Whole Heart Family Medicine

Advanced • Integrative • Compassionate

NEW MEMBER REGISTRATION FORM

First name:		Last name:	
Preferred name:		**Sex:**	Male Female
Date of Birth:		Age	
Address:			
City:	State:	Zip:	
Primary Phone:		Mobile Home Work Other	
Secondary Phone:		Mobile Home Work Other	
Email:			

By providing us with your e-mail address, you authorize Whole Heart Family Medicine to send you periodic reminders or announcements. In addition, you will be given access to an online portal where you can access your medical records and contact the office via email for appointments, refill requests, etc. We will not disclose your email address to any third party. You may terminate receiving e-mails from us at any time.

EMERGENCY CONTACT

Name:

Relationship: Phone:

How did you hear about our practice?

INSURANCE INFORMATION

Primary Health Insurance:

Secondary Health Insurance:

***IF the patient is not the policy holder, please indicate their relationship:** Spouse Child

*Name of policy holder IF different from patient :

Policy holder's date of birth:

PHARMACY INFORMATION

Local Pharmacy Name: **Phone number:**

Address:

Mail Order Pharmacy?

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WHAT IS THE REASON FOR YOUR VISIT TODAY?

☐ Establish medical care ☐ Other:

Your answers will give us a better understanding of your medical concerns and conditions. If you are uncomfortable with any questions, feel free not to answer them. Best estimates are fine; however, be specific whenever you can. Please contact family members if you need assistance completing the family history section. If you need more space, simply attach as many additional pages as you need. THANK YOU!

PRESCRIPTION MEDICATION

	Name	Dose	Taken how often?	Reason
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Do you take hormone replacement therapy? ☐ NO ☐ YES - From whom?

Which ones?

ALLERGIES (or reactions to medicines) Check here if NONE: ☐

(List medications and what type of reaction you had to each)

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VITAMINS/SUPPLEMENTS/OTC MEDICATION

	Name	Dose	Taken how?	Reason
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Do you take daily aspirin? NO YES - Why?

Have you ever been hospitalized for illness? NO YES

If so, when and why:

PAST SURGICAL HISTORY

Check here if you have never had surgery

	Surgery	Date	By whom?
1			
2			
3			
4			
5			
6			

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FAMILY HISTORY ***Please indicate the health status of your immediate family members.***

It is especially important to note any history of heart disease (stents/bypass surgery), strokers, aneurysms, cancers, autoimmune diseases (such as Lupus, Rheumatoid, Hashimotos, etc.), clotting disorders, carotid or other vascular disease, dementia, diabetes, kidney disease, or other serious illnesses. NOTE AGE OF ONSET OF ILLNESS IF KNOWN

MOTHER: Alive ☐ Deceased ☐ Age and cause of death (if applicable):

Health probs:

MATERNAL GRANDMOTHER: Alive ☐ Deceased ☐ Age and cause of death (if applicable):

Health probs:

MATERNAL GRANDFATHER: Alive ☐ Deceased ☐ Age and cause of death (if applicable):

Health probs:

FATHER: Alive ☐ Deceased ☐ Age and cause of death (if applicable):

Health probs:

PATERNAL GRANDMOTHER: Alive ☐ Deceased ☐ Age and cause of death (if applicable):

Health probs:

PATERNAL GRANDFATHER: Alive ☐ Deceased ☐ Age and cause of death (if applicable):

Health probs:

SIBLING #1 Alive ☐ Deceased ☐ Age and cause of death (if applicable):

Health probs:

SIBLING #2 Alive ☐ Deceased ☐ Age and cause of death (if applicable):

Health probs:

SIBLING #3 Alive ☐ Deceased ☐ Age and cause of death (if applicable):

Health probs:

ADDITIONAL INFO

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SOCIOECONOMICS AND LIFESTYLE

Occupation: Employer:

How many hours do you typically work a week? Less than 40 40-55 More than 55

Marital Status: Married Single Divorced Separated Widowed

Spouse/Partner's name:

Who lives at home with you?

How many children do you have? (Please provide names, gender, and ages)

SMOKING/DRUGS:

Do you smoke cigarettes? NEVER QUIT (Date)

Current Smoker - Packs per day?

Other nicotine? (E-cigs/Vape) NEVER QUIT (Date)

Current Use? - Years using?

Are you interested in quitting? NO YES

Have you tried to quit in the past? NO YES

What methods have you tried?

Are you exposed to second-hand smoke? NO YES - How long?

Do you smoke Marijuana? NEVER Ocasionally (How often?) QUIT (Date)

Do you take any illegal drugs? NEVER IN THE PAST CURRENT USER (Which drugs?)

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ALCOHOL/CAFFEINE:

Do you drink alcohol? NO QUIT (Date) YES (How many per week?)

What type?

Does your alcohol intake have you or others concerned? NO YES

Caffeinated drinks per day: What type of drinks?

DIET

How would you rate your current diet? Excellent Good Fair Poor

How many times do you eat out a WEEK?

How much of your diet is fried/fast food/processed foods? 0-10% 10-30% 30-50% +50%

How much water do you typically drink each day? (in ounces)

Have you ever seen a dietician/health coach? NO YES

Do you follow a special diet (gluten-free, low carb, vegan, etc.)?

Do you have any food allergies or sensitivities? NO YES - Explain:

Do you count calories or macros (fat/carbs/prote NO YES - Explain:

EXERCISE:

Do you exercise regularly (cardio)? NO YES What type of exercise?

How long do you exercise in minutes? How often?

Do you weight train? YES NO What type?

How often? If you don't exercise, why not?

Do you have any limitations to your ability to exercise?

Do you do anything else to improve your health (sauna, cold plunge, etc.)?

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STRESS:

How would you classify your stress level at **work?** Low Medium High

How would you classify your stress level at **home?** Low Medium High

Do you often feel anxious, angry, irritated, or rushed? NO YES (Explain)

Do you perceive a lack of control in your environment? NO YES (Explain)

How do you relax/manage your stress?

Do you meditate daily? NO YES (How?)

Do you see a counselor? NO YES (Explain)

SLEEP:

How would you rate the quality of your sleep? Excellent Good Fair Poor

How many hours of sleep do you typically get each night?

Do you have trouble falling asleep? NO YES (Explain)

Do you have trouble staying asleep? NO YES (Explain)

If yes, how many times do you wake up (and why? To urinate, because of pain or because mind is racing, etc.)

What time do you typically go to bed?

What time do you typically get up?

Do you work shift work (night shift?) If so, is it rotating shift?

Do you have sleep apnea (if so, are you treating it and how?)

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COMMUNITY:

What activities do you do with family or friends?

How often do you get together with friends or family in a week?

Do you do any activities with community groups, clubs, or a church?

How often do you talk to friends or family on the phone in a week?

Do you enjoy connecting with people at your work (or school)?

	Excellent	Good	Fair	Poor
Rate your ability to get support from family or friends when you need it				
Rate your confidence to have your say about issues that are important to you				
Rate your sense of being part of a group or community				
Rate your hopefulness for the future				

ORAL HEALTH:

How many times a day do you brush your teeth?

Do you use an electric toothbrush? NO YES

Do you loss regularly? NO YES How often?

How often do you see your dentist?

Do you ever have bleeding gums? NO YES

Have you ever had a root canal? NO YES

Does your oral health concern you? NO YES

Dentist (name and practice):

NAME of your other medical providers	What Type of specialist? (cardiologist, orthopedic . . .)

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CURRENT MEDICAL PROBLEMS FOR WHICH YOU ARE TREATED
(i.e. High blood pressure/ cholesterol, diabetes, thyroid disease, anxiety, sleep apnea, asthma, joint pain, reflux, etc.)

1
2
3
4
5
6
7
8
9
10

When was your last physical? By Whom?

CURRENT SYMPTOMS YOU ARE EXPERIENCING: (i.e. swelling, palpitations, abdominal pain, brain fog, etc.)

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PAST MEDICAL HISTORY (PRIOR OR CURRENT illnesses)

Please indicate if you have EVER had any of the following medical problems. (Include the date it occurred).
Just leave date blank if you don't know.

Stroke		Date		Other Autoimmune Disorder		Date	
High Cholesterol		Date		Asthma		Date	
High Blood Pressure		Date		Periodontal Disease		Date	
Pre-diabetes/Metabolic Syndrome		Date		Gout		Date	
				Thyroid Problems		Date	
Diabetes		Date		Depression		Date	
Mini-stroke or TIA		Date		Anxiety/Panic Attacks		Date	
Atrial Fibrillation		Date		Migraine Headaches		Date	
Poor blood flow		Date		Osteoporosis/osteopenia		Date	
Aneurysm		Date		Restless Legs		Date	
Bleeding/clotting problems		Date		Hormone Imbalance		Date	
Blood clot in legs		Date		Toxin Exposure (lead, mold)		Date	
Pulmonary Embolism		Date		Nerve Problems		Date	
Anemia		Date		Physical Disability		Date	
High HCT/Iron		Date		Irritable Bowel Syndrome		Date	
Cancer (type?)		Date		Stomach ulcers		Date	
Abnormal platelets		Date		Helicobacter Pylori		Date	
Heart arrhythmia		Date		Chronic Heartburn/Reflux		Date	
Heart Valve Problem		Date		Gluten Intolerance		Date	
Kidney Disease		Date		Celiac Disease		Date	
Kidney Stones		Date		Alcoholism		Date	
Gallbladder Stones		Date		FOR MEN:			
History of Hepatitis		Date		Erectile Dysfunction		Date	
Fatty Liver		Date		FOR WOMEN:			
Pancreatic Disease		Date		Miscarriage		Date	
Rheumatoid Arthritis		Date		Gestational Diabetes		Date	
Ankylosing Spondylitis		Date		Pre-eclampsia		Date	
Lupus		Date		Polycystic Ovarian Syndrome		Date	
Psoriasis		Date					
Crohn's/Ulcerative Colitis		Date					

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HIPAA RELEASE FORM

Authorization for Use or Disclosure of Protected Health Information

I authorize the release of information including diagnosis, records, medications, examination rendered to me, claims information, etc.

This information may be released to:

☐ Spouse		Phone:	
☐ Child(ren)		Phone:	
☐ Other		Phone:	

*You have the right to revoke this authorization at any time in writing.

For phone messages - please call: ☐ My cell number ☐ Other

*Information will not be discussed with any unauthorized person who may answer the phone.

If unable to reach me:

☐ You may leave a detailed message ☐ Please leave a message asking me to return your call

☐ Do not leave a message

My preferred method(s) of contact for communication: (check all that apply)

For appointment reminders:	☐ Text	☐ Phone	☐ Email
For health notifications, announcements, & billing:	☐ Text	☐ Phone	☐ Email

*By signing this form, I agree to receive automated phone calls or texts regarding appointment reminders, etc. However, I have the right to refuse to sign this authorization - treatment by any party may not be conditioned upon my signing of this authorization.

I agree that signing this document electronically will be legally binding ☐

Signature: Date:

Print Name

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NOTICE OF PRIVACY PRACTICES

I, _____, hereby give my consent for Whole Heart Family Medicine to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). By signing this form, I authorize the release of my complete health record (list if there are any exceptions - please specify):

This authorization for release of information covers all past, present, and future periods of healthcare (UNLESS other dates are specified here: _____)

A full copy of Whole Heart Family Medicine's "Notice of Privacy Practices" is available at the front desk and will be furnished to me upon my request. I have the right to review the Notice of Privacy Practices prior to signing this consent. Whole Heart Family Medicine reserves the right to revise its Notice of Privacy Practices at any time.

MY RIGHTS:

- I have the right to request that Whole Heart Family Medicine restrict how it uses or discloses my PHI to carry out TPO. By signing this form, I am consenting to allow Whole Heart Family Medicine to use and disclose my PHI to carry out TPO.
- I understand that I have the right to revoke this authorization at any time in writing, except where uses or disclosures have already been made based upon my original permission.
- I understand that uses and disclosures already made based upon my original permission cannot be taken back.
- I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.
- I understand that treatment by any party may not be conditioned upon my signing of this authorization and that I may have the right to refuse to sign this authorization.
- At my request, I will be given a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

I agree that signing this document electronically will be legally binding _____

Signature of Patient or Guardian: _____ Date: _____

Print Patient's Name: _____

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All Members at Whole Heart Family Practice will have access to*:

- **Access to advanced, integrative, compassionate care** with providers who listen well
- **Personalized preventative treatment plans** tailored to your unique risk factors and needs
- **Extended appointment times.** 1 hour for new patient appointments and initial bloodwork reviews and 30-45 minutes for other follow up appointments. More time with the patient always equates with better medical care! (Same day work-in appointments may be shorter)
- **Virtual appointment option for everyone in SC.** Save time and money by minimizing travel to the office. Even those with BCBS are currently eligible. (Subject to change pending insurance coverage)
- **In-office blood draw with private phlebotomist.** Saves long wait times while also minimizing exposure to other sick people at the urgent care lab.
- **Group health coaching classes with our health coach.** (Topics such as: Foundations of Healthy Eating, Gluten Free Eating, Eating to Manage Blood Sugars, Food Elimination Diet, and Intermittent Fasting).
- **10% Discount on all Cardiorisk arterial scans** (CIMT, FIMT, & Abdominal Aortic Ultrasound)
- **Access to extensive online Hearth Health educational program** by Dr. Brad Bale and Amy Doneen at AHAforlife.com ($500 value)
- **Unlimited use of our body composition scan machine** to assess current and goal metrics for body fat, muscle mass, and daily protein intake ($50 value per scan)
- **Weight loss management** with personalized dietary guidance and option to purchase GLP-1 medications when warranted.
- **Access to purchase high quality compounded injectables:** methylated b12 shots with lipotropic amino acids and immune support with glutathione.
- **Increased discount on high-quality supplements** through Fullscript (20% total)v
- **Expedient responses from staff.** ALL phone calls, messages, and refill requests received before noon will be returned or handled the SAME DAY (on days office is open).
- **ALL prior authorizations for medicine or in-office testing will be initiated promptly.** We commit to advocating for the best possible medications and tests available and utilizing insurance coverage for these whenever possible.
- **$200 clinician fee waived** (previously charged for extra time to interpret specialized testing)

- **Galleri multi cancer** early detection blood test (for 50+ types of cancer)
- **Prenuvo** advanced full body MRI scan to assess for precancerous masses or aneurysms
- **Cleerly coronary analysis test** to assess coronary artery health and identify the amount of soft of hard plaque present
- **Genetworx pharmacogenetics testing** to determine if you are at risk of complications from certain medications
- **Genetic Testing** to determine inherited risk of heart disease, Alzheimer's, clotting disorders, gluten sensitivity, and more!
- **Oral DNA salivary diagnostic testing** to assess your oral microbiome and identify any dangerous pathogens
- **Wheat Zoomer** panel to assess for sensitivity to wheat, autoimmune disease, and intestinal barrier stability.
- **CPET cardiopulmonary testing** to measure Vo2 max and assess for early-stage cardiac dysfunction
- **CIMT/FIMT scans** to identify arterial inflammation and early-stage plaque growth
- **Continuous Glucose Monitoring** to monitor blood sugar fluctuations over 10 days
- **Home Sleep Study test** to assess quality of sleep and identify sleep disorders

***Our goal is always to expand and improve our services, but due to many factors, benefits are subject to change over time.**

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FINANCIAL POLICY & PATIENT CONTRACT

As a patient and member at Whole Heart Family Medicine, I agree to adhere to the following guidelines.

(Please initial next to each one)

I agree to furnish Whole Heart Family Medicine with a copy of my current health insurance card(s) and contact the office right away if there is any change in insurance or in my contact information.

I authorize the release of medical information necessary to process my insurance claims and I assign insurance benefits to Whole Heart Family Medicine for services provided to me by Whole Heart Family Medicine health care providers.

I understand that copays are due at the time of service, as required by my insurance company, on the same day of the appointment at Whole Heart Family Medicine.

I understand it is my responsibility to understand the terms and limitations of my health insurance coverage. After my claim has been filed and processed by the insurance company, I understand I am fully responsible for any remaining balance attributed to copays, co-insurances, and deductibles.

I accept full financial responsibility for all charges, self-pay balances, and other fees that may not be covered by my medical plan.

I agree to keep a credit or debit card on file in our secure Athena system to cover any remaining balance after claims have been processed through my insurance. I understand I will get an e-mail explaining the charges due five days before they are automatically billed to the card on file. This allows me time to contact my insurance company if I have any questions about my coverage.

I agree to keep a credit or debit card on file through Square to cover my monthly membership fees. I give permission for my card to be automatically billed monthly. I understand my year-long commitment as a member begins the month I sign up, and that Whole Heart Family Medicine bills for its services in arrears (the first day of the following month). For those individuals who have paid the whole year up front, their monthly billing will start 12 months later.

I understand I am committing to a 12-month membership and the terms of this authorization will remain in effect until I request that they be terminated. I understand the membership may not be cancelled before 12 months. I acknowledge that I am responsible for making a request to cancel my membership in writing at least 60 days in advance of the next scheduled charge date to ensure I am not charged again. I acknowledge that after the initial 12 months, I will continue to be billed monthly as a member until I cancel.

Should my card on file reach its limit or become compromised in any way, I agree to contact the office immediately to resolve the issue and give a new card number to process any fees/balances.

In the event I am unable to pay my bill or monthly membership fees, I will contact the office right away to discuss financial arrangements.

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- [ ] I understand my membership is NOT an insurance plan and it does not cover any medical care or services outside of what is provided at Whole Heart Family Medicine.
- [ ] I agree to give at least 24 hours' notice if I need to cancel an appointment.
- [ ] I understand Whole Heart Family Medicine is not a purely holistic or functional medicine practice, but rather an integrative practice that uses both lifestyle recommendations and prescription medications in their treatment plans.
- [ ] I understand Whole Heart Family Medicine does not typically prescribe schedule II medications (such as stimulants and narcotics) or other chronic controlled medications (such as Ambien and Xanax), so I agree to see another medical provider for these if I need them.
- [ ] If I am a female, I agree to see an OBGYN for my GYN and hormone needs.
- [ ] I understand that children ages 12 and up may be patients at Whole Heart Family Medicine but that they will need to obtain any vaccinations or well-child visits from their pediatrician or other provider.
- [ ] I understand that as a member of the practice, I can always choose which provider I see, but this will be based on appointment/provider availability.
- [ ] I understand that Carey McNamara PA-C is NOT credentialed with Medicare or Tricare so she cannot see these patients at Whole Heart Family Medicine. I agree to notify the office immediately should I obtain one of these insurances.
- [ ] If I am a self-pay patient, I agree to pay the membership fee in addition to the self-pay rate for office appointments and other services obtained at Whole Heart Family Medicine.
- [ ] As a member, I will have access to acute work-in appointments and every effort will be made to accommodate me within 24 hours. However, I understand there could be circumstances (such as during Covid) when we cannot accommodate everyone right away. I understand there is no guarantee of immediate work-in appointments.

I acknowledge that I have received a copy of this financial policy and patient contract. I agree I have read this document, and I will comply with the terms set forth for services rendered by Whole Heart Family Medicine.

I agree that signing this document electronically will be legally binding ☐

Signature: _____ Date: _____

Print Name _____

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Whole Heart Family Medicine
Medical Records Release Form

TO:

FAX:

Phone:

FROM:

Whole Heart Family Medicine
Fax: (843) 654-1260
Phone: (843) 637-4173

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records or a summary or record of my protected health information to the following physician/person/facility/ entity and/or those directly associated with my medical care at:

Whole Heart Family Medicine
2891 Tricom Street Suite C
North Charleston, SC 29406
PHONE (843) 637-4173
FAX (843) 654-1260

The information you may release is as follows: (check)

- ☐ Complete Records
- ☐ Please be sure to include ALL lab results, diagnostic testing such as last mammogram & DEXA, last colonoscopy & eye exam, xray/MRI results, sleep study results, vaccine record, and consult notes from other specialists.
- ☐ Other (explain)

The purpose/reason for this release of information is as follows: (check)

- ☐ Transfer my medical care to new office (continuity of care)
- ☐ Other (explain)

I agree that signing this document electronically will be legally binding ☐

Signature: Date:

Print Name

Informed Consent for Telemed Services

Whole Heart Family Medicine
2891 Tricom Street suite C
North Charleston, SC 29406

Patient Name

Date of Birth

Telemed involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medial records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification systems and imaging data and will include measures to safeguard the data and to ensure its integrity against intention or unintentional corruption.

Possible Risks

As with any medical procedure, there is potential risk associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (i.e. poor resolution of images) to allow for
- appropriate medical decision making by the physician and consultants.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical
- information.
- Telemedicine examinations or care may not be completed as face-to-face examinations or care.

By signing this Form, I attest to and understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during the course of my care at any time without affecting my right to future treatment.
3. I understand that I have the right to inspect all information obtained and recorded during the telemedicine interaction and may receive copies of the information.
4. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
5. 5. I understand I am responsible for my co-pay or co-insurance just like an in-office appointment.
6. I understand some medical conditions require a physical exam and warrant a direct evaluation, so I agree to come in for a separate in-office appointment if deemed necessary.

I agree that signing this document electronically will be legally binding

Please initial after reading this page:

PATIENT CONSENT TO USE TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all o my questions have been answered to my satisfaction.
I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Whole Heart Family Medicine to use Telemedicine in the course of my diagnosis and treatment.

I agree that signing this document electronically will be legally binding

Patient Signature (or authorized person to sign for patient)

Date:

If Authorized signer, Relationship to patient