox			
Pain, weakness, numbness in:	☐ Vomiting '	□ Diabetes			
□ Arms □ Hips	GENITO-URINARY	□ Emphysema			
□ Back □ Legs	☐ Blood in urine	□ Epilepsy			
□ Feet □ Neck	☐ Frequent urination	☐ Glaucoma			
☐ Hands ☐ Shoulders	•	☐ Goiter			
CARDIOVASCULAR	☐ Painful urination	□ Gout			
☐ Chest pain	EYE, EAR, NOSE, THROAT	☐ Heart Disease			
☐ High blood pressure	☐ Blurred vision	☐ Hepatitis			
☐ Irregular heart beat	☐ Crossed eyes	☐ Hernia			
☐ Low blood pressure	☐ Double vision	☐ High Cholesterol			
☐ Poor circulation	☐ Vision – flashes	☐ Kidney Disease ——————————————————————————————————			
☐ Rapid heart beat	☐ Vision – halos	☐ Liver Disease ——————————————————————————————————			
☐ Swelling of ankles	☐ Earache	☐ Measles ———————————————————————————————————			
☐ Varicose veins	☐ Ear discharge	☐ Migraine Headaches ————————————————————————————————————			
SKIN	☐ Loss of hearing	☐ Mononucleosis ———————————————————————————————————			
☐ Bruise easily	☐ Ringing in ears	☐ Mumps — — — — — — — — — — — — — — — — — — —			
□ Hives	☐ Nosebleeds	□ Pacemaker			
☐ Itching	☐ Sinus problems	□ Pneumonia			
☐ Change in moles	☐ Hay fever	□ Polio			
□ Rash	☐ Hoarseness	□ Prostate Problem			
□ Scars	□ Difficulty swallowing	☐ Psychiatric Care			
☐ Sore that won't heal	☐ Persistent cough	☐ Rheumatic Fever			
☐ Skin tags	☐ Bleeding gums	□ Scarlet Fever			
☐ Skin discoloration	· = · = · = · · · · · · · · · · · · · ·	□ STDs			
	E HEALTH	□ Stroke			
WAL	<u>Date</u> <u>Results</u>	☐ Suicide Attempt			
Last Prostate Exam	<u> </u>	☐ Thyroid Problems			
Last PSA Blood Test		☐ Tonsillitis ———————————————————————————————————			
Luci 1 On Diodu 1 ost		☐ Tuberculosis ———————————————————————————————————			
		□ Ulcers ————————————————————————————————————			
		□ Valley Fever			

FAMILY HOTORY Fill's Health before after the constraint				HOODITALIZATIONS						
FAMILY HISTORY Fill in Health Information about your family.			HOSPITALIZATIONS							
Relation	Age	State of Health	Age at Death	Cause of Death	Year	Hospital		Reason for Hospitalization and Outcome		
Father										
Mother										
Brothers										
Sisters					DATE	SERIOUS ILLNESS/INJURIES OUTCO		UTCOME		
Grand										
Parents										
				MEDICATION IN		ION			Γ	
		Medication		Dosage	Dosage / Directions			Doctor Date Started		
		LIFES <sup>-</sup>	TVIF		<b>DIET</b> Check (✓) any that apply				nly	
Stress leve	el on a			ne lowest)	☐ Sweets, soda, ice cream ☐ Chocolate					
		stress causes		☐ Whole grains, legun						
			Times p	oer week	er week ☐ Fried foods			☐ Diet frequently		
Type of ex				<u> </u>		s / Vegetables			out regularly	
		smoke cigarettes		many a day	☐ Drink		Decaffein		s per day	
□ Expose	a to sec	condhand smoke		(//) the exampteme year		☐ Alcoholic beverages # servings per day/weekexperience regularly or you have a history of.				
	MENTA	L FUNCTION	NE Check	, ,			_		PROBLEMS	
		ed or "burned" ou	ıt	MUSCULO-SKELETAL  ☐ Fatigue or loss of energy			☐ Adult mumps, orchitis or testicular			
		sed or negative		☐ Feeling sore all over in joints & muscles			problems			
☐ Feeling					☐ Frequent back or neck pain			☐ Enlarged prostate		
		s or nervous		☐ Decrease in physical endurance			☐ Urinary frequency, reduced flow			
_		ly fatigued			☐ Decrease in muscle size, tone & strength			☐ Increased urination at night		
		ntal sharpness,	Wit	☐ Decrease in athletic performance; loss of			☐ Decrease in urine flow, dribbling			
☐ Forgetfo	•	sertiveness		agility, quickness  ☐ Decline in recovering from physical			☐ Take medicine for enlarged			
		tion or initiative t	o start	exercise				prostate  ☐ Increased PSA		
		articipate in hob		☐ Increased tendency toward muscle pulls			☐ Prostate Cancer			
		ork, rėlationships		or leg cramps		☐ Prostate Operation				
		ost significance	_	☐ Osteoporosis		☐ Inflammation/infection of prostate				
		LIC SYNDROME al cholesterol or	-	□ Neuropathy		☐ Vasectomy or varicocele				
		ai cholesteroi oi		PHYSICAL PROBLEMS  Shortness of breath with activities		☐ Infertility problem☐ Hernia repair				
3,		☐ Lightheadedness, dizzy spells, ringing in		SEXUAL FUNCTION						
☐ High blood sugar or diabetes		the ears or frequent			☐ Decrease in spontaneous early					
☐ High blood pressure ☐			☐ Poor circulation in legs, swollen ankles,		morning erections					
☐ Development of chest pain, heart			varicose veins or hemorrhoids		☐ Decreased libido or desire for sex					
		☐ Changes in visual acuity, inability to read		□ Decrease in fullness of erection						
☐ Unexplained weight gain, particularly in the midsection ☐		•	fine print □ Dry skin on face or hands		☐ Decreased volume or strength of force of climax					
		•	☐ Dry skin on face or nands☐ Excessive sweating during the day or at			☐ Difficulty in maintaining full erection				
☐ Thyroid problem		night	adding th	c day of at		☐ Difficulty in maintaining full election				
					☐ Premature ejaculation					
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										
				I may have made in the				,		

responsible for any errors or omissions that I may have made in the completion of this form.

Signature