



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

MEN'S HEALTH HISTORY

Name _____ Today's Date _____

Age _____ Birthdate _____ Date of Last Physical Examination _____

Current Major Health Concern(s) _____

Medication Allergies _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the last year.

- | | |
|--|---|
| <p>GENERAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats <p>MUSCLE/JOINT/BONE</p> <p>Pain, weakness, numbness in:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders <p>CARDIOVASCULAR</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins <p>SKIN</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal <input type="checkbox"/> Skin tags <input type="checkbox"/> Skin discoloration | <p>GASTROINTESTINAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <p>GENITO-URINARY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination <p>EYE, EAR, NOSE, THROAT</p> <ul style="list-style-type: none"> <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Double vision <input type="checkbox"/> Vision – flashes <input type="checkbox"/> Vision – halos <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Sinus problems <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Persistent cough <input type="checkbox"/> Bleeding gums |
|--|---|

CONDITIONS Check (✓) any conditions you have or have had in the past.

- AIDS / HIV Positive
- Alcoholism
- Anemia
- Anorexia / Bulimia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Cancer
- Cataracts
- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gout
- Heart Disease
- Hepatitis
- Hernia
- High Cholesterol
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio
- Prostate Problem
- Psychiatric Care
- Rheumatic Fever
- Scarlet Fever
- STDs
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Ulcers
- Valley Fever

Comments

Type: _____

Type: _____

MALE HEALTH

Date Results

Last Prostate Exam _____

Last PSA Blood Test _____

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							
Grand Parents					DATE	SERIOUS ILLNESS/INJURIES	OUTCOME

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

TESTOSTERONE Check (✓) the symptoms you experience regularly or you have a history of.

MENTAL FUNCTION	MUSCULO-SKELETAL	UROLOGICAL PROBLEMS
<input type="checkbox"/> Feeling stressed or "burned" out <input type="checkbox"/> Feeling depressed or negative <input type="checkbox"/> Feeling irritable or angry <input type="checkbox"/> Feeling anxious or nervous <input type="checkbox"/> Feeling mentally fatigued <input type="checkbox"/> Decreased mental sharpness, wit <input type="checkbox"/> Forgetful, poor memory <input type="checkbox"/> Decreased assertiveness <input type="checkbox"/> Loss of motivation or initiative to start new projects, participate in hobbies <input type="checkbox"/> Feeling that work, relationships and hobbies have lost significance METABOLIC SYNDROME <input type="checkbox"/> Increase in total cholesterol or triglycerides <input type="checkbox"/> Decrease in HDL "good" cholesterol <input type="checkbox"/> High blood sugar or diabetes <input type="checkbox"/> High blood pressure <input type="checkbox"/> Development of chest pain, heart disease, blocked arteries <input type="checkbox"/> Unexplained weight gain, particularly in the midsection <input type="checkbox"/> Weight gain in chest or hip area <input type="checkbox"/> Thyroid problem	<input type="checkbox"/> Fatigue or loss of energy <input type="checkbox"/> Feeling sore all over in joints & muscles <input type="checkbox"/> Frequent back or neck pain <input type="checkbox"/> Decrease in physical endurance <input type="checkbox"/> Decrease in muscle size, tone & strength <input type="checkbox"/> Decrease in athletic performance; loss of agility, quickness <input type="checkbox"/> Decline in recovering from physical exercise <input type="checkbox"/> Increased tendency toward muscle pulls or leg cramps <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Neuropathy PHYSICAL PROBLEMS <input type="checkbox"/> Shortness of breath with activities <input type="checkbox"/> Lightheadedness, dizzy spells, ringing in the ears or frequent headaches <input type="checkbox"/> Poor circulation in legs, swollen ankles, varicose veins or hemorrhoids <input type="checkbox"/> Changes in visual acuity, inability to read fine print <input type="checkbox"/> Dry skin on face or hands <input type="checkbox"/> Excessive sweating during the day or at night	<input type="checkbox"/> Adult mumps, orchitis or testicular problems <input type="checkbox"/> Enlarged prostate <input type="checkbox"/> Urinary frequency, reduced flow <input type="checkbox"/> Increased urination at night <input type="checkbox"/> Decrease in urine flow, dribbling <input type="checkbox"/> Take medicine for enlarged prostate <input type="checkbox"/> Increased PSA <input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Prostate Operation <input type="checkbox"/> Inflammation/infection of prostate <input type="checkbox"/> Vasectomy or varicocele <input type="checkbox"/> Infertility problem <input type="checkbox"/> Hernia repair SEXUAL FUNCTION <input type="checkbox"/> Decrease in spontaneous early morning erections <input type="checkbox"/> Decreased libido or desire for sex <input type="checkbox"/> Decrease in fullness of erection <input type="checkbox"/> Decreased volume or strength of force of climax <input type="checkbox"/> Difficulty in maintaining full erection <input type="checkbox"/> Difficulty in achieving an erection <input type="checkbox"/> Premature ejaculation

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