

CENTER FOR INTEGRATIVE MEDICINE
PATIENT DEMOGRAPHIC FORM
(PLEASE PRINT)

Primary Provider seen in our office: _____

PATIENT INFORMATION

Legal First Name: _____ Legal Last Name: _____

Middle Name _____ Name you prefer to go by _____

Date of Birth _____ Sex: (please circle) Male Female

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone (_____) _____ (please circle) home cell work

Secondary Phone (_____) _____ (please circle) home cell work

SS# _____ Email Address _____

Would you like to receive a copy of our monthly newsletter via email? YES NO

Marital Status: S M D W Spouses Full Legal Name _____

Employer: _____ Employer Phone: (_____) _____

Emergency Contact (someone not living in your household)

Contact Name _____ Relationship to patient _____

Primary phone _____ Secondary phone _____

Person responsible for bill if patient is a minor: _____

Birth Date: _____ Phone: _____

Address (if different): _____

INSURANCE INFORMATION: (Please complete this section in full. Info needed may not appear on card)

PRIMARY INSURANCE

Insurance Company _____

Primary Cardholder's Information: **please check box if information is the same as above**

Name _____ SS# _____ DOB _____

Relation to Primary Cardholder _____

Secondary Insurance

Insurance Company _____

Primary Cardholder's Information: **please check box if information is the same as above**

Name _____ SSN#: _____ DOB _____

Relation to Primary Cardholder _____

I, THE UNDERSIGNED, GIVE AUTHORIZATION TO TREAT AND ASSIGN DIRECTLY TO THE CENTER FOR INTEGRATIVE MEDICINE, ALL MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS AND AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

SIGNATURE: _____ **DATE:** _____

CENTER FOR INTEGRATIVE MEDICINE

CLINICAL TESTING NOTIFICATION CONSENT

We are thankful to be a partner with you in your healthcare. To keep you informed about your health, we will notify you about the results of clinical testing. Please tell us how you would like to be contacted by ***initialing*** the appropriate response:

_____ Please call me at this number _____ or _____

If I am not available at one of the numbers listed above, I authorize you to leave a message on my answering machine (and/or voice mail)

- Yes No

OR

I authorize you to leave a message with my spouse or family member

- Yes No

_____ Please mail my results to:

We will make 3 attempts to contact you. If we cannot reach you by phone, we will mail you the results at the mailing address you provided in your medical chart.

I understand that it is my responsibility to notify the Center for Integrative Medicine ***in writing*** if this information changes.

Patient Signature:

Witness: _____

Date: _____

Center for Integrative Medicine
1100 East 3rd Street, Suite G100
Chattanooga, TN 37403
Telephone: (423) 643-2246 Fax (423) 643-2030

Notifications and Releases

We want to make your experience with every aspect of our service, meet or exceed your expectations. If you have any questions or concerns, suggestions for improvement in our services, or any comments, please do not hesitate to speak with any of our staff or physicians.

Listed below are several notices that outline certain responsibilities of ours, and yours. ***Please read them carefully and sign where indicated that you have read each statement.***

****General Consent for Treatment**

We look forward to treating you as a patient, however, we need your permission for our physicians to examine you, provide treatments, and perform diagnostic studies as necessary. If more invasive procedures are deemed necessary, the risks and benefits of those invasive treatments will be explained to you. When you agree to proceed with an invasive treatment, you will be asked to sign a more detailed consent.

I give general consent to be treated.

Date: _____

Patient / Patient's representative

****Financial Policy / Assignment of Benefits**

As a courtesy to our patients, the practice accepts assignment from most commercial insurance programs. We will file your primary insurance claim for you. Once the primary insurance has paid, we will also file your secondary insurance, if you have provided us with that information. However, insurance is a contract between you and your insurance company. Therefore, we ask that you acknowledge your responsibility for the payment of our services.

A 24-hour notification is required for cancelled/rescheduled appointments, or you will be subject to a fee. _____ (patient initial)

If the insurance denies coverage, disallows a service, or otherwise does not pay the claim, you are still responsible for the fees. Balances not paid within 30 days after your first treatment will be subject to a 1½% service charge per month. In addition, if the fees for our services are not paid, we may turn the account to a collection agency. Attorney's fees and court costs will also be added to the outstanding balance if it becomes necessary to take legal action to collect past due amounts. Also, your insurance company may ask us to provide information concerning your treatment before they will pay for the services.

I acknowledge it is my responsibility to ensure payment of fees for services provided by the practice and authorize the practice to release any medical information, if necessary, to my insurance company.

Date: _____

Patient / Patient's representative

****Privacy Policy**

New federal regulations require physician practices to keep your medical information private. Our practice has always guarded the privacy of our patients. We only share medical information with other healthcare providers that are participating in your care, your insurance company to provide your benefits, or for medical management issues. We will keep your record as long as you are a patient of the practice and seven years after your last visit.

I acknowledge that I have been informed about the privacy of my medical record, and the practice's Privacy Policy has been made available to me.

Date: _____

Patient

CENTER FOR INTEGRATIVE MEDICINE
Jeffrey S. Jump. M.D.
1100 E. Third Street. Suite G-100
Chattanooga, TN 37403 Phone: (423) 643-2246 Fax:
(423) 643-2030

PRIVACY RESTRICTION

As your healthcare provider, I want you to understand that everything you tell me is confidential. New federal regulations require physician practices to keep your medical information private. Our practice has always guarded the privacy of our patients. We only share your medical information with other healthcare providers that are participating in your care, your insurance company to provide your benefits, or for medical management issues. We will not discuss your condition with anyone else (i.e., parents/guardians, spouses) without your approval in writing.

I understand the above statement and (check one box below):

- I do not mind that my medical information is shared with my parent/guardian or spouse at anytime.
- I want my medical information to remain confidential. My protected health information should *NOT* be shared with any other individual. I realize that unless I pay cash for all services provided, there is a chance that an insurance company may release information to the person(s) paying for my medical insurance. I also realize that this restriction must be approved by Center for Integrative Medicine Privacy Officer, who may deny my request.

Patient Signature

Date

Emergency Treatment EXCEPTION: If the Privacy Office agrees to a restriction, HIPAA privacy regulations provide an exception in emergency treatment situations for a hospital or physician to use and disclose necessary information to treat the patient.

Created on 03/25/03

The Center for Integrative Medicine
1100 E. 3rd St. Suite G100
Chattanooga, TN 37403
Phone 423 643 2246 Fax 423 643 2030
Dr. Jeffery Jump Dr. Natalie Johnson
Gloria Keel-Edwards, RN, BS

Welcome to the Center for Integrative Medicine. We will answer some of the more common questions about bio-identical hormone therapy.

Bio-identical therapy assists in restoring hormone balance and has a beneficial effect on quality of life. The hormones that keep us healthy and happy can be the same hormones that cause emotional and physical distress. Men and women with a healthy hormone balance tend to enjoy long, healthy and productive lives. Long-term hormone imbalance can make life pretty miserable for everyone involved.

Hormone treatments of all kinds are growing more popular. Men and women are taking proactive approaches to finding a healthy hormone balance and seeking options such as bio-identical therapy. Good health is possible to obtain if we are making the right choices. If our bodies needs are not met from our diet, exercise or reducing stress, we may experience health difficulties. Diet, nutrition, exercise and stress reduction are some of the basic changes that need to be made in order to restore balance and bio-identical therapy is an option to assist in this process.

It will take a series of three to four visits to optimize your therapy. Some people respond quickly and others take several months, but be assured this therapy can be very successful.

Our goal is to assess your needs and coordinate your bio-identical hormone therapy to optimize your health and well-being. We look forward to working with you.

Bio-identical HRT Treatment Consent Form

I have been advised by my physician that he/she recommends I have Bio-identical hormone supplementation.

The reason for this recommendation has been explained to me to my satisfaction.

I understand:

- That Bio-identical hormonal supplementation may be outside the parameters of conventional medicine in the U.S.
- That this treatment is recommended and administered with utmost care in conjunction with attention to hormone blood levels, lifestyle, and diet.
- Possible side-effects have been explained to me may include:
 - Allergy to a component of the prescribed agent/carrier
 - Weight Change
 - Headache and/nausea
 - Breast tenderness
 - Dizziness or lightheadedness
 - Breakthrough bleeding
 - Rarely liver inflammation, blood clotting disorders, migraines or hypertension

- That this treatment is not covered by Medicare and may not be covered by private health insurance funds.
- That this treatment may not be regulated by the Federal Drug Administration and that my physician deems that this treatment is in my best interest.
- I have been provided sufficient information to make an informed decision.
- I have informed my health care provider if I have suffered from heart disease, hypertension, chronic liver disease, chronic kidney disease, or strokes before beginning recommended therapy.
- Breast cancer risk is unclear and studies available are based on synthetic hormones.

I am agreeing to this treatment of my own free will and consent and exercise my right to discuss and choose any treatment(s) made available to me with my physician's approval.

Print

Patient _____ Date of Birth _____

Signature _____ Date _____

Troches:

- Dissolve under tongue for approximately 2 minutes
- No eating or drinking for 15-20 minutes after dissolving
- Do not move tongue around while dissolving, that will increase saliva production and increase swallowing.
- Do not leave in the heat (i.e. car)
- Refrigeration is not necessary

Creams

- Apply on inner thighs, upper or lower arms and lower stomach and rub in well. Rotate areas with each application
- Do not apply lotion prior to using
- Do not wash area for at least 1-2 hours after applying
- Refrigeration is not necessary

MALE

Apply creams to chest, inner thighs, upper or lower arms and rotate areas with each application. Rub in well. Do not wash area for at least 1-2 hours after applying
Refrigeration is not necessary.

If you have your troches or creams mailed, you must immediately get them from mailbox. Even though they are shipped on ice packs, the heat can melt them.

Additional Bio-Identical Information

www.womeninbalance.org

Google on the web:

ZRT Laboratory

PCCA (Professional Compounding Centers of America)

Dr. Kenna Stephenson

Dr. C.W. Randolph

Dr. Eldred Taylor

Dr. Christiane Northup

Dr. John Lee

BOOKS:

For Women:

Awakening Athena by Kenna Stephenson, M.D.

What Your Doctor May Not Tell You About Breast Cancer How Hormone Balance Can Save Your Life by John Lee, M..D. and David Zava, PhD.

Are Your Hormones Making You Sick? By Dr. Eldred Taylor

Women's Bodies' Women's Wisdom by Christiane Northup, M.D.

The Hormone of Desire by Susan Rako, M.D.

Adrenal Fatigue The 21st Century Stress Syndrome by Dr. James Wilson

Breakthrough by Suzanne Somers

Once Per Month by Katrina Dalton, M.D.

For Men:

The Testosterone Syndrome by Eugene Shippen, M.D.

Male Menopause by Jed Diamond

MALE HORMONE SCREENING

Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____ Ht: _____ Wt: _____

Phone: _____

Rate the following as they apply to you. Use the numbers 1 - 4, with 1 - 2 being Rare or Mild, and 3 - 4 being Frequent or Severe.

- | | | | | |
|---|---|---|---|---|
| 1. Fatigue, tiredness or loss of energy | 1 | 2 | 3 | 4 |
| 2. Decrease in physical stamina | 1 | 2 | 3 | 4 |
| 3. Feelings of depression - a sense that work, marriage or recreational activities have lost significance | 1 | 2 | 3 | 4 |
| 4. Decreased libido - less desire for sex | 1 | 2 | 3 | 4 |
| 5. Erection or potency problems | 1 | 2 | 3 | 4 |
| 6. Loss of early morning erection | 1 | 2 | 3 | 4 |
| 7. Dry skin on face or hands | 1 | 2 | 3 | 4 |
| 8. Increase in waist size - weight gain, especially around mid-section | 1 | 2 | 3 | 4 |
| 9. Increased fat distribution in chest area or hips | 1 | 2 | 3 | 4 |
| 10. Feeling burned out, loss of motivation | 1 | 2 | 3 | 4 |
| 11. Increase in aches, joint and muscle pains | 1 | 2 | 3 | 4 |
| 12. Frequent use of alcohol - now or in the past | 1 | 2 | 3 | 4 |
| 13. Increased irritability, anger or bad temper | 1 | 2 | 3 | 4 |
| 14. Decrease in muscle mass | 1 | 2 | 3 | 4 |
| 15. The age you are: _____ The age you feel: _____ | | | | |
| 16. Sleep problems | | | | |

CONDITIONS - Check (✓) conditions you have or have had in the past.				
<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Blood Clots <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia	<input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter	<input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease	<input type="checkbox"/> Migraines <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Prostate Problem <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers <input type="checkbox"/> Venereal Disease <input type="checkbox"/> <input type="checkbox"/>

Please complete the back of this form also.

PAST MEDICAL HISTORY: List illnesses & conditions you have had and the year.	
1.	4.
2.	5.
3.	6.

MEDICATIONS: List medications you are currently taking, including OTC & Supplements.		ALLERGIES: To medications or substances
1.	9.	
2.	10.	
3.	11.	
4.	12.	
5.	13.	
6.	14.	
7.	15.	
8.	16.	

SURGICAL HISTORY:		
Type of Surgery	Year	Complications if any

SOCIAL HISTORY: Check (✓) the substances you use and describe how much you use.	
<input type="checkbox"/>	Caffeine
<input type="checkbox"/>	Tobacco
<input type="checkbox"/>	Alcohol
<input type="checkbox"/>	Exercise

FAMILY HISTORY: List any illnesses that run in your family:	
1.	5.
2.	6.
3.	7.
4.	8.

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

Signature

Date

Physician's Signature

Date reviewed

I have reviewed the data and answered all questions.
Proceed with menopause and hormone replacement counselling.