ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Total Approach Wellness and Aesthetics
200 Forsythe Street
Fayetteville, NC 28303
Office: (910) 322-7368
Fax: (910) 483-5796
www.TAWellness.net

I, _____ have read (available at the practices website)
(Name of Patient)

Total Approach Wellness and Aesthetics' "Notice of Privacy Practice".

_____
(Signature of Patient or Guardian)

Staff Will Fill Out This Section if Patient's Signature is Not Obtained

Our office made a good faith effort to obtain **Acknowledgement of Receipt** of our Notice of Privacy Practices, but it could not be obtained for the following reason:

_____ Patient refused to sign.

_____ Emergency situation kept us from obtaining the patient's signature

_____ Language barrier kept us from obtaining the patient's signature

_____ Other: _____

_____

Metabolic Assessment Form

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Name: _____ Age: _____ Sex: _____ Date:_____

Part 1: Please list the 5 major health concerns in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

What is your health goal and how able are you to dedicate efforts towards your health?

_____
_____
_____
_____

Part 2: Please circle the appropriate number to all questions below and then tally your score.

If you never experience the symptom, leave it blank. Rank the system in terms of frequency and severity with 1 being the lowest and 3 the highest. If you have a certain diagnosis, some of these will give you an automatic 5 points.

Category I: GI			
Leaky Gut			
Diagnosis of Celiac, Crohn's, Colitis or IBS (5 points)			5
Diarrhea	1	2	3
More than 3 bowel movements a day	1	2	3
Stools that are green or clay colored	1	2	3
Mucous on the stool	1	2	3
Bloating	1	2	3
Constipation	1	2	3
Hard, Dry, or small stool	1	2	3
Sense of Fullness with little food	1	2	3
Difficulty with fatty foods	1	2	3
GERD/Reflux	1	2	3
Belching, burping	1	2	3
Frequent use of antibiotics	1	2	3
Stomach Pain	1	2	3
Total			

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A. Dysbiosis/Candidiasis			
Gas	1	2	3
Bloating with carbohydrates/sugar	1	2	3
Sugar Cravings	1	2	3
White Tongue	1	2	3
Worse with sugar or carbohydrates	1	2	3
Brain Fog	1	2	3
Foul Smelling Gas	1	2	3
Rectal Itching	1	2	3
Toe fungus, jock itch, athletes foot	1	2	3
Bad breath	1	2	3
Worse with vegetables/fruit/fiber	1	2	3
Total			
Category II: Toxicity			
Gallbladder removal			5
Sensitive to Smells	1	2	3
Can't have caffeine late in the day	1	2	3
Often have opposite reactions to medications and supplements	1	2	3
Use or around pesticides	1	2	3
Frequent dry cleaning	1	2	3
Leakage, wet carpets, or water damage	1	2	3
Feel better when I leave my home	1	2	3
Bitter metallic taste in the mouth	1	2	3
History of gallbladder attacks or stones	1	2	3
Itchy Skin	1	2	3
Reddened skin	1	2	3
Yellowish cast to eyes	1	2	3
Eat fish 3 or more times a week	1	2	3
Never sweat or sweat very easily	1	2	3
Total			
Category III: Inflammation/Pain/Musculoskeletal			
Fibromyalgia	1	2	3
Headaches/migraines (non-hormonal)	1	2	3
Joint Pain	1	2	3
Muscle Aches	1	2	3
Early morning stiffness	1	2	3
Swelling	1	2	3
Frequent use of NSAIDS	1	2	3
Decreased range of motion	1	2	3
Total			

Category IV: Cognitive			
Diagnosis of or feelings of: Depression, Anxiety, Cognitive Decline (5 points for one)			5
Poor memory	1	2	3
Poor concentration	1	2	3
Mood Swings	1	2	3
Total			
Category V: Nervous System			
Numbness	1	2	3
Tingling	1	2	3
Diminished Sensation of hot or cold	1	2	3
Loss of smell	1	2	3
Diminished hearing	1	2	3
Total			
Category VI: Hormones (female)			
A. Menopause			
Hot flashes	1	2	3
Brain fog	1	2	3
Insomnia	1	2	3
Osteopenia or Osteoporosis	1	2	3
Diminished quality of life	1	2	3
Change in voice	1	2	3
Change in skin	1	2	3
Total			
B. Menstruation			
Diagnosis of Endometriosis, PCOS or Fibroids			5
Fertility issues	1	2	3
Cramps	1	2	3
Breast Tenderness	1	2	3
Cycles greater than 32 days or less than 24 days	1	2	3
Pain with period	1	2	3
Scanty or heavy blood flow	1	2	3
Irritability with period	1	2	3
Headaches with period	1	2	3
Acne	1	2	3
Facial hair growth	1	2	3
Hair loss or thinning	1	2	3
Total			
Category VII: Hormones (male)			
Poor libido	1	2	3
Erectile dysfunction	1	2	3
Fatigue	1	2	3
Irritability	1	2	3
Poor muscle mass	1	2	3
Weak Urine Flow	1	2	3
Total			

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Category VIII: Adrenal			
Fatigue	1	2	3
Dizziness or lightheaded	1	2	3
Shaky or irritable when hungry	1	2	3
Sugar cravings	1	2	3
Salt cravings	1	2	3
Worse with exercise	1	2	3
Better with naps	1	2	3
Get a second wind at night	1	2	3
Wake feeling unrefreshed	1	2	3
Stress makes things worse	1	2	3
Difficulty sleeping at night	1	2	3
Use of steroids	1	2	3
Anxious	1	2	3
Headaches with Stress	1	2	3
Inward trembling	1	2	3
Can't get over things easily, easily stressed	1	2	3
Total			
Category IX: Thyroid			
Diagnosis of Hashimoto's or Graves (5 points)	1	2	3
Fatigue	1	2	3
Weight Gain	1	2	3
Constipation	1	2	3
Thin hair and/or breaking nails	1	2	3
Menstrual irregularities	1	2	3
Cold hands and feet	1	2	3
Feeling blue or depressed	1	2	3
Sleep excessively, 9 hours or more	1	2	3
Thinning eyebrows	1	2	3
No body hair	1	2	3
Dry skin	1	2	3
Mental sluggishness	1	2	3
Total			
Category X: Cardiovascular			
Diagnosis of High blood pressure or high cholesterol (5 points)			5
History of Stroke or TIAs			5
Chest tightness/Angina	1	2	3
Arrthymia	1	2	3
Palpitations	1	2	3
Pulse higher than 80	1	2	3
Total			

Category XI: Immune			
Diagnosis of an Autoimmune Disease such as Lupus, RA, MS, Psoriasis, or another (5 points)			5
Low White Count	1	2	3
Takes more than 3-4 days to recover from a cold	1	2	3
Migratory pain	1	2	3
Lymph nodes that swell and remit	1	2	3
Periodic sweating (when not working out)	1	2	3
Fatigue that had a sudden onset	1	2	3
Frequent or recurrent infections	1	2	3
Frequent use of antibiotics	1	2	3
Total			
Category XII: Allergies			
Seasonal Issues	1	2	3
Sensitivities to foods	1	2	3
Hives	1	2	3
Headaches	1	2	3
Itching	1	2	3
Rashes	1	2	3
Eczema	1	2	3
Worse in moldy buildings	1	2	3
Shortness of Breath	1	2	3
Chest Tightness	1	2	3
Total			
Category XIII: Metabolic			
Diagnosis of Diabetes type II, Metabolic Syndrome or PCOS (5 points)	1	2	3
Weight gain	1	2	3
Frequent thirst and urination	1	2	3
Numbness or Tingling	1	2	3
Poor wound healing	1	2	3
Reoccurring yeast infections	1	2	3
Fatigue after meals	1	2	3
Crave sugar	1	2	3
Eat sugar daily	1	2	3
Gain weight around the middle	1	2	3
Gain weight easily even with minimal carbohydrate/sugar intake	1	2	3
Total			

Part 3:

How many alcoholic beverages do you consume per week? _____

How many times do you eat out per week? _____

List your three worst foods you eat during the average week: _____

_____

_____

List the three healthiest foods you eat during the average week: _____

_____

_____

Do you smoke? _____ If yes, how many times a day _____

Rate your level of stress from 1-10 during the average week: _____

Current medications?

Current Supplements?

GENERAL MEDICAL HISTORY

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www.TAWellness.net

➢ *Demographics:*

Date Completed _____ / _____ / _____

First Name: _____ Middle Initial: ____ Last Name: _____

➢ *Chief Goal:*

Briefly explain why it is you came to this practice:

➢ *Past Medical History:*

Please check any medical conditions or health problems that you currently have or have had in the past.

Condition	*Now*		*Past*		*Condition*	*Now*		*Past*	
Ankle swelling	❍		❍		Hepatitis/Liver disease	❍		❍	
Anxiety or excess. stress	❍		❍		Herniated Disc	❍		❍	
Artificial joint/implants	❍		❍		High Blood Pressure	❍		❍	
Asthma	❍		❍		High Triglycerides	❍		❍	
Bleeding disorder	❍		❍		Irregular Heart Beat	❍		❍	
Blood Clotting problems	❍		❍		Kidney disease / Stones	❍		❍	
Cancer	❍		❍		Fibrocystic Breasts	❍		❍	
Carpal Tunnel Synd.	❍		❍		Lung or breathing problems	❍		❍	
Chest Pain	❍		❍		Osteoarthritis	❍		❍	
Chronic bronchitis	❍		❍		Osteoporosis/Osteopenia	❍		❍	
Chronic Indigestion	❍		❍		Psoriasis or eczema	❍		❍	
Constipation/diarrhea	❍		❍		Psych. or Emotional Illness	❍		❍	
Depression	❍		❍		Rectal Bleeding	❍		❍	
Diabetes	❍		❍		Rheumatoid Arthritis	❍		❍	
Fibroid uterus	❍		❍		Seasonal allergies	❍		❍	
Fibromyalgia	❍		❍		Seizures Disorder	❍		❍	
Gallbladder disease	❍		❍		Skin problems/dermatitis	❍		❍	
Glaucoma	❍		❍		Stomach Ulcers	❍		❍	
Headaches	❍		❍		Stroke/vascular disease	❍		❍	
Heart Disease	❍		❍		Thyroid disease	❍		❍	
Heel Pain	❍		❍		Tuberculosis	❍		❍	

➢ ***Past Medical History (cont):***

Any significant birth-related events?

Any significant/traumatic injuries?

➢ ***Family History*:**

Do you have a family member (mother, father, grandparents or sibling) with any of the following?
Abbreviations: MGM = maternal grandmother, MGF = maternal grandfather, PGM = paternal grandmother, PGF = paternal grandfather. If positive, indicate the age in the box at which onset occurred.

						Grandparents			
	Condition	**Mother**	**Father**	**Sister**	**Brother**	**MGM**	**MGF**	**PGM**	**PGF**
☐	Breast Cancer								
☐	Prostate Cancer								
☐	Uterine Cancer								
☐	Ovarian Cancer								
☐	Colon Cancer								
☐	Fibrocystic breast								
☐	Heart Disease/stroke								
☐	High Cholesterol								
☐	Diabetes								
☐	High Blood Pressure								
☐	Osteoporosis/ Osteopenia								
☐	Alzheimer's disease								
☐	Psychiatric illness								

➢ ***Social History:***

Do you use tobacco? ☐ Yes ☐ No
Are you employed? ☐ Yes ☐ No
If yes, what is your occupation? _____
Is the job stressful? ☐ Yes ☐ No
Is your job physically demanding? ☐ Yes ☐ No

Education:
☐ High school/GED ☐ College ☐ Post-Graduate

Martial Status:
☐ Single ☐ Divorced ☐ Married/Partnered

Do you have any children? ☐ Yes ☐ No
If so, kindly provide their gender and their ages: _____

Do they live with you? ☐ Yes ☐ No

➢ ***Surgical History:***

Please list all surgeries that you have had since birth. Include the year.

Surgery	**Year**

➢ ***Previous Studies/Tests:***

Have you had any of the following tests performed?

Yes	No	Test	If yes, what was the month/yr?	Result	
				Normal	Abnormal
☐	☐	Mammography			
☐	☐	PAP Smear			
☐	☐	Uterine Ultrasound			
☐	☐	Bone Density			
☐	☐	Colonoscopy			
☐	☐	Cardiac Testing Type:			

➢ ***Dietary and Exercise History:***

Do you do exercises?	☐ Yes	☐ No
Do you do weight resistant exercises? (Lift weights)	☐ Yes	☐ No
Do you do aerobic exercises?	☐ Yes	☐ No
Do you practice yoga?	☐ Yes	☐ No

I eat at fast-food restaurants _____ times per week.

I consume:

- ☐ Coffee ____ cups per day
- ☐ Regular soft drinks _____ cans/btls per day
- ☐ Diet soda _____ cans/btls per day
- ☐ Energy drinks _____ cans/btls per day
- ☐ Alcoholic beverages _____ per day
- ☐ Water _____ oz. per day

Servings of the following per day:

Meat	_____
Vegetables	_____
Fruit	_____
Nuts	_____
Dairy/Cheese	_____
Bread	_____
Candy/sweets	_____

Do you snack between meals?

What are your favorite snack foods?

➢ ***Prescription Medications – Prescribed by a Physician:***

This includes any medication or therapy prescribed by a physician.

	Medication	**Strength: units in mgs, gms, IU, mcg**	**At what times do you take this medication?**	**Year Started.**	**Are you currently taking this medication?**
1					
2					
3					
4					
5					
6					
7					
8					

Vitamins and Over-the-Counter (OTC) Products:

This includes any pill, substance, or supplement that you bought at a store or pharmacy without a doctor's prescription.

	Supplement	Manufacturer	Major Ingredients	Strength of Ingredients	For what reason do you take this supplement
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

➢ ***Allergies:***

☐ No known allergies to medications

Antibiotics	☐ Penicillin	☐ Sulfa	☐ Other antibiotics:
Prescription Medication:	☐ Morphine	☐ Codeine	☐ Aspirin
Environmental Allergies:	☐ Seasonal	☐ Pets	☐ Ragweed, pollen, grasses
Food Allergies:	☐ _____	☐ _____	☐ _____ ☐ _____
Chemical Sensitivities:	☐ Dyes	☐ _____	☐ _____

Any other allergy not noted above?: (please list):

Please describe the reaction to the allergen listed above. Was it life-threatening?

Describe the extent to which you are exposed to chemicals or metals.

Any Mercury Fillings? ☐ Yes ☐ No

➢ ***Physician Information:***

☐ **No Primary Care Physician** ☐ **No Specialist**

Primary Care Physician
Name: _____

Specialist Physician
Name: _____

Total Approach Wellness and Aesthetics

Patient Demographics:

Last Name: First Name: MI:

DOB: Gender: SSN:

Marital Status: Employ. Status Prof. Title:

Addr Line 1: Addr Line 2:

City: State: Zip:

Home Phone: Work Phone: Work Ext:

Cell Phone: Fax: Email:

Employment Information:

Employ. Name Employ. Phone

Addr Line 1: Addr Line 2:

Employer City: State: Zip:

Emergency Contact:

Contact Name: Relationship to Patient:

Addr Line 1: Addr Line 2:

City: State: Zip:

Home Phone: Cell Phone:

Primary Insurance:

Insurance Co. Name:

Primary Insured: Last Name: First Name: MI:

DOB: SSN of Primary

Patient Relationship To Primary Insured:

Subscriber ID: Group No: Plan Name:

Secondary Insurance:

Insurance Co. Name:

Secondary Insured: Last Name: First Name: MI:

DOB: SSN of Secondary

Patient Relationship To Secondary Insured:

Subscriber ID: Group No: Plan Name:

Guarantor Information: (if different from primary insured or patient)

Guarantor: Last Name: First Name: MI:

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OFFICE POLICIES

1. There is a **cancellation fee** for patients who do not cancel their appointment prior to a full 48 hours. **As a safeguard**, **please email your cancellation in writing to avoid any confusion regarding the cancellation deadline**. If you fail to do so, your credit card will be charged for the missed appointment on the day of the appointment. **For new patient appointments, the cancellation fee is $350.00. You will be billed according to our office fee schedule for the missed appointment.** Please call as soon as possible to let us know if you cannot keep your appointment. In order to provide better service to our patients we do not overbook to compensate for no shows therefore we must bill for missed appointments.

2. If you are late for an appointment you will be seen for the remainder of your appointment time only in order to avoid delays for other patients. There will be no adjustment in the charge for the visit.

3. If you go over your scheduled appointment time, and there is no other patient scheduled, you will be charged on a prorated basis for the additional time spent with the provider. Please be sure to review our office fee schedule.

4. There is a cost for copying medical records plus postage. In accordance with Title 45, Section 164.524© of the Code of Federal Regulations, there is a cost related to medical records retrieval, certification and copying. You must sign our medical release form and pay the copying fees before records are sent. Medical records are sent within 3 weeks of a completed request. All outstanding bills must be paid in full before medical records are sent.

5. Prescription refill request should be done during appointment times or on-line only. **Prescription refills** are called in within 48 hours of their request. Patients who have not been seen recently may be required to come in for an office visit before a prescription is called in. A fee of $10.00 for prescriptions requested over the phone or needed prior to 48 hours may apply.

6. Insurance companies may not cover prescriptions called in to the compounding pharmacy; therefore the compounding pharmacy will call you directly for a method of payment prior to shipping it to you.

7. All lab results are reviewed and discussed during appointment times. Results can only be given over the phone during a phone consultation with the doctor. The charge for the phone consult will depend on the amount of time required for the consult.

8. Medical questions should be addressed during appointment times. Our staff may handle brief questions but in-depth questions will require an appointment with the doctor.

9. The doctors are available for phone consultations for the convenience of our patients who live out of town or have schedules which do not permit them to come in for office visits. If you request to speak with the doctor by phone for any reason your account will be billed accordingly. Please allow our staff to handle simple questions and requests, to avoid a physician's fee. **You will be billed for all phone calls or emails that require time from the physician according to our fee schedule.**

10. **All services and product sales are final**. Patients are responsible for payments for services and labs performed. No refund will be given once a service has been provided or lab test has been performed. There are no refunds on products sold in our office for any reason. Please do not ask the staff or doctor for refunds once you have purchased a product.

11. Patients who show up for unscheduled appointments to speak with the doctor will be billed according to our fee schedule if the doctor is available. You will be billed for the amount of time that you speak with the physicians even if you do not have an appointment. Please be considerate of other patients who have appointments so that the office can run smoothly and efficiently and schedule an appointment.

12. We require a credit card to be on file for patients in the event that products, lab kits, etc. have to be sent to patients, and for appointment and cancellation fees. Patients who request credit card **charge backs** for any reason will be billed **$150.00 per charge back** in addition to the original charges for services provided by our office. All fees are due at the time of services. Patients are responsible for all fees incurred by Total Approach Wellness and Aesthetics for collections. Credit card charge backs will be immediately turned over for collections at the expense of the patient.

13. We do not provide disability forms for patients who desire disability coverage. Your primary care physicians must complete these forms.

14. Our office specializes in functional medicine, and stress, hormone, and health lifestyle programs. **We do not assume the responsibility for treatment of major medical illnesses that you are currently being treated for by your primary physicians.** Please continue treatment with your primary care physician or OB/GYN for routine medical problems.

15. Patients please call the office before coming to the office to pick up supplements, tests, etc., to avoid delaying appointments for patients on the schedule for that day and to allow us to prepare for your needs. Please be patient with our staff until patients with appointments have been assisted.

16. We reserve the right to immediately discharge a patient from our practice if a patient is abusive to the staff or refuses to honor our office policy.

17. Our office policy is designed to provide structure for our office so that we provide good consumer service and ensure that all patients receive the same quality service and treatment. We strive to make your experience a good one and welcome your helpful feedback.

18. If you are dissatisfied for any reason, please alert our office and we will make every effort to correct the problem and accommodate your needs.

Thank you for choosing Total Approach Wellness and Aesthetics to provide your medical needs. Your business is greatly appreciated.

By signing below you acknowledge that you have read this document and agree to abide by our office policies and fee schedule. Please initial each section of the office policy.

_____
Patient's Name (Please Print)

_____
Patient's Signature

_____
Date

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CREDIT CARD AUTHORIZATION

I, (please print name)________________________________, authorize Total Approach Wellness and Aesthetics to charge my credit card for the following reasons: Office Visits, Mail Orders/Products, Phone Consultations, Cancellation Fees, and Procedure Deposits.

____
Patient Signature

____
Date

Note:
Information is provided for credit card with the last four digits ________, expiring ________.
The provided information is to be removed from the patient file and stored in a secure location.

Cut ➔ >>>
Credit Card Authorization
>>>
>

Patient Name: _______________________________ Date: ____________
(Print)

Patient Signature: ____

Credit Card: Visa / MasterCard / American Express

Card Number: ____

Card Expiration: ______________ Security Code: _______________

Information is to be used only as specified on the Credit Card Authorization Form.

CONFLICT RESOLUTION AGREEMENT

Total Approach Wellness and Aesthetics
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Office: (910) 322-7368
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This contract is between Total Approach Wellness and Aesthetics, hereafter referred to as "TAWA" and _____, hereafter referred to as "Patient." This contract establishes an agreement for TAWA to provide certain medical services to the Patient ("Agreement"). The terms of this agreement are detailed below:

COVERED MEDICAL SERVICES:

TAWA agrees to provide the medical services as indicated below. The medical services are designed to incorporate metabolic and nutritional medicine for the Patient to analyze lifestyle, environmental considerations, and prevention of disease.

_____ Metabolic and Nutritional Medicine

_____ Weight Management

_____ Nutritional Supplements

_____ Bio-Identical Hormones

_____ Wellness Testing

_____ Functional Medicine

_____ Mental Health

MEDICAL SERVICES EXCLUDED:

TAWA does not prescribe any medicine that requires a prescription from a medical doctor with the exception of hormones and occasional other compounded medications. Instead, the medical services provided are therapeutic products designed to aid with disease prevention and overall wellness. TAWA shall not provide criticize or consult Patient in regards to the medical advice prescribed by a provider other than TAWA. In addition, TAWA shall not provide medical advice in regards to any medications prescribed by a medical provider other than TAWA. At no time should any medical services, advice, or pharmaceuticals provided by TAWA be construed by the Patient as an alternative or substitution for medical advice or prescriptions given by any other medical providers of the Patient. Instead, any medical services, advice provided, or pharmaceuticals prescribed by TAWA shall be viewed and utilized as a supplement to medical advice or prescriptions given by any other medical providers of the Patient.

COSTS FOR SERVICES:

The costs for services provided under this Agreement are subject to separate agreements between the parties. The consideration for this Agreement, the receipt and sufficiency of which are both hereby acknowledged, are the medical services provided herein.

CONFLICT RESOLUTION:

For the consideration and services provided for herein, receipt of which is acknowledged by the parties, any controversy or claim arising out of or relating to this Agreement, or its breach, shall be settled by arbitration in Cumberland County, North Carolina in accordance with the Commercial Rules of the American Arbitration Association, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. If any legal action or arbitration based in contract is necessary to enforce or interpret the terms of this Agreement, the prevailing party will be entitled to reasonable attorneys' fees and costs in addition to any other relief to which that party may be entitled. The parties to this Agreement hereby expressly waive any right they may otherwise have to a trial by jury in the Twelfth Judicial District, Cumberland County, North Carolina.

IN TESTIMONY WHEREOF, the parties hereto have set their hands and seals this the ____ day of _____, 20__.

PATIENT

_____

_____

WITNESS