**Alaska Functional Medicine Clinic**
**Personalized Care with Chris Anne McDonald, FNP**
9138 Arlon Street, Suite A-2, Anchorage, AK 99507
Telephone: (907) 375–9395 Fax: (907) 375–9396

## Patient Information

Name: _____ I prefer to be called: _____
Address: _____ City: _____State: _____ Zip: _____
Primary Phone: (_____)_____ Secondary Phone: (_____)_____
May we leave you a message? Primary Phone: ☐Yes ☐No Secondary Phone: ☐Yes ☐No
Date of Birth: _____ Social Security Number: _____
E-mail Address: _____
May we discuss your health information with a spouse or relative: ☐ Yes ☐ No
If so, who? Name and relationship to the patient:_____
Check appropriate box: ☐Minor ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced
Employer: _____ Phone: (____)_____
Address: _____ City: _____ State: _____
Emergency Contact: _____ Phone: _____Relation:_____
Whom may we thank for referring you? _____

## Insurance Information

*We require proof of insurance before each visit.*
*If you do not have your insurance card with you, full payment at time of service is required.*

Who is financially responsible for your visit today? Please check one: ☐Self ☐Spouse ☐ Parent ☐Other

Primary Insurance

Name of Insured: _____ DOB: _____
Relation to Insured: _____ Social Security Number: _____
Name of Employer: _____ Work Phone: _____
Address of Employer: _____ City: _____ State: ____ Zip: _____
Insurance Company: _____Group #: _____ ID#: _____
Insurance Co. Address: _____ Insurance Co. Phone: _____

Secondary Insurance (leave blank if none)

Name of Insured: _____ DOB: _____
Relation to Insured: _____ Social Security Number: _____
Name of Employer: _____ Work Phone: _____
Address of Employer: _____ City: _____ State: ____ Zip: _____
Insurance Company: _____Group #: _____ ID#: _____
Insurance Co. Address: _____ Insurance Co. Phone: _____

*We have the right to call and obtain information over the phone with your insurance carrier for your benefit. However, eligibility and benefit information given by phone does not constitute an authorization, and does not guarantee payment. Actual payment is subject to the patient's contracted and eligibility at the time of service.

*By signing below, I have read and do fully understand that about benefits and eligibility explained to me by AFMC, Inc. I also understand that in the event my insurance does not cover any of the above benefits or denies any of the above benefits due to medical necessity, I am fully responsible for payment in full. AFMC is in-network with Premera Blue Cross Blue Shield and Aetna.

Cancellation Policy: We require 24 hours notice of canceling an appointment. Canceling with less than 24 hours notice, or not showing up for your scheduled appointment will result in a $50.00 fee.

Returned Checks: Any checks that have bounced or have been returned will result in a $50.00 fee.

Patient Signature: _____ Date: _____

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# Financial Responsibility

- Payment of your deductible, if not already met, and the patient portion of your charges are required **at the time of service**. Payment can be made by cash, check or credit card.
- Alaska Functional Medicine Clinic bills your insurance as a courtesy. However, there are many insurance plans in the United States and it is impossible for AFMC to know the specific benefits of your plan. It is your responsibility, not your insurance companies, to make sure your bill is paid.
- If you want AFMC to bill your insurance, you must provide us with:
    - An assignment of benefits
    - A copy of your insurance card
- Your insurance must pay on charges according to their usual and customary fee scale. AFMC's fees are set independently from the insurance company guidelines. In the event your insurance company determines a service to be "not covered" or "above the usual or customary charges", you will be responsible for the balance due.
- AFMC does not bill Medicaid or Medicare as a primary or secondary insurance. All charges must be paid at time of service.
- **It is the patient's responsibility to preauthorize with their insurance company prior to any procedures or testing.**
- In many instances, your practitioner may order services or testing which are independent from Alaska Functional Medicine Clinic. Such organizations include laboratories, pathologists, x-ray facilities and hospitals. These organizations and physicians will directly bill you and your insurance for their services. Our office may provide them with billing information.

I authorize Alaska Functional Medicine Clinic to bill my insurance and release medical or other information necessary to process my medical claims. I request payment of government benefits either to myself or to the party that accepts assignment. _____***Initial***

I acknowledge and agree to all financial responsibilities outlined at the bottom of this agreement.
_____***Initial***

I understand that AFMC has opted out of Medicaid and Medicare, and that it is illegal to seek reimbursement for services rendered at AFMC. I agree to pay in full at the time of service, for any and all services provided. As a curtsey to our Medicaid and Medicare patients, we will offer a 25% discount on professional services rendered. _____***Initial***

I acknowledge and agree that I have received a copy of Alaska Functional Medicine Clinic's *Notice of Privacy Practices.*

Patient Name: _____ Date: _____

Patient Signature: _____

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## RECEIPT OF NOTICE OF PRIVACY POLICIES AND CONSENT

Date: _____

Patient Name: _____ DOB: _____

Patient Address: _____

Patient Contact: Home: _____Work: _____ Cell: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices*.

Our *Notice of Privacy* Practices will be updated whenever our privacy practices change. When you sign this document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. You also signify that you have received a copy of our *Notice of Privacy Practices*.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described on our *Notice of Privacy Practices*, we are not obligated to agree to these restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Alaska Alternative Medicine Clinic.

Patient Signature: _____ Date:_____

*If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:*

Name and Source of Authority: _____

Relationship to Patient: _____ Date: _____

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# Medical History

## Medications:

(Prescriptions, over-the-counter, Vitamins, Herbs, etc.)

| *Medication* | *Dose & Frequency* |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

## Allergies:

(Medications, X-Ray Dyes, other substances, etc.)

| | |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

## Family History:

Have any members of your family(including parents, grandparents and siblings) ever had the following?

| ***Illness*** | ***Family member(s) affected?*** | ***Age of Diagnosis*** |
|---|---|---|
| Cancer (describe type) | ---------- | ---------- |
| Hypertension(high blood pressure) | ---------- | ---------- |
| Heart Disease | ---------- | ---------- |
| Diabetes (Describe type) | ---------- | ---------- |
| Strokes | ---------- | ---------- |
| Mental Disease(anxiety, depression, etc.) | ---------- | ---------- |
| Drug or Alcohol addiction | ---------- | ---------- |
| Thyroid disease | ---------- | ---------- |
| Bleeding Disease | ---------- | ---------- |
| Other_____ | ---------- | ---------- |

## Operations & Hospitalizations:

Operations: _____

_____

Hospitalization other than surgery: _____

_____

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Date: _____

Patient Name: _____ DOB: _____

Major Complaints: _____

Date of last physical and/or physicians visit: _____

Check boxes below and circle symptoms when necessary.

| Present | Past | General Symptoms |
|---|---|---|
| ☐ | ☐ | Tired, weak, lack of energy |
| ☐ | ☐ | Weight gain or loss |
| ☐ | ☐ | Frequent colds or other illness |
| ☐ | ☐ | Headaches or migraines |
| ☐ | ☐ | Dizziness, fainting |
| ☐ | ☐ | Fever, chills |

| Present | Past | Skin and Hair |
|---|---|---|
| ☐ | ☐ | Acne or pimples |
| ☐ | ☐ | Skin rashes |
| ☐ | ☐ | Itching |
| ☐ | ☐ | Dry skin |
| ☐ | ☐ | Hair loss |
| ☐ | ☐ | Hair dry and brittle |

| Present | Past | Respiratory |
|---|---|---|
| ☐ | ☐ | Cough frequently, allergies |
| ☐ | ☐ | Wheezing, shortness of breath |
| ☐ | ☐ | Pneumonia, bronchitis |
| ☐ | ☐ | Coughing up mucous or blood |

| Present | Past | Eyes |
|---|---|---|
| ☐ | ☐ | Nearsighted or farsighted |
| ☐ | ☐ | Blurry vision |
| ☐ | ☐ | Dry, burning, itchy eyes |

Date of last eye exam: _____

| Present | Past | Ears |
|---|---|---|
| ☐ | ☐ | Ringing in the ears |
| ☐ | ☐ | Loss of hearing |
| ☐ | ☐ | Excessive ear wax |

| Present | Past | Nose and Throat |
|---|---|---|
| ☐ | ☐ | Sinusitis acute or chronic |
| ☐ | ☐ | Sore throat or runny nose |
| ☐ | ☐ | Cold sores or herpes |
| ☐ | ☐ | Decreased smell or taste |
| ☐ | ☐ | Cavities, tooth pain |
| ☐ | ☐ | Bleeding gums, infections |
| ☐ | ☐ | Chronic congestion |
| ☐ | ☐ | Thyroid Disease |

| Present | Past | Sleep |
|---|---|---|
| ☐ | ☐ | Sleep too much or sleep too little |
| ☐ | ☐ | Trouble falling asleep |
| ☐ | ☐ | Trouble staying asleep |
| ☐ | ☐ | Restlessness or restless legs |
| ☐ | ☐ | Snoring or sleep apnea |

| Present | Past | Musculoskeletal |
|---|---|---|
| ☐ | ☐ | Tingling and numbness |
| ☐ | ☐ | Heel pain, foot pain |
| ☐ | ☐ | Weakness |
| ☐ | ☐ | Tremors, cramps |
| ☐ | ☐ | Muscle stiffness, where?_____ |
| ☐ | ☐ | Fractures_____ |
| ☐ | ☐ | Bone pain? _____ |
| ☐ | ☐ | Painful or stiff joints |

| Present | Past | Gastrointestinal |
|---|---|---|
| ☐ | ☐ | Increased appetite |
| ☐ | ☐ | Loss of appetite |
| ☐ | ☐ | Nausea or vomiting |
| ☐ | ☐ | Bad breath, metallic taste |
| ☐ | ☐ | Heartburn, indigestion |
| ☐ | ☐ | Heaviness after eating |
| ☐ | ☐ | Frequent gas or burping |

| Present | Past | Gastrointestinal cont. |
|---|---|---|
| ☐ | ☐ | Stomach or abdominal pain |
| ☐ | ☐ | Headaches, irritability if skip meals |
| ☐ | ☐ | Diarrhea or loose stool |
| ☐ | ☐ | Constipation |
| ☐ | ☐ | Dark stool |
| ☐ | ☐ | Blood in stools |
| ☐ | ☐ | Undigested food in stools |
| ☐ | ☐ | Hemorrhoids |
| ☐ | ☐ | Anal itching, bleeding |

How often do you have bowel movement?____

| Present | Past | Cardiovascular |
|---|---|---|
| ☐ | ☐ | Heart beats fast or irregular |
| ☐ | ☐ | Tightness or pain in chest |
| ☐ | ☐ | Dizziness upon standing |
| ☐ | ☐ | Swollen feet or ankles |
| ☐ | ☐ | Cold hands or feet |
| ☐ | ☐ | Leg pain when walking |
| ☐ | ☐ | Varicose veins |
| ☐ | ☐ | Heart murmur |
| ☐ | ☐ | High blood pressure |
| ☐ | ☐ | Low blood pressure |
| ☐ | ☐ | Heart attacks or strokes |
| ☐ | ☐ | Aneurysms |

| Present | Past | Urinary |
|---|---|---|
| ☐ | ☐ | Painful or burning urinating |
| ☐ | ☐ | Urinating frequently at night |
| ☐ | ☐ | Incomplete urination/dribbling |
| ☐ | ☐ | Narrowing of stream |
| ☐ | ☐ | Uncontrolled urination |
| ☐ | ☐ | Bladder infection |
| ☐ | ☐ | Kidney infection or disease |
| ☐ | ☐ | Kidney stones |

| Present | Past | Neurological/Psychological |
|---|---|---|
| ☐ | ☐ | Speech problems |
| ☐ | ☐ | Depression, anxiety, mood swings |
| ☐ | ☐ | Trouble concentrating |
| ☐ | ☐ | Memory problems |
| ☐ | ☐ | Lack of interest in activities/work |
| ☐ | ☐ | Weepy, cry easily |
| ☐ | ☐ | Counseling or Psychiatric care |
| ☐ | ☐ | Obsessive/compulsive behavior |

| Present | Past | Exposure and Work History |
|---|---|---|
| ☐ | ☐ | Farming |
| ☐ | ☐ | Gardening |
| ☐ | ☐ | Industrial work |
| ☐ | ☐ | Pesticides |
| ☐ | ☐ | Petroleum Products |
| ☐ | ☐ | Welding, Construction |
| ☐ | ☐ | Laboratory, Mechanical work |

| Present | Past | Female History |
|---|---|---|
| ☐ | ☐ | Irregular Menstruation |
| ☐ | ☐ | Premenstrual/Menstrual pain |
| ☐ | ☐ | Depressed/mood swings w/ Menses |
| ☐ | ☐ | Lumps/discharge from breasts |
| ☐ | ☐ | Low libido |
| ☐ | ☐ | Pain with Intercourse |
| ☐ | ☐ | Difficulty having an orgasm |
| ☐ | ☐ | Infertility |
| ☐ | ☐ | Vaginal discharge or dryness |
| ☐ | ☐ | Pain/Itching in Vaginal area |
| ☐ | ☐ | Hot flashes |
| ☐ | ☐ | Vaginal Infections |
| ☐ | ☐ | Cysts, Fibroids |
| ☐ | ☐ | Sexually transmitted disease(s) |

Age period began: _____ Last Period? _____

Duration of period: _____ Length of cycle: _____

Amount of flow: light medium heavy

Type of birth control:_____

Birth control use: Yes No How long?_____

Pregnacies:____ Miscarriages:_____ Children: _____

Date of last PAP smear:_____

Any abnormal PAP's: Yes No

| Present | Past | Male History |
|---|---|---|
| ☐ | ☐ | Prostate problems |
| ☐ | ☐ | Pain/discomfort in genital area |
| ☐ | ☐ | Low libido |
| ☐ | ☐ | Difficulty maintaining an erection |
| ☐ | ☐ | Pain, Lump or mass in testicules |
| ☐ | ☐ | Discharge from penis |
| ☐ | ☐ | Sexually transmitted disease(s) |
| ☐ | ☐ | Infertility |

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If you have **one or more** of these symptoms, there is a 95% probability you'll benefit from a food toxicity test. Please review the following list and check any symptoms you may have and any symptoms that you have "learned to live with". Be sure to discuss these symptoms with your provider.

**Digestive Tract**
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloated feeling
- ☐ Belching
- ☐ Passing gas
- ☐ Stomach pains

**Energy & Activity**
- ☐ Fatigue
- ☐ Sluggishness
- ☐ Apathy
- ☐ Hyperactivity
- ☐ Restlessness
- ☐ Lethargy

**Joint & Muscles**
- ☐ Pain in joints
- ☐ Arthritis
- ☐ Stiffness
- ☐ Limited movement
- ☐ Aches in muscles
- ☐ Feeling of weakness

**Skin**
- ☐ Acne
- ☐ Hives, rashes
- ☐ Hair loss
- ☐ Flushing/hot flashes
- ☐ Excessive sweating

**Ears**
- ☐ Itchy ears
- ☐ Ear aches
- ☐ Ear infections
- ☐ Drainage from ear
- ☐ Ringing in ears
- ☐ Hearing loss

**Eyes**
- ☐ Watery eyes
- ☐ Itchy eyes
- ☐ Swollen eyelids
- ☐ Sticky eyelids
- ☐ Dark circles
- ☐ Blurred vision

**Mouth & Throat**
- ☐ Chronic coughing
- ☐ Gagging
- ☐ Often clear throat
- ☐ Sore throat
- ☐ Swollen tongue/lips
- ☐ Canker sores

**Lungs**
- ☐ Chest congestion
- ☐ Asthma, bronchitis
- ☐ Shortness of breath
- ☐ Difficulty breathing

**Emotions**
- ☐ Mood swings
- ☐ Anxiety, fear
- ☐ Irritability, anger
- ☐ Depression
- ☐ Aggressiveness
- ☐ Nervousness

**Weight**
- ☐ Binge eating
- ☐ Cravings
- ☐ Excessive weight
- ☐ Compulsive eating
- ☐ Water retention
- ☐ Underweight

**Nose**
- ☐ Stuffy nose
- ☐ Sinus problems
- ☐ Hay fever
- ☐ Sneezing attacks
- ☐ Excessive mucous

**Mind**
- ☐ Poor memory
- ☐ Confusion
- ☐ Poor concentration
- ☐ Stuttering/stammering
- ☐ Learning disabilities

**Head**
- ☐ Headaches
- ☐ Faintness
- ☐ Dizziness
- ☐ Insomnia

**Other**
- ☐ Irregular heartbeat
- ☐ Rapid heartbeat
- ☐ Chest pains
- ☐ Frequent illness
- ☐ Urgent urination
- ☐ Genital Itch