PATIENT MEDICAL FORM

Name: _____ DOB: _____/_____/_____ Date Today: _____

Address: _____ City: _____ State: _____ ZIP: _____

Occupation: _____ Phone: _____ Cell: _____ Sex: M / F

Email address: _____ May we contact you via email and text? ☐Yes ☐No

Emergency Contact: _____ Phone: _____ Relationship: _____

What is the reason for your visit today? _____

HOW DID YOU HEAR ABOUT US?

Client/Employee Name: _____

Facebook_____ Instagram _____ Twitter _____Yelp _____ Google _____ Walk-In _____ Other_____

Please circle Yes or No:

Are you pregnant?	Yes	No
Do you have dental fillings/metal pins?	Yes	No
Recent vaccinations?	Yes	No
Facial implants?	Yes	No
Are you a diabetic?	Yes	No
Do you have family history of overweight/obesity?	Yes	No
Are you taking D3, Omegas?	Yes	No
History of Facelift?	Yes	No
Do you wear contact lenses?	Yes	No
History of skin cancer or atypical moles?	Yes	No
Any tattoos or permanent cosmetics?	Yes	No
Are you taking any herbal preparations? (St. John's Wort)	Yes	No
Have you been on Accutane in the last 6 months?	Yes	No
Do you use Glycolic products, exfoliating products, or Retin-A?	Yes	No (If yes, please list products below)

_____ Date last used: _____

Which statements best describe why you are here today? (Please check all that apply)

☐ Weight Loss ☐ I want to have more energy and feel better ☐ I want to nourish my body ☐ Poor diet ☐ I want to prevent getting sick ☐ Low mood or depression ☐ Fatigue or low energy ☐ Headaches or migraines ☐ Brain fog or trouble concentrating ☐ I want to cleanse my body of toxins ☐ I want to lose weight ☐ Botox ☐ Filler ☐ Threads ☐ Facial/Massage ☐ Laser ☐ Other: _____

MEDICAL HISTORY:

Pharmacy: _____Phone: _____ Address: _____

Any known drug or food allergies: _____

What Medications are you currently taking? _____

Have you undergone chemotherapy or radiation recently? ___Yes ___No

Habits? (Please check all that apply)

□ I smoke cigarettes or cigars _____ per day □ I use e-cigarettes _____ a day □ I use caffeine _____ a day

□ I drink alcoholic beverages _____ per week □ I exercise _____ a week

Pre-Existing Conditions

Please checkmark if you have a history of or are currently suffering from any of the following

Skin

_____ Athlete's Foot
_____ Sin/Toenail Fungus
_____ Hyperpigmentation
_____ Rashes
_____ Warts
_____ Boils/Abscesses
_____ Eczema
_____ Cuts/Open Wounds/Bruises
_____ Keloid Scarring

Circulatory

_____ Cardiovascular Disease
_____ Hypotension
_____ Hypertension
_____ Ongoing Fever
_____ Varicose Veins/Clots/Phlebitis
_____ Lymph Edema
_____ Hemophilia
_____ Stroke
_____ Pacemaker
_____ Swelling/Stiffness

Other

_____ Cancer/Tumors
_____ Diabetes
_____ Depression
_____ Drug/Alcohol Addiction
_____ Nicotine/Caffeine Addiction
_____ Breast Implants
_____ Facial Implants
_____ Acute Trauma
_____ Sleep Disorder
_____ Auto Immune Disorder
_____ Infectious Conditions
_____ Sinus Problems
_____ Asthma
_____ Thyroid Dysfunction
_____ Hepatitis A, B, C
_____ Cold Sores
_____ HIV
_____ Birth Control
_____ Other _____

Digestive

_____ Constipation
_____ Bloating
_____ Diverticulitis
_____ IBS

Nervous System

_____ Seizures
_____ Pinched Nerves
_____ Herpes/Shingles
_____ Numbness/Tingling
_____ Sciatica
_____ Multiple Sclerosis

PLEASE ANSWER THE FOLLOWING TO THE BEST OF YOUR ABILITY

When exposed to the sun **without protection** for about 1 hour:

I.	Always burns, never tans	_____
II.	II. Always burns, sometimes tans	_____
III.	II.I. Sometimes burns, sometimes tans	_____
IV.	IV.. Always tans	_____
V.	V. Hispanic, Asian, Mediterranean, Middle Eastern, Native American	_____
VI.	VI. African American	_____

What is your ethnic ancestry? _____
When were you last exposed to the sun or tanning booth? _____Do you use tanning lotions? YES NO
Have you ever had skin resurfacing or photo rejuvenation? YES NO
What are your goals for your skin? _____
What skincare products are you currently using? _____
_____
_____

HEALTH ASSESSMENT

Symptoms

	None (0)	Mild (1)	Moderate (2)	Severe (3)	Very Severe (4)
• Hot flashes	☐	☐	☐	☐	☐
• Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
• Sleep problems	☐	☐	☐	☐	☐
• Depressive mood (feeling down, sad, on the verge of tears, lack of drive)	☐	☐	☐	☐	☐
• Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
• Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)	☐	☐	☐	☐	☐
• Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
• Sexual problems (change in sexual desire, sexual performance, sexual activity, orgasm and/or satisfaction)	☐	☐	☐	☐	☐
• Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	☐	☐	☐	☐	☐
• Vaginal symptoms/Erectile changes (sensation of dryness or burning in vagina, weaker erections, loss of morning erections)	☐	☐	☐	☐	☐
• Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
• Difficulties with memory	☐	☐	☐	☐	☐
• Problems with thinking, concentrating, or reasoning	☐	☐	☐	☐	☐
• Difficulty learning new things	☐	☐	☐	☐	☐
• Trouble thinking of the right word to describe persons, place, or things when speaking	☐	☐	☐	☐	☐
• Increase in frequency or intensity of headaches/migraines	☐	☐	☐	☐	☐
• Rapid hair loss, thinning or change in texture	☐	☐	☐	☐	☐
• Feel cold all the time or have cold hands or feet	☐	☐	☐	☐	☐
• Weight gain, increased belly fat, or difficulty losing weight despite diet and exercise	☐	☐	☐	☐	☐
• Infrequent or absent ejaculations	☐	☐	☐	☐	☐
• Dry or wrinkled skin	☐	☐	☐	☐	☐

Total score: _____

Score: Mild: 1-20 / Moderate: 21-40 / Severe: 41-60 / Very severe: 61-80

INFORMED CONSENT

This document is a binding agreement (the "Agreement") between Emerge Integrative Medicine ("Amy Oden, APRN, FNP-C, ABAAHP") and the individual patient whose name and signature appears below ("You" "I"). In consideration of the health care services which may be provided to you by Amy Oden, APRN, FNP-C, ABAAHP at the present and always in the future. You agree as follows (your agreement indicated by placing your initials on the lines following each section and by signing in the space provided):

1. **Consent for Treatment.** I understand that the practice of medicine is not an exact science, and that diagnosis and treatment may involve risk of injury or death. I hereby consent to authorize Amy Oden, APRN, FNP-C, ABAAHP to provide you with health care treatments which, depending on your health conditions, may include one or more of the following procedures: Integrative Medicine, Intravenous Infusions, Intramuscular Injections, Hormonal Replacement Therapy, Herbal Medicine, Threads, Dietary and Nutritional Consultation, Platelet Rich Plasma Injections; together the "Treatments" administered by Amy Oden, APRN, FNP-C, ABAAHP or her staff. **Initials ____**
2. **Insurance Coverage.** I acknowledge that Amy Oden, APRN, FNP-C, ABAAHP has not made any guarantees or promises as to the outcome or the safety and efficacy of the above listed treatments. I also understand that many insurance plans have clauses that limit coverage to "usual-and-customary fees for reasonable and necessary services". I realize that some treatment of the integrative medical services provided by Amy Oden, APRN, FNP-C, ABAAHP will not fall under this description, and I do not hold her responsible for the possible decision by an insurance company that services provide to me are not covered under a specific insurance contract. **Initials ____**
3. **Experimental Nature of Treatments.** I acknowledge and agree that the treatments may consist in whole or part of experimental procedures and methods, in which no governmental (including the U.S. Food and Drug Administration), scientific or medical authority has confirmed the safety or efficacy thereof. I acknowledge that the safety and efficacy record of some of the Treatments appear to be relatively safe and effective. Amy Oden, APRN, FNP-C, ABAAHP has informed you that the treatments may alter, address, or decrease your symptoms or complaints, but also may have no effect. You are consulting with Amy Oden, APRN, FNP-C, ABAAHP solely for reasons concerning your health. You are not consulting Amy Oden, APRN, FNP-C, ABAAHP to provide any information to any enforcement, regulatory, or investigative agency of any kind. **Initials _____**
4. **Intravenous Therapy, Injection Therapy Risks, Side Effects, Complications.** Amy Oden, APRN, FNP-C, ABAAHP hereby inform you that there are certain unavoidable risks and potential side effects and complications to the treatments, including without limitation, swelling, severe pain, bleeding, dizziness, numbness, scarring, allergic reactions, itching, headaches, soreness, inflammation, bruising, phlebitis, vomiting, fainting, metabolic disturbances. Treatments may very rarely cause infection or injury to nerves. **Initial _____**
5. **Description of Treatments.** The exact procedure, as well as the recommended sequence of treatments, will be explained to you when Amy Oden, APRN, FNP-C, ABAAHP or her nurse who administers the treatments. I acknowledge that any of the treatments may involve insertion of needles into your skin and veins and the injection of standardized formulas which may include various nutritional substances, hormones, homeopathic medicine, and FDA approved prescriptive medicines, local anesthetic (i.e., Procaine), concentrated sugar water (Dextrose), concentrates of your own blood (platelet rich plasma) and, on occasion, other substances which will be explained to you before injections. **Initials _____**
6. **Information You Provide Emerge Integrative Medicine.** I have provided Emerge Integrative Medicine with a complete list of all prescription and non-prescription medications (i.e., dietary supplements) you are currently taking. Also, I will provide a complete list of all known allergies you may have and all allergic reactions you have had in the past to any medicines, dietary supplements, or medical treatments of any kind. I agree to update Emerge Integrative Medicine immediately should this list change. **Initials _____**

By my signature below, I certify that I have read and understand the above.

Signature of Patient: _____ Date: _____

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been in our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services, www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other health-care providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes several vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM .

PRINT NAME: _____ DATE: _____

SIGNATURE: _____

Emerge Integrative Medicine

Dr. Ladd Atkins, D.O. Amy Oden, MSN, APRN, FNP-C, ABAAHP

Missed Appointment/Cancellation Policy

We understand the need to move or cancel an appointment, however, to protect our providers and be courteous to patients on our waiting list, we ask you cancel or reschedule within 24 hours or a $50 fee ($130 fee for Wellness services) will occur. This applies to appointments that are missed without notice. Your time is valuable as is ours, and we continually strive to serve you better. Please note if you arrive for your appointment 15 minutes beyond scheduled start time, we are required to reschedule your appointment. Cancellation fees will apply. **Call or text 918-922-9122**

Returned Check Policy

It is Emerge policy on returned checks to charge a fee of $45 plus the amount of the check. This fee must be paid in cash or with credit card within 7 days. If we do not receive the payment in our office within 7 business days, the check will be sent to Tulsa County District Attorney. **We do not accept checks over $250**.

Refund Policy

Products may be returned within 2 weeks of purchase (restrictions may apply) along with the original receipt to receive a Emerge Integrative Medicine Account Credit. This credit will be applied to use towards a future purchase. All sales are final on services.

We accept the following forms of payment:

Master Card, Visa, Discover, American Express, Care Credit, FSA/HSA, and Cash

I attest the above statements to be true, my treatment provider and Emerge relies on the information I provided for safe and effective treatment.

Signature: _____ Date: _____

Photo and Video Consent and Authorization

I _____ do hereby consent and authorize to the following. I am allowing Emerge and/or delegated photographer to take photos and videos of my treatment and/or treated areas to be used for the purpose of monitoring my progress. I give permission for my photos and/or videos to be used at all Emerge locations for educational, advertising, and social media purposes within the Emerge brand.

Print Name: _____

Signature: _____ Date: _____