A FEW NOTES:

Please complete ALL of the attached forms. Bring them completed to your visit.

Bring DL and Insurance cards--- we verify this at EVERY visit

We accept Cash, Credit, or debit for copays and deductibles (checks, American Express, or Discover are NOT accepted)

Please list ALL medications, including supplements and vitamins, as well as the dose and instructions on the med list provided.

Please make sure you have all of the above items or your appointment will be prolonged and may require rescheduling.

Call 205-593-4200 if you have questions.

We look forward to seeing you!

Functional Medicine of Alabama

Patient Demographics

Last: _____ First: _____ Middle: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

DOB: _____ Sex: _____ Marital Status: _____

Email: _____ may we share information via email yes/no

Social security #: _____ DL #: _____

Occupation: _____ Employer: _____

Insurance

Primary: _____ Secondary: _____

Insurance subscriber, if other than patient: _____

DOB: _____ relationship: _____

Emergency Contact

Name: _____ Relationship: _____

Phone: _____

Consent to share information with the following individuals:

_____ _____ _____

Consent to treat

I, the undersigned patient, hereby authorize Dr. St. Petery and her staff to administer diagnostic testing, procedures, and treatments as considered necessary based on the findings during the course of the examination and treatment. I hereby certify that I have read and fully understand the above Consent to Treat. I also certify that no guarantee or assurance has been made as the end results following my treatment.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Assignment of Benefits

I, _____, hereby assign all medical and or/surgical benefits, to include major medical benefits to which I am entitles, including government sponsored programs, private insurance, and any other private insurance plans for services rendered by Functional Medicine of Alabama, PC. This assignment will remain in effect until revoked by me in writing. I hereby authorize Functional Medicine of Alabama, PC to release all information necessary to secure payment of said benefits.

Financial Responsibility and Non-coverage statement

I, _____, am responsible for all charges on this account. I am aware that there are services that may be rendered that may not be covered by insurance. This could include services beyond maximum benefits allowed in a calendar year, not medically necessary, etc. I understand that if services are billed to my insurance and are denied for any reason, that I am financially responsible. This includes denials for maximum benefits paid, non-coverage, insurance termination, unmet deductibles, etc. I understand that my claims are being filed as a courtesy and that any balance that remains is my responsibility. Overdue accounts may be placed with a collection agency or an attorney for collection. In the event that my account is turned over to a collection's agency or attorney, I agree to pay the collection charges, attorney fees, court costs, and any other reasonable costs to collection.

HIPAA Patient Consent

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

-Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment, both directly and indirectly.
-Obtain payment from third party payers
-Conduct routine healthcare operations, such as quality assessments and physician certifications.

By reading this paper, I have been informed by Functional Medicine of Alabama, PC of the existence of the office's Notice of Privacy Practice, which contains a more complete description of the uses and disclosures of my health information. I realize that I have the right to review the office Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practice from time to time, and that I may contact this organization at any time (during routine business hours) to obtain a copy of the Notice of Privacy Practice.

I understand that I may request in writing that Functional Medicine of Alabama, PC restrict how my private information is used or disclosed to carry out treatments, payment, or healthcare operations. I also understand that Functional Medicine of Alabama, PC is not required to agree to my requested restrictions, but that if they do agree, the office will be bound to abide by such restrictions.

I understand I may revoke this consent in writing at any time.

Printed Name: _____

Patient Signature: _____ Date: _____

Functional Medicine of Alabama, PC
Payment Policy

We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Missed appointments:** Our policy is to charge $150.00 for all missed appointments not cancelled with a notice of 24 business hours prior to the scheduled visit. Saturday and Sunday are not included in business days and messages left on those days are not valid and will result in a missed appointment fee. Monday appointments must be cancelled by close of business the Thursday prior to the appointment. These charges will be your responsibility and billed directly to you. Phone call reminders and emails are a courtesy and do not excuse a missed appointment. Please help us to serve you better by keeping your regular scheduled appointment. In the event of a missed appointment you will be charged $150.00.
2. **Insurance:** We are participating providers with several insurance plans. We will file all of the insurance claims for these plans. **Please remember that insurance is a contract between the patient and the insurance company an ultimately the patient is responsible for payment in full**. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.
3. **Copays and deductibles:** All copays and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copays and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copay at each visit.
4. **Non covered services:** Please be aware that some, and perhaps all, of your services you received may be non-covered or not considered reasonable or necessary by Medicare of other insurers. You must pay for these services in full at the time of visit.
5. **Proof of insurance:** All patients must complete our patient information before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
6. **Coverage changes:** If your insurance changes, please notify us before your next visit so me can make appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 calendar days the balance will automatically be billed to you.
7. **Nonpayment:** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payment will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency and you and your immediate family members will be discharged from this practice.
8. **Non participating insurance accounts/self-pay:** We contract with some insurance carriers, but not all. If you are insured by a company with which we do not contract, you will be considered a self-pay patient and full payment is due at the time of service. We can supply you with the statement of your charges. You may submit this, along with any additional forms your insurance requires, to your insurance company for reimbursement. **Due to many different insurance products, our staff cannot guarantee your eligibility and coverage. It is your responsibility to check with your insurer's member benefits department about services and providers before your appointment.**
   _____ I have non-participating insurance policy and will be self- pay
   _____ I have no health insurance and will be self-pay
9. **Forms of payment:** We accept cash, Visa, and Mastercard. NO checks, American express or Discover. Our practice is committed to providing the best treatments to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have questions or concerns.
10. **Supplements:** All supplement sales are FINAL. It is the patient's responsibility to check supplements to see if they are allergic to any of its ingredients. **NO REFUNDS OR EXCHANGES ARE ALLOWED.**

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party: _____ Date: _____

Staff signature: _____Date: _____

Medication List

Name: _____ DOB: _____

Allergies:_____

Please list all medications, including supplements, as well as the strength and instructions:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

History and Physical

Name: _____ DOB:_____

Hospitalizations/Surgery

Date: _____ Reason: _____ Date: _____ Reason: _____
Date: _____ Reason: _____ Date: _____ Reason: _____
Date: _____ Reason: _____ Date: _____ Reason: _____

Medical History

____Allergies	____Diverticulosis	____Kidney stones	____Throat-frequent sore
____Anemia	____Fatigue- chronic	____Lactose intolerant	____Urination-loss of control
____Swollen ankles	____Gallbladder trouble	____Mental illness	____ urination-decrease
____Appetite- loss of	____Gout	____Osteoporosis	____urination-painful
____Asthma	____Headaches	____Thyroid disease	____Varicose veins
____Back Pain	____Heart Murmur	____Prostate disease	____venereal disease
____Bone/Joint injury	____Hemorrhoids	____Psoriasis/Eczema	____ Other
____Bowel changes	____Hernia	____Sexual/Menstrual	_____
____Cancer	____High blood pressure	____Sinus issues	_____
____Convulsions	____Indigestion	____Stool-bloody	_____
____Constipation	____Infections-recurrent	____Stroke	_____
____Diabetes	____Jaundice/Hepatitis	____swallowing difficulty	
____Diarrhea	____Kidney stones	____sleep issues	

Family History

	Father	Mother	Sibling	Grandparent
Alcoholism	_____	_____	_____	_____
Asthma	_____	_____	_____	_____
Bleeding disorder	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Epilepsy/Seizures	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____
Kidney disease	_____	_____	_____	_____
Mental illness	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____
Stroke	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Habits

Alcohol: yes / no amount:_____ Exercise: _____
Coffee: yes / no amount:_____ Smoker: yes / no / former amount: _____
Caffeine: yes / no type/amount:_____ salt intake: _____

7 Day Food Journal----Please list EVERYTHING you eat and drink!

Day 1

Breakfast_____

_____

Lunch_____

_____

Supper_____

_____

Other_____

_____

Day 2

Breakfast_____

_____

Lunch_____

_____

Supper_____

_____

Other_____

_____

Day 3

Breakfast_____

_____

Lunch_____

_____

Supper_____

_____

Other_____

_____

Day 4

Breakfast_____

_____

Lunch_____

_____

Supper_____

_____

Other_____

_____

Day 5

Breakfast_____

_____

Lunch_____

_____

Supper_____

_____

Other_____

_____

Day 6

Breakfast_____

_____

Lunch_____

_____

Supper_____

_____

Other_____

_____

Day 7

Breakfast_____

_____

Lunch_____

_____

Supper_____

_____

Other_____

_____

THE INSTITUTE FOR FUNCTIONAL MEDICINE®

Toxin Exposure Questionnaire (TEQ-20)

Patient Name_____ Date_____

Please check YES or NO for each of the following questions. Your provider will discuss your answers with you.

QUESTIONS	YES	NO
1. Do you consume conventionally grown (non-organic) fruits and vegetables regularly? If so, which ones do you eat most often? _____	☐	☐
2. Do you consume conventionally raised animal products (meat, dairy, eggs) regularly? If so, which ones do you eat most often? _____	☐	☐
3. Do you consume fish or seafood more than twice a week? If so, please describe what you eat and whether it is farmed or wild. _____	☐	☐
4. Do you consume fast foods, canned/packaged foods, soda, or foods with artificial colors, flavors, preservatives or sweeteners more than three times a week?	☐	☐
5. Have you lived in a mobile home, boat, or RV, or a very old or brand-new home? If so, please describe: _____	☐	☐
6. Have you recently been exposed to new construction materials or furniture (e.g., paint, laminate flooring, particle board, new carpeting, bedding, furniture, etc.)?	☐	☐
7. Does your home or workplace have cracking paint or decaying insulation or foam, visible mold, water damage, or damp windows, basement, or crawlspaces?	☐	☐
8. Are you often exposed to adhesives, paints, flea treatments, varnishes, solvents, welding/soldering materials, or other air-borne chemicals at home or work?	☐	☐
9. Have you been exposed to treated lumber, lead paint, paint chips or dust, broken mercury thermometers or fluorescent bulbs, or other toxic substances you know of?	☐	☐
10. Do you drink water from a well, spring, or cistern, or from plumbing pipes or fixtures installed before 1986?	☐	☐
11. Do you regularly use conventional cleaning chemicals, disinfectants, hand sanitizers, air fresheners, scented candles, or other scented products at home or work?	☐	☐
12. Are your health concerns related to time spent living or working adjacent to a highway, factory, incinerator, gas station, power plant, or other industrial pollution source?	☐	☐
13. Have you lived in an agricultural area or often been exposed to herbicides, pesticides, fungicides at home, work, parks & golf courses, or roadsides?	☐	☐
14. Do you live near a cell phone tower, high-voltage power lines, or other known source of electromagnetic radiation?	☐	☐
15. Do you live or work in a sealed building with recirculated air or a building that has wood, propane, or gas stoves or appliances?	☐	☐
16. Do you smoke or are often exposed to second-hand smoke, fly often, or run or bike to work along busy streets?	☐	☐
17. Are you highly sensitive to smoke, perfumes, fragrances, cleaning products, gasoline, or other fumes? If so, please explain: _____	☐	☐
18. Have you had root canals, tooth extractions, "silver" fillings, crowns, dental sealants, dentures, retainers, aligning trays, braces, mouth guards, dental implants, etc.?	☐	☐
19. Have you had any unusual reactions to anesthesia or to prescription or over-the-counter medications? If so, please describe: _____	☐	☐
20. Do you have a history of heavy use of alcohol or recreational or prescription drugs? If so, please describe or discuss with your provider: _____	☐	☐

THE INSTITUTE FOR FUNCTIONAL MEDICINE®

Medical Symptoms Questionnaire (MSQ)

Patient Name_____ Date_____

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale
0 – ***Never or almost never*** have the symptom
1 – ***Occasionally*** have it, effect is ***not severe***
2 – ***Occasionally*** have it, effect is ***severe***
3 – ***Frequently*** have it, effect is ***not severe***
4 – ***Frequently*** have it, effect is ***severe***

HEAD

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia

Total _____

EYES

_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
(Does not include near or far-sightedness)

Total _____

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss

Total _____

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation

Total _____

MOUTH/THROAT

_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores

Total _____

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating

Total _____

HEART

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain

Total _____

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing **Total** _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain **Total** _____

JOINTS/MUSCLE

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness **Total** _____

WEIGHT

_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight **Total** _____

ENERGY/ACTIVITY

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness **Total** _____

MIND

_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities **Total** _____

EMOTIONS

_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression **Total** _____

OTHER

_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge **Total** _____

Grand Total _____