

Welcome to the Lifetree Center for Integrated Medical Practice

Thank you for requesting an appointment with us. We look forward to meeting you soon.

For appointments with:

__ John MacCallum, MD

Upon **completing and returning the enclosed information**, we will contact you to schedule your first visit. New patients are added on this basis only. Your commitment to participate in your treatment and keep scheduled appointments is very important. No Shows on first appointment will not be rescheduled. Also, please note Center's cancellation policy.*

__ Sheri Browning, MA, LCSW

Please **bring all completed information** at your first visit, so that session time is not used for paperwork. Please note cancellation policy.*

__ Qingguo Shang, OMD

Please **arrive 15 minutes early** to complete contact information. Payment is required at time of service. We provide receipt to submit to your insurance. First visit: \$60. Return visits: \$50. Herbs are additional. Please note cancellation policy.*

__ Dallas Martin, DO

Services are elective and not covered by insurance. Payment is required at time of service. Please **arrive 15 minutes early** to complete contact information. Please note cancellation policy.*

__ Derenda Weekly, LMT

Massage fee is due at time of service. We provide receipt to submit to your insurance. Please **arrive 15 minutes early** to complete paperwork so that session time is not used for this. Please note cancellation policy.*

__ Thermography Staff

Thermography is not yet covered by insurance. The \$150 fee is required at time of service. Please **arrive 15 minutes early** to complete contact information.

**Cancellation policy: Patient agrees to pay full fee for cancellations less than 24 hrs. and for No Shows.*

Our cancellation policy is enforced, except in clearly non-choice circumstances,
in respect for our time commitment to you
and in support of persons waiting and needing to be seen.

If forms are included in this mailing, please **read and complete all sections, including each signature line**. Call if you have any questions (304-757-3368). Please **bring your current insurance card(s)** for us to copy. The enclosed brochures will inform you regarding our many services

If you are unable to keep your appointment, kindly call as soon as possible so we can schedule the next earliest time for you and offer the time to someone who has been waiting on our cancellation list. Again, we look forward to meeting you and doing our best to support your health and well-being.

Thank you for choosing to work with us.

Sincerely,

The Lifetree Center for Integrated Medical Practice

Your appointment: will be scheduled upon receipt of your information
 is on _____ at _____

Our location is 3855 Teays Valley Rd., Hurricane, WV, beside Appalachian Tire Products and across from the KO Carwash (5 min. off the Teays Valley Exit from I64, near the intersection to Putnam General Hospital). Our name is included in the sign out front and there is ample off-street parking. Our entrance is at the left rear corner of the building, directly behind Teays Valley Chiropractic in the front. **304-757-3368**

Date _____

PATIENT REGISTRATION

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

PATIENT INFORMATION

SOCIAL SECURITY# _____

HOME ADDRESS _____

FIRST NAME _____ MIDDLE _____

LAST NAME _____

CITY _____ STATE _____ ZIP _____

SEX _____ DATE OF BIRTH _____

EMAIL _____

MARITAL STATUS MARRIED SINGLE
 DIVORCED WIDOWED

HOME PHONE _____

WORK PHONE _____

(CHECK ONE) EMPLOYED RETIRED FULL TIME STUDENT

OTHER _____

REFERRING PHYSICIAN _____

EMPLOYER _____

HOW DID YOU HEAR OF US? _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

Commercial Medicaid Medicare Worker's Compensation Other _____

INSURANCE COMPANY _____

INSURED/CARD HOLDER'S NAME _____ RELATIONSHIP _____

POLICY # _____ GROUP # _____ PHONE _____

SECONDARY INSURANCE INFORMATION

Commercial Medicaid Medicare Worker's Compensation Other _____

INSURANCE COMPANY _____

INSURED/CARD HOLDER'S NAME _____ RELATIONSHIP _____

POLICY # _____ GROUP # _____ PHONE _____

WORKERS' COMPENSATION INFORMATION

COMPANY NAME _____

COMPANY PHONE _____

SUPERVISOR'S NAME _____

SUPERVISOR'S PHONE _____

EMERGENCY CONTACT

SOCIAL SECURITY # _____

SEX _____

FIRST NAME _____ MIDDLE _____

HOME PHONE _____

LAST NAME _____

WORK PHONE _____

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY# _____

SEX _____ DATE OF BIRTH _____

RELATIONSHIP _____

DAYTIME PHONE _____

FIRST NAME _____ MIDDLE _____

EMPLOYER _____

LAST NAME _____

ADDRESS _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

CITY _____ STATE _____ ZIP _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

SIGNATURE (Patient or Parent if Minor) _____ DATE _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process my insurance claims.

SIGNATURE _____ DATE _____

JANUARY 6, 2006

THE INSURANCES THAT WE ACCEPT ARE:

ACORDIA

ACORDIA PEIA

ACORDIA CHIPS

AETNA

MOUNTAIN STATE BLUE CROSS BLUE SHIELD

CARELINK (MEDICAL)

MEDICARE

Lifetree Center for Integrated Medical Practice

Admission Agreement

To be accepted as a patient or client,

we want you to be a committed partner to your own healing
and expect you to be respectful of and agreeable to our business policies:

1. I agree to pay my deductible, co-pay, and any balance in full at each appointment.
2. I agree to pay full fee for cancellations less than 24 hours, and missed appointments.
3. I agree to allow 24 hours, to pick up any prescription which must be called in.
4. I agree to pay the fee (\$30 minimum) for special reports requested.
5. I agree to participate in person and on the phone in the same spirit of kindness and respectfulness the Center Staff is committed to in its relationship with me.

My signature confirms that I accept these agreements and believe that I fully understand their meaning.

Signature: _____

Date: _____

Printed Name: _____

I verify the above named person has chosen to be accepted as a patient/client.

Staff Witness: _____

We support your freedom of choice.
Choosing not to keep these agreements at any time will be a sign
that your relationship with us may no longer be a good fit.
If ever needed, we will try to offer other resource information

“We devote our healing skills and talents to mutually respectful relationships.”

Lifetree Center for Integrated Medial Practice

CLIENT CONSENT TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I understand I have the right to review Lifetree Center for Integrated Medial Practice Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me.

_____ (*Client Initials*). The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information (PHI) that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Lifetree Center for Integrated Medial Practice. My “protected health information” means health information, including my demographic information (name, address, phone number and other) that is collected from me and created or received by my healthcare providers or health insurer. This PHI related to my past, present or future physical or mental health condition and identifies me, or there is reasonable basis to believe the information my identify me. The Notice also describes other potential releases of my PHI that may occur with or without my authorization and my right regarding my health information.

Lifetree Center for Integrated Medial Practice reserves the right to change the privacy practices that are described in the Notice. Lifetree Center for Integrated Medial Practice will proved me with a copy of any revisions to the Notice upon request. I may obtain a revised Notice by visiting Lifetree Center for Integrated Medial Practice office by call Lifetree Center for Integrated Medial Practice and requesting a revised copy by sent in the mail or by asking for one at the time of my next visit.

I understand that I have the right to request restrictions on how my PHI is used or disclosed to carry out treatment, payment, or healthcare operation. Lifetree Center for Integrated Medial Practice is not required to agree to the requested restrictions, however, if there is agreement, the restrictions is binding on Lifetree Center for Integrated Medial Practice until the agreement is terminated.

By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations and acknowledge receipt of our Notice of Privacy Practices.

I authorize the following people to discuss my treatment, payments and healthcare operations.

| | |
|---|---------------|
| _____ Signature of Client (12 years of age or older) | _____ Date |
| _____ Signature of Parent/Legal Representative | _____ Date |
| _____ Witness Signature | _____ Date |

Lifetree Center for Integrated Medial Practice
3855 Teays Valley Road
Hurricane, WV 25526

Today's Date _____

Name Date of Birth

Single/Married/Divorced/Widowed(circle one)

How Long? _____

Occupation _____ How Long _____

Hours Per Week _____

Job Satisfaction Yes/No _____

Spouse Name _____ Age _____ Occupation _____

Health of spouse: Excellent/Fair/Poor (circle one)

Concerns: _____

Children: _____

Name Age Concerns

Name Age Concerns

Name Age Concerns

What Problems are you seeking help for today?

List of doctors/health practitioners currently being seen.

| Name | Reason |
|-------|--------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Past Medical History

| Diagnosis | Date of Onset | Treatment |
|-----------|---------------|-----------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Past Surgical History

| Surgery | Date | Additional Information |
|---------|-------|------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Current Medications
Name of Medication

Dosage

When Taken

| | | |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

List allergies to any medications:

Vitamins/Supplements

| Name | Dosage | When Taken |
|-------|--------|------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Habits

Tobacco Use: Yes No Quit/When _____

Drug Use: Yes No
Details _____

Alcohol Use: Yes No
Frequency _____

Caffeine Use: Yes No

Carbonation Drinks: Yes No

Dairy Intake Yes No

High Yeast Foods: Yes No

Exercise: Yes No Rarely Occasionally Frequently
Type: _____

Approximate Daily Water Intake: _____

Sleep:
Average Hours per night: _____

Do you feel rested? Yes No

Family History:
Circle any that apply: Heart Disease High Blood Pressure Thyroid Disease Diabetes
Others:

Female History:

Age periods began: _____

Premenstrual Symptoms: _____

Date of last period: _____

Menopausal? Yes No

Hot Flashes: Yes No

Night Sweats: Yes No

Day Sweats: Yes No

Mood Swings: Yes No

Taking Hormones: Yes No

How long: _____

Date of most recent pelvic exam _____

Date of most recent Bone Density Test _____

Breasts:

Fibrocystic Disease: Yes No

Breast Cancer: Yes No

Breast Tumor: Yes No

Mark your Energy Level

Low

Normal

High

Mark your Libido Level

Low

Normal

High

Check all that apply and describe in detail on the right:

HEENT:

Headaches, Dizziness, Visual Changes, Cataracts,
Ringing in Ears, Vertigo, Hearing Difficulties,
Nose Bleeds, Sinusitis, Difficulty Swallowing,
Dental Problems, Amalgam (silver) Fillings,
Earache, Voice Changes, Hearing Changes

GI:

Change in Appetite, Upset Stomach/Burning,
Reflux, Nausea/Vomiting, Vomiting Blood,
Bloody Stools, Gas, Constipation, Diarrhea,
Laxative Use, Abdominal Pain, Ulcers,
Hemorrhoids, Black or Tarry Stools

GU:

Painful/Frequent Urination, Hesitancy, Urination at night,
Incontinence, Blood in Urine, Kidney Stones, Infections

Female: Discharge, Vaginal Infections/Bleeding,
Sexually Transmitted Disease

Male: Discharge, Impotence, Testicular Masses
Sexually Transmitted Disease

M-SK:

Joint Swelling/Pain/Deformity, Arthritis, Muscle Aches
Muscle Pain, Weakness, Spasm, Loss of Strength, Injury,
Fractures, Osteoporosis, Osteopenia

ENDOC:

Excessive Consumption of Liquids/Excessive Urination,
History of Diabetes, Skin/Hair Changes
Thyroid Problems, Cold/Heat Intolerance,
Hormonal Therapy, Weight Gain, Weight Loss

INTEG:

Rashes, Ulcers, Discolorations, Dry Hair/Skin, Bruising

Practitioner Use Only:

Height: _____ Weight: _____ T _____
P _____ R _____

Blood Pressure: (R) (L)

| | | |
|---------------|-------|-------|
| Lying: | _____ | _____ |
| Sitting: | _____ | _____ |
| Standing: | _____ | _____ |
| Heart Sounds: | _____ | _____ |
| Lung Sounds: | _____ | _____ |

Additional Information