Whole Heart Family Medicine

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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?

___ I am a Previous Patient ___ A Friend – Who? _____

___ Facebook/Instagram ___ Medical Office Referral – Who? _____

___ Billboard ___ Website – wholeheartfamilymed.com

___ Pamphlet ___ Other: _____

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 : _____

Date of Birth: _____

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PHARMACY INFORMATION

Local Pharmacy Name: _____ **Phone number:** _____

Address: _____

_____

Mail Order Pharmacy? _____

WHAT IS THE REASON FOR YOUR VISIT TODAY?

___ Establish medical care ___ Other: _____

What does optimal health look like to you? Where do you see yourself 10 or 20 yrs from now?

_____

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?	Reason
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Do you take hormone replacement therapy? ___ NO ___ YES - Which Ones? _____

From whom? _____

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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? _____

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

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

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

Include if the person has DECEASED and the person's age now (or at time of death). If applicable, list the cause of death, and any other relevant comments.
It is especially important to note any history of heart disease (stents/bypass surgery), strokes, aneurysms, cancers, autoimmune disease (such as Lupus, Rheumatoid, Hashimotos, etc.), clotting disorders, carotid or other vascular disease, dementia, diabetes, kidney disease, or other serious illnesses.

MOTHER:

___ Alive	Age: _____ Health Status: _____
___ Deceased	Age (at time of passing): _____ Cause of death _____

Comments: _____

MATERNAL GRANDMOTHER:

___ Alive	Age: _____ Health Status: _____
___ Deceased	Age (at time of passing): _____ Cause of death _____

Comments: _____

MATERNAL GRANDFATHER:

___ Alive	Age: _____ Health Status: _____
___ Deceased	Age (at time of passing): _____ Cause of death _____

Comments: _____

FATHER

___ Alive	Age: _____ Health Status: _____
___ Deceased	Age (at time of passing): _____ Cause of death _____

Comments: _____

PATERNAL GRANDMOTHER

___ Alive	Age: _____ Health Status: _____
___ Deceased	Age (at time of passing): _____ Cause of death _____

Comments: _____

PATERNAL GRANDFATHER

___ Alive	Age: _____ Health Status: _____
___ Deceased	Age (at time of passing): _____ Cause of death _____

Comments: _____

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SIBLING #1

___ Alive	Age: _____ Sex: F ___ M ___ Health Status: _____
___ Deceased	Age (at time of passing): _____ Cause of death _____

Comments: _____

SIBLING #2

___ Alive	Age: _____ Sex: F ___ M ___ Health Status: _____
___ Deceased	Age (at time of passing): _____ Cause of death _____

Comments: _____

SIBLING #3

___ Alive	Age: _____ Sex: F ___ M ___ Health Status: _____
___ Deceased	Age (at time of passing): _____ Cause of death _____

Comments: _____

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CHILD #1

___ Alive	Age: _____ Sex: F ___ M ___ Health Status: _____
___ Deceased	Age (at time of passing): _____ Cause of death _____

Comments: _____

CHILD #2

___ Alive	Age: _____ Sex: F ___ M ___ Health Status: _____
___ Deceased	Age (at time of passing): _____ Cause of death _____

Comments: _____

CHILD #3

___ Alive	Age: _____ Sex: F ___ M ___ Health Status: _____
___ Deceased	Age (at time of passing): _____ Cause of death _____

Comments: _____

Please use this space to list any additional family members:

SOCIOECONOMICS AND LIFESTYLE

Occupation: _____ Employer: _____

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

Fight/flight career? (i.e. fireman/women, policeman/women, trauma nurse, etc.) ___ NO ___ YES (explain): _____

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) _____

Where were you born? _____ Where did you grow up? _____

Where do you live now and for how long? _____

SMOKING/DRUGS:

Do you smoke cigarettes?

___ NEVER

___ QUIT (Date) _____

___ Current Smoker - Packs per day? _____

Other nicotine? (E-cigs/Vape)

___ NEVER

___ QUIT (Date) _____

___ Current Smoker - Years using? _____

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Are you exposed to second-hand smoke?

NO YES - How long?

Are you interested in quitting?

NO YES

Have you tried to quit in the past?

NO YES

What methods have you tried?

Do you smoke Marijuana?

NEVER

QUIT (Date)

Ocasionally - How often?

Do you take any illegal drugs?

NEVER IN THE PAST

CURRENT USER

(Which drugs?)

ALCOHOL/CAFFEINE:

Do you drink alcohol? NONE QUIT (Date)

YES - How many per week? What type?

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

Caffeine intake per day: Coffee Energy drinks Diet Soda

Regular Soda Tea

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 many servings do you have a WEEK of:

Red Meat Dessert Fried food Junk food

How many servings do you have PER DAY of: Vegetables Fruits Water (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: _____

WEIGHT:

Are you satisfied with your weight? ___ YES ___ NO What is your goal weight? _____

When did you last weigh your goal weight? _____ How long were you at that weight? _____

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.)? _____

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) _____

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STRESS:

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?) _____

COMMUNITY:

How would you rate the quality of your sleep? _____

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	___	___	___	___

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ORAL HEALTH:

How many times a day do you brush your teeth? _____ Do you use an electric toothbrush? ___ NO ___ YES

Do you floss 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 _____

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

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?**

PREVIOUS CARDIAC TESTING/PROCEDURES (Check all that apply and list date)

Coronary artery calcium score test	___	Score:	_____	Date:	_____
Cardiac CTA of heart (dye test looking for blockages)	___			Date:	_____
Cardiac catheterization	___			Date:	_____
Coronary Stent	___	How many?	_____	Date:	_____
Coronary Artery Bypass Surgery	___	How many vessels?	____	Date:	_____

Do you know your blood type? _____

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.)

When was your last physical? _____ By Whom? _____

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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.

Heart Disease ___ Date _____
Stroke ___ Date _____
High Cholesterol ___ Date _____
High Blood Pressure ___ Date _____
Pre-diabetes or Metabolic Syndrome ___ Date _____
Diabetes ___ Date _____
Mini-stroke or TIA ___ Date _____
Atrial Fibrillation ___ Date _____
Poor blood flow to extremities ___ Date _____
Aortic aneurysm ___ Date _____
Brain aneurysm ___ Date _____
Bleeding/clotting problems ___ Date _____
Blood clot in legs ___ Date _____
Pulmonary Embolism ___ Date _____
Anemia ___ Date _____
High hemoglobin/ hematocrit ___ Date _____
Cancer (type?) ___ Date _____
Leukemia ___ Date _____
Hodgkin's Disease ___ Date _____
Abnormal platelets ___ Date _____
Heart arrhythmia ___ Date _____
Heart Valve Problem ___ Date _____
Kidney Disease ___ Date _____

Kidney Stones ___ Date _____
Gallbladder Stones ___ Date _____
History of Hepatitis ___ Date _____
Fatty Liver ___ Date _____
Pancreatic Disease ___ Date _____
Creases in earlobes (Frank's sign) ___ Date _____
Fordyce Granules (sebaceous gland bumps on lips) ___ Date _____
Xanthoma (cholesterol deposits under the skin) ___ Date _____
Acanthosis Nigrans ___ Date _____
Baldness (male pattern ___ Date _____
Rheumatoid Arthritis ___ Date _____
Ankylosing Spondylitis ___ Date _____
Lupus ___ Date _____
Psoriasis ___ Date _____
Crohn's Disease or Ulcerative Colitis ___ Date _____
Sjogren's Syndrome ___ Date _____
Other Autoimmune Disorder ___ Date _____
Asthma ___ Date _____
Periodontal Disease ___ Date _____
Dental infections ___ Date _____
Root Canal ___ Date _____
Bleeding gums ___ Date _____

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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.

Gout ___ Date _____
Polycystic Ovaries ___ Date _____
Thyroid Problems ___ Date _____
Depression ___ Date _____
Suicide Attempts ___ Date _____
Anxiety/Panic Attacks ___ Date _____
Post-Traumatic Stress Syndrome ___ Date _____
Mental Disability ___ Date _____
Migraine Headaches ___ Date _____
Osteoporosis/osteopenia ___ Date _____
Restless Legs ___ Date _____
Sleep Apnea ___ Date _____
Hormone Imbalance ___ Date _____
Toxin Exposure (lead, mold, etc.) ___ Date _____
Unexplained Nerve Problems ___ Date _____
Physical Disability ___ Date _____
Irritable Bowel Syndrome ___ Date _____
Stomach ulcers ___ Date _____
Helicobacter Pylori ___ Date _____
(stomach infection) ___ Date _____
Chronic Heartburn/Reflux ___ Date _____
Gluten Intolerance ___ Date _____

Celiac Disease ___ Date _____
Alcoholism ___ Date _____
Drug use ___ Date _____
HIV/AIDS ___ Date _____
Resting Heart Rate >75 ___ Date _____
Blood Pressure >120/80 ___ Date _____

FOR MEN:
Erectile Dysfunction ___ Date _____

FOR WOMEN:
Miscarriage ___ Date _____
Gestational Diabetes ___ Date _____
Pre-eclampsia ___ Date _____
Polycystic Ovarian Syndrome ___ Date _____
Menopausal Hot Flashes ___ Date _____

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REVIEW OF SYSTEMS

CHECK OFF ANY CURRENT SYMPTOMS YOU HAVE

Chest Pain	___	Memory Loss	___
Palpitations (irregular heartbeats)	___	Lightheadedness	___
Swelling of feet or legs	___	Excessive Fatigue	___
Shortness of Breath with Exertion	___	Increased weakness	___
Cough/Wheeze	___	Tingling, pain, or numbness in hands/feet	___
Pain in extremities with exercise	___	Depression	___
Abdominal Pain	___	Anxiety	___
Diarrhea/Constipation	___	Irritability or impatience	___
Heartburn/Reflux	___	Brain fog/attention issues	___
Loss of Appetite	___	Bleeding or swollen gums	___
Headaches	___	Bad breath	___
Problems with Sleep	___	Easy bruising/bleeding	___
Snoring	___	Chronic joint problem	___
Excessive Thirst or Urination	___	Unusual muscle weakness/aches	___
Urination at night that interrupts sleep	___	Large Varicose Veins	___
Unusual visual changes/double vision	___		

OTHER SYMPTOMS? Please list:

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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.

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.

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 Heart Health educational** program by Dr. Brad Bale and Dr. Amy Doneen at AHAforlife.com
- **Unlimited use of our body composition scan machine** to assess current and goal metrics for body fat, muscle mass, and daily protein intake
- **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
- **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)

- **OPTIONAL ADD ON SERVICES:** cutting-edge specialty tests with in-office interpretation (some of these tests are an additional cost and some can be run through insurance).

  - **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

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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.

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.

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.

Patient Signature (or authorized person to sign for patient)

Date:

If Authorized signer, Relationship to patient

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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) _____

Signature: _____ Date: _____

Print Name _____