Biorestoration
MEDICAL GROUP

Patient Information

First Name _____ M.I. _____ Last Name _____
Address _____ City _____ State _____ Zip _____
Email _____ (by providing email; consent is given to send PHI)
Date of Birth _____ Social Security # (optional) _____
Primary Phone # _____ (circle) home cell work Secondary # _____
Gender (circle) Male Female Marital Status (circle) Married Single Divorced Widowed
Place of Employment _____ Emergency Contact _____
Emergency Contact Phone # _____
How did you find us? _____ BIORESTORATION WEBSITE SUMMIT INTEGRATVE WEBSITE
Reason for visit? _____

Primary Insurance Information
Name of Primary Insurance Company _____
ID # _____ Group# _____
Name of Policy Holder _____ Policy Holder Date of Birth _____

Office Payment Policy- *PLEASE READ CAREFULLY* then sign this policy statement. If you have any questions about the cost of our services or our payment policy, please inquire at the front desk before services are provided.

Payment in full is to be made at the time services are provided. You may pay with cash, check or credit card. If we are not providers with your insurance company, it is your responsibility to pay us and then work out financial arrangements with your insurance company for reimbursement.

Medical insurance coverage varies greatly. Many plans only cover one preventive visit a year and may require you to pay out of pocket for follow up visits until you have met your deductible. **It is ultimately the patient's responsibility to know ahead of time what their insurance policy will cover**. We understand financial constraints and are willing to work with you, however, please know we have a medical responsibility to follow your care which means you may need to come in for additional follow up visits. Please let us know if you have financial concerns or constraints and we will try to work with you as best as we can.

If legal prosecution or collection services are required to collect payment, you will be required to pay all fees associated with the process.

INITIALS (understanding of above terms and conditions) _____

INSURANCE MAY NOT COVER ALL SERVICES OFFERED AT BIORESTORATION. EXTENDED CONSULTATIONS, NUTRITONAL COUNSELING, BODY BUILDING AND ALTERNATIVE TREATMENTS MAY NOT BE COVERED. ADDITIONAL FEES COULD APPLY.

I HAVE READ THE ABOVE POLICY STATEMENT AND AGREE TO PAY BIORESTORATION MEDICAL FOR SERVICES WHEN THEY ARE PROVIDED. I ALSO AGREE TO PAY A SERVICE CHARGE OF 2% PER MONTH ON ANY UNPAID BALANCE OVER 30 DAYS. SHOULD MY ACCOUNT BE REFERRED FOR COLLECTION, I AGREE TO PAY ALL COLLECTION COSTS, LAWYER'S FEES, COURT COSTS, ETC.

I AGREE TO PAY A $150.00 CANCELLATION / NO SHOW FEE IF I DO NOT GIVE MORE THAN 24 HOURS NOTICE.

BY SIGNING BELOW, I ATTEST THAT I HAVE RECEIVED AND READ THE NOTICE OF PRIVACY PRACTICES.

SIGNATURE: _____ **DATE:** _____

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Medical History Questionnaire

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

Height _____ Weight _____ Foods you crave _____

Alcohol frequency _____ Tobacco frequency _____ Illicit drug frequency _____ Caffeine/day _____

Average Stress Level (circle) none - 1 2 3 4 5 6 7 8 9 10 - too much

Exercise: Days per week # _____ - Duration (min.) 30 60 90 - Light Moderate Vigorous

Sleep Quality: Poor / Fair / Good # Hours of sleep a night _____ Awake refreshed? Yes / No Snore? Yes No

Any traumatic emotional experiences in your life? _____

Previous medically supervised diets (like HCG)? _____

Any allergies (meds, foods, lidocaine, etc.) _____

Most recent labs _____ Primary Care Physician _____ Phone # _____

Are you pregnant or breastfeeding? _____

Past surgical procedures and Diagnostic testing (Including Mammograms, Colonoscopy, X-Rays, MRI, CT Scans etc.) _____

_____

_____

Family Medical History (excluding self)	Yes	No	Family Members
Diabetes			
Thyroid Disease			
Severe Obesity			
Depression/Anxiety			
High Cholesterol/Triglycerides			
Alcoholism/Drug Abuse			
Sleep Apnea			
Cancer –please list which type			
Heart Attack			
Stroke			

Your Past and Current Medical History (Diagnoses/diseases)

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

Current Medications & Supplements (Vitamins, Herbs etc.)

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

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Controlled Substance Agreement:

If any provider at Biorestoration feels it is my best interest (the patient) to prescribe any controlled substance medication for the treatment of any condition, the patient agrees to following contingencies. If the patient does not adhere to this agreement, Biorestoration will discontinue prescribing these medications and refer the patient to the appropriate provider for continuance of care. Biorestoration does not prescribe pain medications or manage chronic pain.

Please sign below the following to confirm understanding and acknowledgement of conditions as follow;

1. I will use only one pharmacy and one provider for my medications.

2. I am aware that I have to be seen by the provider at least every three months (every 6 months for Testosterone prescriptions) to keep my prescription current. I agree to schedule these appointments in advance and keep them.

3. I agree to only take the medications as prescribed and avoid alcohol and other medications that may interact with my medications.

4. I understand that written prescriptions cannot be replaced, even in the event of loss or theft.

5. I will not sell or share this medication with others.

6. I agree to seek counseling, therapy or other resources if necessary.

7. I understand I may be asked for a random urine drug screen, and I consent to this.

_____ _____

Signature (I agree to the above terms) Today's Date

_____

Patient Name Printed