INTEGRATIVE
FAMILY MEDICINE

330 Mallory Station Rd., Suite B3

Franklin, TN 37067

Phone: 615-944-3530 Fax: 615-550.2641

PATIENT INSTRUCTIONS FOR PAPERWORK

Thank you so much for trusting your care to Integrative Family Medicine. Attached are the new patient forms. Please complete all forms entirely and return them by email, mail, fax, or drop them by the office. After we have received them, we will contact you to schedule your first visit.

Email: info@daniwilliamson.com

Fax: 615-550-2641

Please provide the following documents and information prior to your appointment:

1. **Copy of front and back of insurance card**
2. **Recent lab results and recent medical records**
3. **Typed medical history (if you do not have your medical records)**
4. **List of symptoms you are currently experiencing (p. 2, include additional pages if needed)**
5. **List of ALL supplements and medications with dosage you are taking (p. 2)**
6. **If you are using bio-identical hormones, please bring actual prescription to the appointment**

Providing this information will allow you and Dani to optimize your appointment time to develop your personalized care plan, rather than rebuilding all your health information.

Please be prepared to spend about 2.5 hours during your initial visit and 30 – 45 minutes for follow up visits.

Please call or email us with any questions or concerns.

We look forward to seeing you soon!

INTEGRATIVE
FAMILY MEDICINE

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Cell Phone #: _____ Home #: _____ Work #: _____

Email Address: _____

Sex: M ◯ F ◯ Marital Status: S ◯ M ◯ D ◯ W ◯

Employer Name: _____ Employer Status: FT ◯ PT ◯ Retired ◯ N/A ◯

EMERGENCY CONTACT

Contact Name: _____ Phone #: _____

Relationship to Patient: _____

RESPONSIBLE PARTY (IF NOT PATIENT)

Name: _____ DOB: _____

Phone #: _____ Relationship to Patient: _____

Billing Address: _____ City, State, Zip: _____

INSURANCE INFORMATION

Primary Cardoholder Name: _____ DOB: _____

Insurance Company Name: _____

Member ID: _____ Group/Policy #: _____

OTHER INFORMATION

Pharmacy Name: _____ Address: _____

Pharmacy #: _____ Pharmacy FAX: _____

Patient Name: _____ **D.O.B.** _____

MEDICAL HISTORY / ACTIVE PROBLEM – ***Make a list & include date of onset (What brings you to see Dani?)***

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES

_____
_____

All PRESCRIPTIONS and SUPPLEMENTS

NAME **Strength, frequency, route**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SURGICAL HISTORY

Date **What was done / Reason**

_____
_____
_____
_____

Do you have Breast Implants? YES ◯ or NO ◯ Date of surgery:_____

FAMILY MEDICAL HISTORY

This is a particularly important area of information to Dani and the way she practices, please fill it out to the best of your ability. *****INCLUDE: **age (or age of death), living/deceased, any health issues, cause of death***

Father: _____

_____

Mother: _____

_____

Sibling (brother or sister): _____

Sibling (brother or sister): _____

Sibling (brother or sister): _____

Maternal Grandfather: _____

Maternal Grandmother: _____

Paternal Grandfather: _____

Paternal Grandmother: _____

SOCIAL HISTORY

Occupation: _____

Stress level: _____ Marital Status: _____

Exercise (what type/frequency/duration): _____

_____

Caffeine (how many cups/amount per day): _____

Alcohol: YES ◉ or NO ◉ Amount per week?: _____

Smoking: YES ○ or NO ○ How many years? _____How much per day? _____

Recent travel outside the US?: _____

Primary Care Provider: _____ Phone #: _____

Other provider/specialist: _____ Phone #: _____

Other: _____ Phone #: _____

OBGYN: _____ Phone #: _____

Date of last PAP smear: _____ Date of last mammogram: _____

Please provide any other information you think is pertinent to your health and/or history:

_____

_____

_____

REVIEW OF SYSTEMS (within the last 2 weeks)

Constitutional

weight loss	☐ Yes	☐ No
weight gain	☐ Yes	☐ No
loss of appetite	☐ Yes	☐ No
fever	☐ Yes	☐ No
fatigue	☐ Yes	☐ No

ENT/Respiratory

congestion	☐ Yes	☐ No
cough	☐ Yes	☐ No
nose bleeds	☐ Yes	☐ No
hearing loss	☐ Yes	☐ No
change in voice	☐ Yes	☐ No
sore throat	☐ Yes	☐ No
ringing in ears	☐ Yes	☐ No
sinus pain	☐ Yes	☐ No
shortness of breath	☐ Yes	☐ No
wheezing	☐ Yes	☐ No

Cardiology

decreased exercise tolerance	☐ Yes	☐ No
murmurs	☐ Yes	☐ No
palpitations	☐ Yes	☐ No
high blood pressure	☐ Yes	☐ No
chest pain	☐ Yes	☐ No
swelling	☐ Yes	☐ No
varicose veins	☐ Yes	☐ No
poor circulation	☐ Yes	☐ No

Gastroenterology

blood in stool	☐ Yes	☐ No
diarrhea	☐ Yes	☐ No
vomiting	☐ Yes	☐ No
constipation	☐ Yes	☐ No
nausea	☐ Yes	☐ No
difficulty swallowing	☐ Yes	☐ No
abdominal pain	☐ Yes	☐ No
change in bowel habits	☐ Yes	☐ No
heartburn	☐ Yes	☐ No

Musculoskeletal

joint stiffness	☐ Yes	☐ No
joint pain	☐ Yes	☐ No
joint swelling	☐ Yes	☐ No
sciatica	☐ Yes	☐ No
fracture	☐ Yes	☐ No
wrist pain/tingling	☐ Yes	☐ No
knee pain	☐ Yes	☐ No
back pain	☐ Yes	☐ No

Dermatology

rash	☐ Yes	☐ No
change in size/shape of moles	☐ Yes	☐ No
lumps	☐ Yes	☐ No
dry or sensitive skin	☐ Yes	☐ No
acne	☐ Yes	☐ No

Genitourinary Male

difficulty urinating	☐ Yes	☐ No
frequent nighttime urination	☐ Yes	☐ No
hernia	☐ Yes	☐ No
undescended testicle	☐ Yes	☐ No
blood in urine	☐ Yes	☐ No
penile discharge	☐ Yes	☐ No
genital sore/ulcer	☐ Yes	☐ No

Genitourinary Female

irregular periods	☐ Yes	☐ No
painful periods	☐ Yes	☐ No
heavy periods	☐ Yes	☐ No
pelvic pain	☐ Yes	☐ No
painful urination	☐ Yes	☐ No
increased urinary frequency	☐ Yes	☐ No
blood in urine	☐ Yes	☐ No
vaginal discharge	☐ Yes	☐ No
genital sore/ulcer	☐ Yes	☐ No

Ophthalmology

diminished vision	☐ Yes	☐ No
eye irritation or discharge	☐ Yes	☐ No
blurring of vision	☐ Yes	☐ No
spots in vision	☐ Yes	☐ No
sudden vision loss	☐ Yes	☐ No

Hematology/Lymphatic

easy bleeding/bruising	☐ Yes	☐ No
swollen lymph nodes	☐ Yes	☐ No

Endocrinology

excessive sweating	☐ Yes	☐ No
excessive thirst	☐ Yes	☐ No
excessive urination	☐ Yes	☐ No
cold intolerance	☐ Yes	☐ No
heat intolerance/hot flashes	☐ Yes	☐ No

Psychology

depression	☐ Yes	☐ No
anxiety/panic	☐ Yes	☐ No
sleep disturbances/insomnia	☐ Yes	☐ No
irritability	☐ Yes	☐ No
mood swings	☐ Yes	☐ No
mental, physical or sexual abuse	☐ Yes	☐ No
excessive energy	☐ Yes	☐ No
trouble staying on task	☐ Yes	☐ No

Neurology

weakness	☐ Yes	☐ No
numbness/tingling	☐ Yes	☐ No
headache	☐ Yes	☐ No
dizziness	☐ Yes	☐ No
balance problem	☐ Yes	☐ No
memory loss	☐ Yes	☐ No

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name (please print): _____

Date of Birth: _____ Phone #: _____

Address: _____

I, the undersigned, authorize you to furnish a copy of my medical records to:

☐ Integrative Family Medicine or to _____

We are requesting medical records for the patient named above to be sent TO/ FROM the medical provider named below:

Provider Name: _____

Specialty: _____

Address: _____

City, State and Zip: _____

Phone Number: _____ Fax number: _____

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. I, the undersigned, have read the above and authorized the staff of the specified facility named to disclose such information as hearin contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless for complying with this "Authorization for Release of Medical Information". This order will remain in effect until revoked by me in writing.

Signed: _____ Date: _____

Relationship to Patient if not self: _____

PLEASE RETURN A COPY OF THIS FORM WITH RECORDS

CLINIC FINANCIAL POLICY

Thank you for choosing us as a healthcare provider. We are committed to providing you with the best possible medical care at the lowest possible cost. Please understand that payment of your bill is part of your treatment. The following is our Financial Policy that we require you to read and sign.

In order to achieve the practice goals of providing the finest medical care at the lowest possible cost, we need your assistance and understanding of our payment policy:

Full payment for professional services is due at time of service. We accept cash, checks (with ID) or Visa/MasterCard, Health Savings and Flexible Spending accounts. There will be a charge of $50 for returned checks and future checks will not be accepted.

In order to keep our fees to a minimum, payment is required at the time of service. We may order laboratory or specialized testing as a part of our comprehensive and follow-up evaluations. Payments for these tests are also due and payable at the time of service. Adult patients are responsible for payment in full at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been preauthorized to a Visa/MasterCard or payment by cash or check.

We require a Credit card number at the time of booking, and we will keep this number on file. This information is stored in a password protected computer and would only be charged in the event of a No-Show or late cancellation with less than 24-hour notice.

Please give us 24-hour notice in advance if you cannot keep your appointment for any reason. Monday appointments must be cancelled by 8 AM on the Friday before. There is a $75 No-Show/late cancellation Fee for follow ups and $150 for a New Patient visit. This policy will be enforced.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Signature of Administrator/Practice Manager Date

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You must make a choice about receiving these laboratory tests, procedures and/or purchasing supplements.

By signing this acknowledgement, you understand there are procedure, laboratory tests and supplements which may not be paid for by your health insurance companies, and if you chose to receive them, you will be responsible for payment for these procedures, supplements and any additional testing.

Danielle Williamson, NP cares for patients with acute and chronic ailments utilizing a bio-medical approach that is an integration of both traditional medicine and validated complimentary techniques and treatment strategies. As a result, some of the tests utilize labs that are out of network for your health plan; and some procedures and certainly none of the supplements are covered by your plan. We expect that your Health Insurance Provider will not pay for the laboratory test(s), procedures or the supplements that are described below.

Your Health Insurance Provider may or may not pay for:

- Dunwoody Labs
- ZRT Saliva Testing for Hormones and Adrenals
- Food Sensitivity Testing
- Neurotransmitter Testing
- Spectracell Nutrient Testing
- Any other testing we may decide on

You may submit the costs of any lab tests to your insurance company. We will provide you with the documentation to help you do this. However, the insurance company may pay a fraction of your expenses, or none at all. You cannot file for the cost of supplements purchased or for certain procedures that are listed (if applicable). These procedures include but are not limited to the administration of IV vitamin/minerals and/or the injections of vitamins. These procedures must be paid for at the time of your office visit.

☐ **Option 1. YES. If I choose to receive these items or services.**

I understand that I am responsible for payment of these services directly to service provider. The service provider may be able to file your insurance, but Integrative Family Medicine will not participate in that billing process and is not responsible for non-covered services. I understand I will work directly with service provider to resolve any billing disputes. I also understand that any supplements purchased are not covered by insurance and I agree not to file a claim for medical reimbursement.

☐ **Option 2. NO. I have decided not to receive these items or services.**

*PLEASE CHOOSE ONE OPTION AND CHECK IT ACCORDINGLY. SIGN & DATE

_____ _____

Signature of patient or person acting on patient's behalf Date

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your Health Insurance Provider, your health information on this form may be shared with your Health Insurance Provider. Your health information which your Health Insurance Provider sees will be kept confidential by your Health Insurance Provider.

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Provided By HCSI

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – this means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – you have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – if we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – we will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

HIPAA COMPLIANCE OFFICER: Dani Williamson
Phone: 615-944-3530
Email: dani@daniwilliamson.com

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Provided By HCSI

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of INTEGRATIVE FAMILY MEDICINE Notice of Privacy Practices. By signing below I am "only" giving acknowledgement that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____
Print Name

_____ _____
Signature Date

INTEGRATIVE
FAMILY MEDICINE

How did you hear about us?

Who can we thank for your referral? ☐ Doctor ☐ Patient ☐ Pharmacy ☐ Social Media ☐ Other

Name: _____

RECOGNITION OF INFORMATION AND ACCURACY

*Initials _____ *Please initial that you have received the information and that you have submitted to us the correct and accurate information above to the best of your knowledge.

*Initials _____ *I am the patient or the legal guardian or representative of the patient. "I", "my" in this document refers to me as the patient or legal guardian or representative of the patient. I hereby authorize the assignment of benefits (payments) directly to Integrative Family Medicine for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service. If the account is in default and turned over for collection, I acknowledge that I will be responsible for all reasonable costs associated with collection. I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company.
I permit a copy of this authorization to be used in place of the original.

*Initials _____ *I have received a copy of the HIPAA Notice of Privacy Practices.

_____ _____

Signature of Responsible Party Date

_____ _____

Signature of Witness Date

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____/____/_____

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse_____
- ☐ Child(ren)_____
- ☐ Other_____

☐ Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call: ☐ my home ☐ my work ☐ my cell Number:_____

If unable to reach me:

- ☐ you may leave a detailed message
- ☐ please leave a message asking me to return your call
- ☐ _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: ____ /____ /_____

Witness: _____ Date: ___ /____ /_____

Provider Opt-Out of Medicare Declaration

Danielle C Williamson MSN, FNP
Integrative Family Medicine
330 Mallory Station Road, Suite B3
Franklin, TN 37067

Patient (Beneficiary) Name _____

Legal representative_____

Medicare Part B ID: _____

This private contract agreement is between the practitioner and and beneficiary noted above. The beneficiary is a Medicare Part B beneficiary and is seeking services covered under Medicare Part B. The provider above has informed the beneficiary or his/her legal representative they have opted-out of the Medicare Program.
The current Medicare opt-out period is from September 2, 2015 to September 2,2021.
The provider noted above is not excluded from participating in Medicare Part B under §§1128, 1156 or 1892 of the Act.
The beneficiary or his/her legal representative has read and agree to the following terms of the private contract by placing their initials by the items below:
_____I, or my legal representative, accept full responsibility for payment of the practitioner's charge for all services furnished by this practitioner
_____I, or my legal representative, understands that Medicare limits do not apply to what the practitioner may charge for items or services provided by the practitioner;
_____I, or my legal representative, agree not to submit a claim to Medicare or to ask the physician/practitioner to submit a claim to Medicare;
_____I, or my legal representative, have been informed of the expected or known expiration date of the opt-out period which is September 2, 2015 to September 2, 2021;
_____I, or my legal representative, understand that Medicare payment will not be made for any items or services furnished by the practitioner that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted;
_____I, or my legal representative, enter into the contract with the knowledge that the beneficiary has the right to obtain Medicare covered items and services from physicians and practitioners practitioners who have not opted out of Medicare, and that the beneficiary is not compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians or practitioners who have not opted out;
_____I, or my legal representative, understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare;
_____I, or my legal representative, agree this contract was not entered into during a time when the beneficiary required emergency care services or urgent care services.

Beneficiary or Legal Representative's Signature _____
Date _____

Practitioner's Signature _____
Date _____