In-depth Functional Medicine / Hormone Form
for Central Family Practice

Thank you for contacting Central Family Practice for an appointment.

While we are a general primary care office, several of our practitioners have specific areas of interest.
Since we do not rely on insurance reimbursement, we have the luxury of spending more time with you to listen and think of the body as an entire system, with all of the pieces acting together. We believe in standard medical practices, as well as complementary and alternative therapies, so we use an integrative approach.

Having a detailed history of your medical problems and symptoms can help us schedule you with the most appropriate practitioner who can help you put the pieces of the puzzle together. It is important that we have adequate time for your first visit to gather as much information as possible to help determine our initial plan. It is also important to have regular follow-up appointments to evaluate your progress, review test results with you, answer your questions and determine the next steps of treatment. Our visit fees reflect the time spent (outside your appointment time) reviewing your records, test results and researching and determining your treatment plan as well as the need to pay our overhead costs and the salaries of our wonderful staff. We will try to respect your time, hard-earned money and energy in this process. If you are ready to work together to improve your health, please read the next sections which cover boring details such as costs and paperwork.

While we don't accept insurance, we will provide you with a detailed bill including medical billing codes, and many patients submit this to their insurance for possible reimbursement. If you have an HSA or FSA fund, this money can be used for your visits. If you have concerns about the costs of tests, medications, etc., we can help you determine the most efficient approach. If you have insurance, it can be used for regular lab tests. If you do not have insurance, our office offers cash pricing through Quest Laboratories. Sometimes we utilize specialty labs and these tests are typically not covered by insurance. If you attempt to use your insurance for specialty testing, you may end up paying 2-3 times the cash price, so we recommend simply paying the cash price for these tests. Visit fees are based on medical billing codes which take into account the time spent during the visit as well as the complexity (whether or not we order labs, reviewing past medical records, medical decision making and the number of problems addressed). Please note: Our schedulers can provide you with a range of costs for follow-up visits, but they will not always be able to provide you with an exact fee. If the complexity of the visit is greater than what the schedule anticipated, the visit fee may be greater than what you were originally quoted.

In order to maximize our time in the office, it is helpful for us to review your information ahead of time. Please return the forms listed below to our office. Once we review the information and determine which practitioner will be the best fit for your needs, our staff will contact you to schedule your appointment and notify you of the price of the initial visit. The range for initial visits is $775-$950. Half of the visit fee will be required to schedule the appointment since we spend time reviewing your information and entering your history into our system before the appointment. The balance will be due at the time of your visit. Please expect 2-4 longer initial visits to thoroughly evaluate your case and determine the initial treatment plan. Once your condition is stable, many issues can be managed with shorter visits. Follow-up visit prices initially are $370-450 and then $190-370 for shorter visits. Specialty test costs range from $100-500. (prices subject to change)

Please complete and return the following forms:
--In-depth Patient History Form (the rest of this document)
--General Registration (if you are a new patient)
--Copies of ALL tests sent to forms@centralfamilypractice.com (labs, x-rays, MRIs, etc) that are pertinent to your concerns.
We can only address tests that have been received at least 48 hours prior to your visit. General labs done in the last 6-12 months are very useful, as are food allergy tests, stool tests, urine organic tests, genetic tests. If you aren't sure if it is important, go ahead and include it. If you do not have copies, please fill out the Medical Records IN form on the website so we can request these from another provider.

CENTRAL FAMILY PRACTICE
AUSTIN'S OLDEST INTEGRATIVE HEALTH CARE

720 W. 34th St. #105
Austin, TX 78705
512.371.9260

Please print

Date: ________________ DOB: ________________ Age: ____________ Sex: M F

Legal Name: ____
Last **First** **Middle**

Preferred Name: ____

Address: ____
Apt#

____
City **State** **Zip code**

Phone: ____________________________ ____________________________
(Primary: Circle - Home, Work or Cell) **(Secondary: Circle - Home, Work or Cell)**

Employer: ________________________ Occupation: ____________________________

Emergency Contact: ____

Relationship: ______________________ Phone: ____________________________

List any Medication Allergies: ____

Household members currently living with you:

Name	Age	Relationship	Health Status

How did you hear about Central Family Practice? ______________________________

How may we contact you?

Check all that apply: ☐ Phone ☐ Cell ☐ Fax ☐ Email

Home Phone: ______________________________ May we leave a message? ☐ yes ☐ no

Work Phone: ______________________________ May we leave a message? ☐ yes ☐ no

Cell Phone: ______________________________ May we leave a message? ☐ yes ☐ no

Fax: ______________________________ May we leave a message? ☐ yes ☐ no

Email: ______________________________ May we leave a message? ☐ yes ☐ no

Central Family Practice Billing Information

I understand that the practitioners at Central Family Practice are NOT Medicare or Medicaid providers (we are opted out), and that claims from our practice can't be submitted to Medicare or Medicaid for reimbursement.

I also understand that Central Family Practice does not participate in any form of third party billing (private insurance plans) and expects payment at the time of services. I understand that I am responsible for filing claims with my own insurance company for reimbursement, and realize that Central Family Practice would be considered an out of network provider.

(Central Family Practice also recommends that since our practitioners are not on your insurance plan, you contact your insurance provider to determine coverage before having any blood work done by labs such as Quest, CPL, or LabCorp. In some instances, it may be less expensive to pay out of pocket for blood work than to pay your insurance portion of lab costs.)

______________________________ ____________________

Patient Signature Date

720 W. 34th St. #105
Austin, TX 78705
512.371.9260

Privacy Notice Acknowledgment

(see page 4)

I acknowledge that I have received a copy of the Privacy Notice for Central Family Practice.

Privacy Notice Revision Date: July 31, 2007

____
Patient or Representative Signature

____
Date

____
Representative's Relation to Patient

Above: Patient or representative use only.
****
Below: Provider use only.

Documentation of Good Faith Effort

The patient identified above was provided with a copy of the HIPPA Privacy Rules on this date. A good faith effort has been made to obtain a written acknowledgment of the patient's receipt of the HIPPA Privacy Rules. However, acknowledgment has not been obtained because:

□ Patient refused to sign the Privacy Notice

□ Patient was unable to sign because:__________________________________

□ There was a medical emergency. Provider will attempt to obtain acknowledgment as soon as practical.

□ Other reason (describe):_____________________________________

____

____ ____________
Employee Signature Date

720 W. 34th St. #105
Austin, TX 78705
512.371.9260

We follow federal HIPPA guidelines in maintaining the privacy of our patient's medical records. The federal HIPPA Privacy Rule and Public Health standards can be found in their entirety at the website: www.hhs.gov/ocr/hipaa/

A summary of our policy for handling your protected health information (PHI) in accordance with HIPPA is as follows:

Upon written request, we will provide you with a copy of your PHI (protected health information). We will process this request in no longer than 30 days following receipt of the request. In certain circumstances, we will send PHI to you without written consent if it is being sent directly to you at the address we have on file and is, for example, a small amount of information such as a lab report. We will also accept verbal authorization from you to send vaccine records to your child's school.

We may deny an individual access to all or part of his or her PHI when:

- Requested information contains psychotherapy notes;
- Information is compiled in anticipation of or for use in a civil, criminal, or administrative action or proceeding;
- Information is requested by an inmate
- A licensed healthcare professional determines that it is reasonable likely that access to the requested information would endanger the life or physical safety of the individual or another person.

PHI can be shared with other practitioners within our practice here at CFP on a "need to know" basis and with the understanding that all practitioners follow HIPPA guidelines related to privacy. You have the right to request restrictions on the uses or disclosures of your PHI. For example, you may request that a particular medical procedure be kept confidential and not shared with other providers. Although we are not required to agree to such a restriction, if we enter into an agreement to restrict, we must abide by the agreement, except in emergency circumstances

Written authorization must be received from you in order for us to release your records to outside entities. In some circumstances, a fee is charged for records requests. Exceptions to written authorization are if the information is being requested for billing/ insurance purposes, if the information is being sent to a practitioner that we have referred you to and is needed in order to provide you with appropriate medical care, in which case permission has been implied in accepting the referral to the practitioner outside of our practice. Another exception would be when PHI is required by other local, state or federal laws, as in the case of reporting abuse or neglect, for example.

If you disagree with a medical opinion in your PHI, you can submit a second opinion to be included in your medical record. However, CFP may deny an individual's request for amendment, for example, if we determine that we did not create the information or that the information would not be available for inspection because the individual does not have a right to access. All requests for amendments must be submitted in writing. Any denial of your request must be explained to you in writing.

Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting Central Family Practice at 512-371-9260.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

______________________________ ______________________________

Patient/Parent/Guardian Printed Name Patient/Parent/Guardian Signature

____

Date

Patient Portal Consent Form

Central Family Practice is offering a secure, HIPAA compliant electronic tool as a free courtesy to our patients. You can access your lab results and emails from your caregiver through this "patient portal". This form is intended to inform you of the facts and risks surrounding its use. By signing below, you confirm that you have read, understand, and agree to comply with our procedures and guidelines for using the Patient Portal. You also agree not to hold Central Family or any of their staff liable for network infractions beyond their control. If there is information that you don't want transmitted via online communication, please inform us.

It works like this: If you provide us your email address and sign this permission form, CFP sends an invitation to your email to accept the portal. The message will contain a user name and a temporary password, (which you will change). Your email address, username and password are confidential and protected. We never share your personal information without your consent. Please remember to keep your password private.

We feel this is a great way for your healthcare provider to communicate directly with you. You can log on and see your results and recommendations at any time. Of course, we will always call you directly for immediate concerns.

Yes, I want to receive information electronically (fill out below information). **OR**

No, I am declining this option

Confidential email (print clearly): ____

Patient Name:____________________________________ Date of Birth:______________

Print name of Parent/Guardian requesting access:________________________________

Signature:____ Date:________________

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NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following telephone number:
1-800-201-9353

For more information, please visit our website at **www.tmb.state.tx.us**

In-Depth Patient History for Central Family Practice

Name:___________________ (First) _____________________ (Last) _____________________ (Preferred Name) DOB Sex: M F

Are you visiting with Dr. Pugh or Dr. Ziedonis

Please list your current symptoms/concerns:

)

Please stop here and continue on last page if more space is needed.

Past Medical History — Please check if you currently have, or have a significant history of the following (brief details are all that are needed, we will clarify questions at your visit):

General: Chronic fatigue Intermittent fatigue Weight gain Weight Loss How many pounds?_______
Fevers Chills Night Sweats Trouble going to sleep Trouble staying asleep Daytime drowsiness

Eyes: Glaucoma Dry eye Uveitis Episcleritis Cataracts Surgery and dates:______________________
Other eye issues:

Allergies: Seasonal Year-round Hives Aspirin allergy Latex allergy Nasal polyps Mold exposure
Medication allergies:
Food allergies:

Heart: Chest pain Heart racing Irregular heartbeat Trouble breathing when lying down High cholesterol
High blood pressure Heart murmur Heart attack Stent Stroke Varicose veins Blood clots
Other heart issues:

Lungs: Shortness of breath Chronic cough Chronic sputum (phlegm) Dry cough Pneumonia
Frequent bronchitis COPD/emphysema Exposure to tuberculosis Exposure to Asbestos
Asthma: Childhood Chronic Occasional Ever hospitalized? Y N Ever intubated? Y N
Currently use inhaler or other asthma med? Y N If so, what brand(s):
Other Lung issues:

GI: Abdominal pain: Left Right Upper Lower Middle Cramping Vomiting Bloating Loose stool
Watery stool Hard stool Clay-colored stool Bloody stool Mucous in stool Excessive gas Burping
Acid reflux/heartburn Trouble swallowing Stool urgency Intestinal infection/parasite Celiac disease
Irritable bowel syndrome Crohn's disease Ulcerative Colitis Gallbladder problems: surgery? Y N
Have you had an endoscopy? Yes No Date_______ Have you had a colonoscopy? Yes No Date__________
How often are your bowel movements? #________per day week Hemorrhoids
Other stomach issues:

Kidneys/bladder: Burning with urination Difficult to urinate Chronic urine frequency Chronic bladder pain
Blood in urine Urine urgency Kidney stone Frequent urine infections: #_____ per year
Other kidney/bladder:

Skin: Frequent rashes Itching Psoriasis Rosacea Eczema Frequent boils/abscesses Nail problems
Skin cancer? Type:_____________When:____________ Skin Cancer screening? Yes No Date:_____________
Other Skin:

Name:____ Date of birth:______________

Musculoskeletal: Joint pain Joint stiffness Joint swelling Joint redness Hot joints Muscle pain
Bone pain Muscle fatigue Muscle cramps Muscle twitches Muscle weakness Osteoporosis/Osteopenia
Osteoarthritis (general wear and tear) Rheumatoid arthritis Gout Lupus
Other musculoskeletal:

Neurological: Headaches (if frequent, please complete headache history form) Numbness Tingling
Vision problems Hearing problems Memory problems Foggy headed MS Epilepsy
Other neurological disease:

Endocrine: Diabetes Hypothyroid Hashimoto's Hyperthyroid/Graves Adrenal problem Intolerant to cold
Intolerant to heat Always thirsty Always hungry Crave sweets Crave salt

Blood/lymph: Swollen lymph glands Easy Bruising Anemia Platelet disorder Blood clot
Infections: HIV Hepatitis A B C Syphilis Gonorrhea Chlamydia Herpes: Cold sores Genital
Chicken pox Shingles Mono/Epstein Barr Chronic yeast infections HPV/Genital warts
Cancer (where/when?): ________________________ Positive TB Skin Test Exposure to HIV

Psych: Depression Anxiety Panic attacks Bipolar Schizophrenia Ever hospitalized? Y N
History of sexual abuse History of physical abuse History of mental/emotional/other abuse Alcoholism Stress

Men: Trouble getting erection Trouble maintaining erection Low sex drive Nighttime urination
Length of time with current sexual partner: _________

Women: Irregular periods Heavy Periods Painful Periods PMS Menopause/Perimenopause Last menstrual period: _______
Number of times pregnant: ____ Miscarriages/abortions: ____ Number of live births: ____ Number of still births: ____
Breast pain Discharge from nipples Breast lump (undiagnosed) Vaginal pain Vaginal Discharge
Vaginal itching Hot flashes Vaginal dryness Low sex drive
Date of last: Pap:_________ Mammogram: ___________ Bone density: ___________
Hysterectomy: uterus only/uterus and ovaries removed Reason:___________
Period length (days): _____ Usual interval between periods (days): _____ Age of first intercourse: _____ Age of first period:
Infection: ovary or fallopian tube Ovarian cyst Abnormal pap smear DES exposure Currently trying to get pregnant
Difficulty achieving orgasm Length of time with current sexual partner: _________

Which of the following contraceptive methods have you used: (please circle)

IUD Diaphragm
Birth control pills
Condoms
Foam
Vasectomy
Tubal ligation
None
Other _____________________
None, same sex preference
Natural family planning

Hormonal Symptoms:
For women - Please rate all that apply from 1-10, with #1 being barely noticeable to #10 being unendurable.

Abdominal bloating _____
Allergies _____
Anxiety _____
Angry _____
Appetite increase _____
Appetite decrease _____
Bleeding and spotting (not menses) _____
Breast tenderness and swelling _____
Craving sweets and starches _____
Craving salt and fat _____
Craving (other) specific _____
Constipation _____ Crying _____
Depression or sadness _____
Diarrhea _____

Fatigue _____
Headaches _____
Heavy menstrual bleeding _____
Hot flashes _____
Irritable _____
Insomnia _____
Menstrual cramps _____
Moody _____
Nausea _____
Night sweats _____
Sexual pleasure/arousal (inc/dec) _____
Swelling _____
Trouble concentrating/remembering _____
Vaginal dryness _____

Name:____ Date of birth:______________

Surgeries: Tonsillectomy Adenoidectomy Appendectomy Gallbladder removal (cholecystectomy)
Thyroid surgery: Partial Full
Other:

Any other conditions not listed?

Childhood history:

Any problems at birth or in childhood? (surgeries, infections, birth defects)
Did you have antibiotics more than 3 times in childhood? Yes No

Social history:

Alcohol intake: None <5 drinks per year <5 drinks per month <7 drinks per week
7--14 drinks per week >14 drinks per week Are you concerned about your drinking?

Smoking/Tobacco: Current smoker/tobacco user? Yes No Type: Cigarettes E Cig Smokeless

If yes, how many per day? Interested in quitting? Yes No

Past smoker? Yes No Year started using: _______ Year Quit: ________

Any use of the following? Marijuana Cocaine IV drugs Inappropriate prescription use Other:__________

Do you exercise? Yes No How many times per week? _____ Activities:_________________________

Are you exposed to any toxins at home, work or during hobbies? _________________________ Mold exposure

Anything we need to know about stress, home situation, etc?

Diet:

Do you follow any particular diet? Vegetarian Vegan Pescatarian Gluten Free Dairy Free Other:________
Do you: Drink Milk Drink soy milk Drink Almond Milk Eat soy Eat sugar/sweets often
Do you cook? Yes No Are you open to trying diet changes? Yes No
Do you avoid any foods for religious or other reasons?
How often do you eat out? Number of days per week____________
How many fruits/vegetables do you have per day? ___________
Do you drink soda? Yes No If yes, # per week: ____________ Regular or Diet sodas _____________
Do you have a history of eating disorder or unhealthy eating habits? Yes No
Do you have problems with any particular foods? (List food and reaction)
Are you concerned about your eating habits? Yes No
Do you consider your diet healthy? Yes No
Are you having problems with over-eating? Yes No

Name:____ Date of birth:______________

<u>Family History:</u> Please list any known medical conditions for each family member. All things are important, but be sure to include cancers (including type), heart attacks (age it occurred, stents, bypass surgery, etc.), strokes, diabetes, blood clots, autoimmune diseases, genetic diseases, mental health issues, etc. A detailed history is useful (if known), so please use back if more space needed. If deceased, please state so and list age of death.

Mom:

Dad:

Brother(s):

Sister(s):

Maternal grandmother:

Paternal grandmother:

Maternal grandfather:

Paternal grandfather:

Aunts/uncles:

Aunts/uncles:

If you see any specialists on a regular basis (cardiologist, allergist, etc.) please list their name and specialty:

We often recommend vitamins and other supplements in my treatment recommendations. Supplements are not regulated by the FDA, and can vary between manufacturers. We believe that good quality supplements can augment other treatments and can sometimes treat conditions for which we do not have prescription options. Are you open to the use of supplements in your treatment? (Circle One)

Definitely, I prefer them to prescriptions Yes, whatever is best Maybe No, they make expensive urine

Name:____ Date of birth:______________

<u>Medications/supplements:</u> Please list all prescription and non-prescription medications. OK to list on separate page if needed, but please include all information. No need to list dose of combination supplements. Make note of any specific information (brand needed, etc.). Also list medications that you take as needed (headache medication, allergy medication, etc.)

Name (For supplements, list name and manufacturer)	Dose	Number of pills	Times per day

If you take a lot of supplements, it is most helpful if you bring the actual bottles to your appointment so we can look at all of the ingredient lists together to avoid duplication

Name: ____ **Date of Birth:** ____________________

Additional information: