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: ____

____

Rev. 10/23/17

General Medical History

Total Approach Wellness and Aesthetics
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➢ 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: ______________________

Metabolic Assessment Form

Total Approach Wellness and Aesthetics
200 Forsythe Street
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Fax: (910) 483-5796
www.TAWellness.net

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			

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			

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?

Symptoms groups listed in this flyer are not intended to be used to diagnose or treat conditions. Questions are for educational purposes only.

Consent for Treatment

Total Approach Wellness and Aesthetics
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The Nature of the Treatment

I hereby give my consent to evaluation and treatment of menopause, andropause, thyroid disorders, adrenal fatigue/stress and other hormone imbalances by the administration of bioidentical hormone replacement therapy and/or nutritional supplements, including vitamins, minerals and anti-oxidants and/or drugs designed to alter hormone levels. The nature of the procedure is to raise levels of hormones in my body to levels which will improve quality of life, improve my functional ability and the goal of which is to decrease the incidence of sickness and disease. Regarding the nutritional supplements, the goal is to raise levels of vitamins, minerals and anti-oxidants in order to maximize the physiologic processes in my body and minimize damage by naturally produced free radicals.

The General Nature and Extent of Treatment-Related Risks

All hormone deficiencies have unwanted symptoms and the potential for illness when the hormone level is low. In addition, all hormones have unwanted symptoms and the potential for harm when the levels are too high. Along with my doctor, I believe that it is when the hormones are within a range to eliminate my symptoms but not cause side effects and in addition when the hormones are balanced with the other hormones of the body, that we will obtain the optimum goal in my health.

In menopause, women lose the majority of their hormones within a few years causing in many cases severe distress both mentally and physically. Through the use of bioidentical hormone replacement therapy, one can counter this decline and help alleviate the symptoms due to menopause. In addition, it is now being shown that bioidentical hormone therapy is effective in the treatment of osteoporosis, as well as other disease processes associated with hormone decline as we age.

The potential adverse effects for women on estrogen, progesterone and/or testosterone include breast swelling and/or discomfort, fluid retention, dizziness, palpitations, break through bleeding requiring an endometrial biopsy, acne, unwanted hair growth, oily skin and hair, and headache.

In andropause, men gradually lose their ability to produce testosterone and some men develop elevated levels of estrogen. As men undergo an ever-increasing loss of testosterone, they are faced with anxiety, irritability, erectile dysfunction, bone loss, muscle loss, loss of strength, and loss of energy and memory impairment.

The possible side effects for men on testosterone replacement are acne, oily skin and hair, unwanted hair growth, enlargement of the prostate, loss of sperm production (sterility), enlargement of breast tissue, testicular atrophy (shrinking), and in some study an increased risk of prostate cancer growth.

In respect to adrenal function, my doctor has explained the risks of adrenal therapy with me including the long term use of corticosteroid (cortisol) which has been associated with osteoporosis. I understand that my doctor will use other methods to help reestablish my own adrenal hormone production, but that this may involve the short term use of cortisol, In addition, I will be informed of long term complications if my doctor and I feel that long time use of cortisol is indicated.

In hypothyroidism, many studies have shown how physicians under-treat this condition. I understand my physician will be working with me on resolving my symptoms and improving my quality of life by using my symptoms not simply my thyroid hormone levels to monitor the treatment of my disease. I understand that the potential side effects in using thyroid medication could include osteoporosis, palpitations, dizziness, psychiatric problems (mania), and heart beats so fast that I could pass out or end up hospitalized.

In respect to aging and the incidence of adult growth hormone deficiency syndrome, I appreciate that there are certain risks associated with the use of human growth hormone. While growth hormone has been shown to increase muscle mass, lower fat mass and improve bone density, it has yet to be established the clinical guidelines for the diagnosis and treatment of such a hormone loss. Therefore, my physician at Total Approach Wellness and Aesthetics and I have discussed the benefits of human growth hormone and the associated risks. These risks include water retention, which may result in leg swelling and elevated blood pressure, and which may be reversed with dose adjustment, mild increase in fasting blood sugar and occasional bruises at the injection site. I may also develop infection at the injection site if I use improper technique.

I understand that there are reasons to avoid the use of human growth hormone, if I am prescribed such a medication, and they are: the presence of a cancer or tumor; uncontrolled diabetes; unusual lung diseases such as pulmonary fibrosis; pneumoconiosis; bronchiolitis; obliterans; systemic sclerosis or pregnancy. I do not currently have nor have I been diagnosed with any of these medical problems. I understand that if I am diagnosed with any of these medical problems, I should stop the entire treatment protocol immediately and notify my physician, so that my treatment plan can be re-evaluated. I understand that taking growth hormone raises IGF-1 levels in the blood. In addition to the risks discussed above, I am aware that there are reports that indicate there may be an increased risk of prostate cancer associated with higher IGF-1 levels.

Safety of Hormone Replacement

Although in my physician's opinion, the majority of data points toward safety, no one has yet proven or has yet disprove a causal relationship between the use of bioidentical hormone therapy and cancer. I understand that careful surveillance and close monitoring are requirements of all patients to minimize any possible risk.

I understand there are other studies that point to a higher incidence of cancer in patients who take bioidentical hormone replacement therapy. However, studies like these, which show an association (two variables present simultaneously), do not demonstrate cause and effect. I realize that it may be a number of years before we know if there is any true cause and effect between bioidentical hormones and increased risk for cancer in women or men.

I also understand there are possible benefits associated with these procedures. I understand that no guarantee has been made to me regarding outcomes neither of this treatment nor on resolution of my

symptoms. I understand that not all patients receive the same degree of response. I also understand that the benefits derived from therapy will cease and those derived from hormone therapy and drugs that alter hormone levels may not reverse if the therapy is discontinued.

I also understand that if I am female and become pregnant, I should stop the entire treatment protocol immediately and notify my physician. I understand that this hormone therapy is not for the purpose of preventing pregnancy, and that if I become pregnant on this therapy it could present risk to the fetus (unborn child).

I understand that each hormone has been approved by the FDA for use in the treatment of certain diseases. I also understand that the FDA only approves or disapproves of products made by manufacturers which are produced in an established dosage and form. Therefore by definition, the FDA does not “approve” or “disapprove” of bioidentical hormones which are given in an individual dose and in an appropriate form for each patient as determined by my doctor at Total Approach Wellness and Aesthetics. I also understand that my doctor may choose to discuss with me and provide to me medications that are off-label in order to offer to me the widest range of therapies possible. (“Off-label” use means the use of FDA approved drugs for purposes other than those for which the FDA has approved them.) “Off-label” prescribing is a legal and common practice by physicians in the United States.

I also understand that my physician may recommend the use of other drugs, which are only available outside the United States and are not approved by the FDA. I understand that these products may only be available under the FDA’s personal use importation policy. (The FDA allows for the importation of small amounts of drugs that are legal in other countries under the personal use importation policy if certain requirements are fulfilled.) I will use such drugs as directed for my condition and in accordance with the FDA’s policy. I understand that the use of these medications is completely elective.

Any questions I have regarding this treatment have been answered to my satisfaction. I understand that I will be responsible for administering the hormones prescribed to me. I will conform and comply with the recommended dose and methods of administration. I also agree to conform to the request for initial and subsequent blood tests, as required to monitor my hormone levels. I understand that failure on my part to follow my physician’s recommendations in dosage and use of my hormones and medication may result in unwanted and potentially harmful problems. I understand that failure to have appropriate laboratory testing done at the interval established by my physician and failure to follow up with my physician at the recommended appointments may lead also to adverse (unwanted) side effects.

I authorize my physician to perform this treatment. I understand they will be assisted by other health professionals, as necessary, and agree to their participation in my care as it relates to anti-oxidant and hormone modulation therapy. I certify that I am under the regular care of another physician for all other medical conditions. I understand that this is a specialized practice and does not hospitalize patients. I also understand that I will continue under the care of my other physician(s) for any on-going medical condition as well as for any medical consultation that I may need. I assume full liability for any adverse effects that may result from non-negligent administration of the proposed treatment. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the procedure, except as that claim pertains to negligent administration of the procedure.

I hereby confirm that the nature and purpose of portions of the aforementioned treatment are considered by some to be medically unnecessary and/or experimental because they are not aimed at treating a disease, and there are no long-term studies documenting the results. The risks involved and the possibilities of complications have been explained to me. I fully understand that the treatment to be provided may be considered experimental and unproven by scientific testing and peer-reviewed publication.

I further consent to the utilization of the results of my progress in any research study performed by my physician. I understand that my name will not be used and that every effort will be made to protect my privacy. I also understand that photographs taken of me by my physician will not be used without my expressed written authorization. I understand that I may suspend or terminate treatment at any time and hereby agree to immediately notify the physician of any such suspension or termination.

To attest to my consent to this treatment, I hereby affix my signature to this authorization to treatment.

______________________________	______________________________
Patient Name (please print above)	Witness Name (please print above)
______________________________	______________________________
Signature of Patient (please sign above)	Signature of Witness (please sign above

Patient Demographics

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Fax: (910) 483-5796
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Patient Demographics:

Last Name:______________________________ First Name:______________________________ MI:_____

DOB:______________________ Gender:________________ SSN:_____________________________

Marital Status:_____________ Employ. Status: _______________ Prof. Title:_______________________

Address Line 1:_____________________________________ Address Line 2:________________________

City:_______________________________________ State:_______________ Zip:______________________

Home Phone: __________________________Work Phone:____________________ Work Ext:_________

Cell Phone:______________________________ Fax:___________________________

Email: ____

Employment Information:

Employer Name:_______________________________ Employer Phone:____________________________

Address Line 1:_______________________________ Address Line 2: _______________________________

Employer City: ___________________________________ State: __________ Zip: ___________________

Emergency Contact:

Contact Name: _________________________________ Relationship to Patient:____________________

Home Phone:_________________________________ Cell:________________________________

Primary Insurance: (Labs Only)

Insurance Co. Name:____

Primary Insured: Last Name:_____________________________ First Name:_________________ MI:____

DOB: ____________________ SSN of Primary: ____________________________

Patient Relationship To Primary Insured: ___________________________

Subscriber ID:______________________________ Group #:______________________ Plan:___________

Total Approach Wellness and Aesthetics reserves the right to charge a fee for any scheduled visits that are:

1. Cancelled with less than 24 hour notice
2. Are missed without calling to cancel (no show)
3. There are NO refunds for consultation Fee ($87.00)

Cancellation Fee Schedule: New Patient Consult $87.00; Established Patient : $350.00

** All Patients credit card will be charged No Show Fee on day of appointment*

OFFICE POLICIES

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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

Total Approach
Wellness and Aesthetics

CREDIT CARD AUTHORIZATION

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

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.

Rev. 10/23/17

CONFLICT RESOLUTION AGREEMENT

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

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