



PATIENT'S NAME	DATE OF BIRTH	OCCUPATION
ADDRESS	MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/>	EMPLOYER
	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
CITY STATE ZIP	SOCIAL SECURITY #	EMERGENCY CONTACT
HOME PHONE CELL PHONE	PRIMARY PHYSICIAN	EMERGENCY CONTACT PHONE
WORK PHONE	PRIMARY PHYSICIAN'S PHONE #	THERAPIES BEING USED
E-MAIL	HOW DID YOU HEAR OF US	

INSURANCE INFORMATION		RELEASE OF INFORMATION AUTHORIZATION	
We are a fee for service facility. Payment is due at the time services are rendered. We are able to send a courtesy claim to your insurance if you choose. There is no guarantee of benefits. Payment will be credited to your account. However, Dr. Sadilek is not a Medicare participant. Medicare will not cover any services or labs for this office.		Please list contacts that have your consent to receive your medical information.	
NAME OF INSURANCE	WOULD YOU LIKE US TO SUBMIT <input type="checkbox"/> YES <input type="checkbox"/> NO	Myself by: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Answering Machine	
ID #	Group #	Contact _____ phone# _____	Contact _____ phone# _____
		Contact _____ phone# _____	Contact _____ phone# _____

FINANCIAL ARRANGEMENTS AND TREATMENT POLICY

We feel that everyone benefits when there is a definite and clear understanding of our treatment and financial policies prior to treatment. They are intended to allow us to be fair to our entire family of patients and help control the administrative cost.

Medical Consent

By seeking services from Integrative Medical Associates, you authorize the doctor and practice staff to perform necessary services for the patient named above, any treatment, which is deemed advisable by the doctor. You also agree that all disputes concerning the Medical Consent and the treatment shall be resolved by arbitration, which shall be final and binding, held in Pima County, Arizona according to A.R.S. Title 12, Chapter 9, Article 1, as may be amended from time to time.

Appointments

We have exclusively reserved the doctor, nurse, or staff and facilities for your personal health care. We ask our patients to give us a 24 hour notice if you need to cancel or reschedule. If you do not come in for your appointment, or break your appointment without sufficient notice, a \$50.00 per hour broken appointment fee will be applied to your account and you will be required to pre-pay for your next appointment.

For IVs and injections, the fee will be the cost of the IV or injection, unless there is an available time slot for the patient to be rescheduled within 48 hours.

If you are scheduled for multiple appointments for the same day, and you do not come in for your appointment, or break your appointment without sufficient notice, a \$50.00 per hour broken appointment fee will be applied to your account per each appointment missed and you will be required to pre-pay for your next appointment.

Fees

The fees for quality health care are based on the treatment rendered and the time needed to complete the treatment. Our office believes that the fees are a fair representation of the standard of care we provided and in-step with the industry standard.

Payments

All fees are due at the time of service. We accept Cash, Personal Check, Visa and MasterCard.

Insurance

While Integrative Medicine is growing in popularity among healthcare consumers, many insurance companies do not provide coverage for these services. At this time due to insurance limitations, the consultation will remain on a fee for service basis. We do however offer a courtesy insurance billing, provided we have current and accurate benefit coverage information. We will submit your visit to your insurance company

CONTINUE ON OTHER SIDE

for possible reimbursement, depending on your insurance guidelines. However, we will not get involved in any dispute between you and your insurance company.

Please understand that your health benefit program is a contract between you, your employer and the insurance company. We do not have a contract with your insurance company and we do not know the details of what your insurance plan covers. You hold the contract. Therefore, you are responsible to know what your plan covers. In the event that your insurance company pays Integrative Medical Associates, we will gladly apply it to your account, so you would be able to use it towards future visits or purchases. If you would prefer, just ask and we would also be willing to send you a refund check.

If you have authorized us to provide you courtesy insurance billing, then you are agreeing to the following:

- You authorize the insurance company(s), attorney and any third party payers to pay directly to Integrative Medical Associates for any and all services rendered to me or minor who I am responsible that were provided by Integrative Medical Associates.
- You acknowledge that insurance is billed as a courtesy; and you are ultimately responsible for the bill.
- You agreed that Integrative Medical Associates may deliver and release medical records, consultations, depositions and court appearances to any insurance company, adjuster, attorney or legal service bureau.
- You also grant Integrative Medical Associates full power of attorney to endorse and/or sign your name on any and all checks for payment of any debt owed to this office.

Medicare

Medicare does not cover Integrative Medicine. Integrative Medical Associates is not a Medicare participant. We do not submit any claims to Medicare.

Medicare will not pay for integrative services done in this office and will not cover any labs ordered by any of our doctors. If any of our doctors request labs to be done, you have several options, 1) you may take the request to your participating Medicare physician and ask them to process those labs. 2) Have the lab tests done and prepay for your labs here at this office at a discounted rate. 3) Decline to have the tests done.

Finance Charges

Even though we encourage patients to maintain a zero-balance account, in the event your account is not paid in full, a service fee will be incurred on any unpaid balance that is older than 45 days. The service fee will be a minimum of two dollars or 1 ½ % per month (18% annually) of the unpaid balance which ever is greater. In the event that collection efforts become necessary to collect on your account, you are responsible to pay all costs including collection fees and returned check fees.

Returned Checks

There is a minimum of \$30.00 fee for any returned check.

Request for Records, Health Savings Letters and Other Forms

Medical Records: It is the policy of Integrative Medical Associates to charge for the processing of medical records relating to purposes other than continuing care, along with requiring pre-payment of these fees. This is in accordance with ARS 12.2295, A., which states that except as otherwise provided by law, a health care provider or contractor may charge a person who requests copies of medical records a reasonable fee for the production of the records and may require the payment of any fees in advance. Our fees are set at \$25.00 professional fee plus \$1.00 per page up to 20 pages, and \$.25 per page thereafter.

Letters and Forms: When a patient requests a letter or form to be filled out by the doctor or other staff member, a fee will occur when it is not for a medical necessity. There will be a charge for Health Saving Account forms or letters, disability forms, insurance forms, etc.

Termination of Treatment

You play an important role in your own health care. Just as a patient can choose to discontinue care at any time, Integrative Medical Associates reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans and/or financial policies.

Our office would like to thank you for your time, cooperation and trust in us to deliver comfortable, safe and quality care to you, your family and friends. We also appreciate your understanding in the necessity of the aforementioned guidelines and procedures.

I am the patient, parent, guardian, or personal representative of the person listed on page one of the Financial Arrangement and Treatment policy. There are no court orders in effect that prohibit me from signing this consent. **I have read, understand and will abide by the information concerning these office policies.**

Responsible Party Signature

Date

FAMILY HISTORY Fill in health information about your family.					HOSPITALIZATIONS		
Relation	Age	State of Health	Age at Death	Cause of Death	Year	Hospital	Reason for Hospitalization and Outcome
Father							
Mother							
Brothers							
Sisters					DATE	SERIOUS ILLNESS/INJURIES	OUTCOME
Grand Parents							

MEDICATION INFORMATION			
Medication	Dosage / Directions	Doctor	Date Started

LIFESTYLE	DIET Check (✓) any that apply
Stress level on a scale of 1 to 10 (1 being the lowest) _____	<input type="checkbox"/> Sweets, soda, ice cream <input type="checkbox"/> Chocolate
Identify the major stress causes _____	<input type="checkbox"/> Whole grains, legume, cereals <input type="checkbox"/> Skip meals
Exercise daily? _____ Times per week _____	<input type="checkbox"/> Fried foods <input type="checkbox"/> Diet frequently
Type of exercise _____	<input type="checkbox"/> Fruits / Vegetables <input type="checkbox"/> Dine out regularly
<input type="checkbox"/> Use tobacco / smoke cigarettes How many a day _____	<input type="checkbox"/> Drink coffee <input type="checkbox"/> Decaffeinated # cups per day _____
<input type="checkbox"/> Exposed to secondhand smoke	<input type="checkbox"/> Alcoholic beverages # servings per day/week _____

MENSES Check (✓) the symptoms you experience regularly		
One to two week(s) before your period	During your period	Throughout the month
<input type="checkbox"/> Anxiety <input type="checkbox"/> Irritability <input type="checkbox"/> Nervous Tension <input type="checkbox"/> Aggressive or hostile <input type="checkbox"/> Weight gain <input type="checkbox"/> Water retention <input type="checkbox"/> Abdominal bloating <input type="checkbox"/> Tender, swollen and/or painful breasts <input type="checkbox"/> Breast lumps increased in size and tenderness. <input type="checkbox"/> Discharge from nipples <input type="checkbox"/> Craving for sweets <input type="checkbox"/> Increased appetite <input type="checkbox"/> Fatigue <input type="checkbox"/> Headaches <input type="checkbox"/> Insomnia / difficulty sleeping <input type="checkbox"/> Heart palpitations <input type="checkbox"/> Shaky or clumsy <input type="checkbox"/> Withdrawn <input type="checkbox"/> Confused <input type="checkbox"/> Forgetful	<input type="checkbox"/> Cramping in lower abdomen or pelvic area <input type="checkbox"/> Sharp intermittent pain <input type="checkbox"/> Dull aching pain <input type="checkbox"/> Upset stomach <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Low back aches <input type="checkbox"/> Headaches <input type="checkbox"/> Unusual fatigue (take naps) <input type="checkbox"/> Weight gain <input type="checkbox"/> Painful and/or swollen breasts <input type="checkbox"/> Irritability <input type="checkbox"/> Depression <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Mood swings <input type="checkbox"/> Accident prone <input type="checkbox"/> Decreased productivity	<input type="checkbox"/> Decline of vital energy and sense of well being <input type="checkbox"/> Hot Flashes / Night Sweats <input type="checkbox"/> Spontaneous sweating <input type="checkbox"/> Chills <input type="checkbox"/> Depressed <input type="checkbox"/> Anxiety <input type="checkbox"/> Anger <input type="checkbox"/> Headaches <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Urinary problems <input type="checkbox"/> Vaginal problems <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Irregular periods <input type="checkbox"/> Stopped menstruation <input type="checkbox"/> Joint and muscle pain <input type="checkbox"/> Change in sexual desire <input type="checkbox"/> Difficulty with orgasm <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal bleeding after sex <input type="checkbox"/> Vaginal discharge

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____

Date _____