

NEW PATIENT PACKET

Welcome to the Institute for Personal Development.

The Institute for Personal Development provides the highest quality of mental health care. Our goal is to assist with alleviating emotional pain and suffering for individuals, families and communities. Our plan for treatment is to improve each individual's quality of life.

We feel that your emotional health is a priority! Our plan is to provide services that are individualized for each and every client. Our clinicians will work with you to provide services that are comfortable for each individual while meeting their personal needs. It is important to us that you recognize improvement and obtain results in improving your quality of life.

Our team of clinicians is professional and well trained with scientific knowledge of useful treatment techniques. Such techniques can be used to assist individuals to cope with stressful situations at home, at work, at school and in the community. Within treatment, we use traditional and complementary approaches with the highest level of clinical and ethical standards.

As a new patient, there are several things we will be asking for:

1. Please fill out all forms completely.
2. We will need a copy of your (guarantor's if patient is a minor) driver's license. (If you are writing checks for services rendered, we need this on file.)
3. A copy of your current insurance card(s).
4. Please verify that your physician/therapist is a member of your insurance plan. You can do that by calling your insurance company and/or working with our Benefits team.

Depending on whether you are here for medical or mental health reasons, your benefits might be different. Find out if you are required to pre-certify your visits. It might mean the difference in how, or if, your insurance company pays.

NEW PATIENT INFORMATION SHEET

Personal Information (must be filled out completely)

| | | | | | |
|---|--------|------|--------------------------------|--------------|--|
| Doctor/Therapist you are seeing today | | | | Today's Date | |
| Patient Name | | | | | |
| Home Address | | | | | |
| | Street | City | State | Zip | |
| E-Mail Address | | | | | |
| Home Telephone | | | Work Telephone | | |
| Cell Telephone | | | Other Telephone | | |
| Patient Date of Birth | | | Patient Social Security Number | | |
| Employer | | | | | |
| Employer's Address | | | | | |
| | Street | City | State | Zip | |
| Employer's Phone | | | Extension | | |
| Spouse's Name | | | Spouse's Work phone | | |
| Referral Source (i.e.: Doctor, phone book, etc) | | | | | |
| Referral Address | | | | | |
| | Street | City | State | Zip | |
| Referral Phone Number | | | | | |
| Patient's Mothers Maiden Name | | | | | |
| Whom may we contact in an emergency? | | | | | |
| Telephone number | | | Relationship | | |
| Address | | | | | |
| | Street | City | State | Zip | |

Insurance Information

| | |
|----------------------------------|-------------------------|
| PRIMARY Insurance | |
| Group Number | Policy Number |
| Insured's Name | Insured's Date of Birth |
| Insured's Social Security Number | |
| SECONDARY Insurance | |
| Group Number | Policy Number |
| Insured's Name | Insured's Date of Birth |
| Insured's Social Security Number | |

| | |
|--|--|
| What is your ethnic background? | American Indian and Alaska Native |
| | Asian |
| | Black or African American |
| | Native Hawaiian and Other Pacific Islander |
| | White |
| | Hispanic or Latino |

THE INSTITUTE FOR PERSONAL DEVELOPMENT

Administrative Policies & Procedure Overview

Thank you for choosing the Institute for Personal Development for your health care needs. We are committed to providing high quality, personalized and comprehensive patient care. We ask that these policies be reviewed and initialed so that we can provide quality service and ensure reimbursement. Please initial next to each policy indicating that you have read the terms and conditions and agree to abide by them:

1. Consent for Treatment:

a. I hereby authorize, and acknowledge to work with, the authorities of the Institute for Personal Development, and the physician(s)/therapist(s) in charge of my/the case, to administer such medications and treatments as may be deemed necessary for the interest and care of me/the patient described on this form.

2. Pre-Authorization for Benefits:

a. I acknowledge that I am also required to call my insurance company to verify my benefits and insurance coverage for services rendered and that a quote of benefits is not a guarantee of payment:

3. Payment Guarantee:

- a. Sessions shortened by the patient will still be charged at full reserved fee.
- b. Full payment is due at time of each appointment, unless managed care insurance covers authorized services in full or payment arrangement made with IPD Billing Department.
- c. Co-payments are due in FULL at time of each visit.
- d. Checks written and returned NSF/Account Closed will be charged an additional \$35.00.
- e. All future payments must be made via Cash/Credit or Debit card if any personal check is returned NSF.
- f. If you do not have insurance, payment is due in full at each visit and services may be turned away at the discretion of the physician.
- g. RESPONSIBILITY of an account balance is always the Patients, NOT the insurance company.
- h. IPD bills primary and secondary insurance companies as a courtesy. IPD does not bill tertiary (3rd) insurances.

4. Release of Insurance-Related Information:

- a. I authorize insurance payment(s) to be made directly to providers of the Institute for Personal Development.
- b. I authorize the Institute for Personal Development to release any information about me to insurance carriers needed to process claims.

5. Delinquent Accounts:

- a. Patients must settle past due account balances prior to scheduling future appointments.
- b. All outstanding balances are due in full at the time of service unless payment arrangements have been made with IPD Billing Department.
- c. Non-payment of delinquent balances will be grounds for termination of services rendered by IPD until the delinquent balance is resolved in its entirety.
- d. Delinquent balances will be sent to our collection agency. In the event that services are not paid in full and we must pursue legal action, all attorneys' fees, court costs, and filing fees will be the responsibility of the patient/guarantor.

Administrative Policies & Procedure Overview Continued

6. **Overpayments:**

I understand patient overpayments for actively treated patients will be used toward future copays/ deductibles/ coinsurance/ balances. I understand should I decide to no longer continue treatment at IPD, I must submit a written request to the IPD Billing Department for a refund of any patient overage on my account. I understand that refunds will not be processed until all claims billed to my insurance have been processed by my insurance. I understand refunds take 90 days to process. I also understand after I have received my refund that if my insurance at some point takes back their payment made to IPD on my behalf creating an amount owed, that I am responsible to pay that balance.

7. **Phone Consultation with Clinician**

IPD clinicians do charge for clinical phone consultations with patients. Charges are according to the Individual Clinician's specific fee schedule. You will see such charges on your patient statements. Please be aware that phone consultations cannot be billed to insurance. All phone consultation charges are solely patient's responsibility.

8. **Medical Records Charge:**

- a. We take the time and consideration to ensure your records are kept confidential. There is a standard processing fee of \$30 for any medical records that are released.
- b. Medical Record releases take in minimum of 10 business days from the date IPD receives a signed release form.

9. **Completion of Forms/Letters**

The charge for the completion of forms/letters typically can range between \$30 - \$150. However, please note that depending upon the length of the forms or documentation being requested, this charge could be higher.

Please sign below to authorize treatment indicating that you acknowledge your full financial responsibility for services rendered:

| | |
|-------------------------|------|
| Printed Name of Patient | Date |
| Signature of Patient | Date |
| Signature of Guarantor | Date |

If patient is a minor or unable to sign, state reason:

INSTITUTE FOR PERSONAL DEVELOPMENT

Late Cancellation/ Missed Appointment Policy

At the Institute for Personal Development, treatment begins with a partnership. We cultivate a clinician- patient partnership that is based on trust and collaboration, focusing on patients as individuals. Our clinicians and support staff strive to be fair and courteous in all of our dealings.

The following policy has been established to help us serve our patients better. It is necessary for IPD to make appointments in order to see our patients as efficiently as possible. No-shows and late cancellations cause problems beyond financial impact to our practice. When a patient is scheduled for an appointment, our clinician is reserving his or her time specifically for that patient. When an appointment is made, it takes an available time slot away from another patient in need of care. Not cancelling an appointment in a timely fashion restricts our ability to make the appointment available to another patient. For these reasons we have developed the following No- Show/Late Cancellations policy.

A No-Show is defined as missing a scheduled appointment without calling IPD in advance to cancel the appointment. A Late Cancellation is defined as failing to cancel or reschedule a scheduled appointment at least 24 hours before your scheduled appointment. If you need to cancel or reschedule your appointment, you must contact our office no later than 24 hours before your scheduled appointment so that we may offer the appointment time to another patient who is in need of attention.

The following is our policy regarding appointment cancellations.

1. Fee for failure to provide 24-hour advanced notice.
 - a. When a patient cancels an appointment with less than 24-hour advance notice the patient will be charged \$75 for the late cancellation.
2. Fees for failure to attend scheduled appointment.
 - a. When a patient misses an appointment the patient will be charged \$125 for the no show.
3. Waiver of fees by IPD clinical providers
 - a. We understand that the circumstances beyond your control may arise, where adequate notice is not possible. These limited situations will be considered on a case by case basis. While we value the input of the clinical providers when it is required, please note that IPD clinical providers are unable to personally waive any fees regarding this policy.
4. Patient responsibility for failure to provide 24-hour advance notice of appointment cancellation
 - a. Patients are advised that fees charged for failure to provide 24-hour advance notice of an appointment cancellation are not covered by insurance. These fees are the responsibility of the financially responsible party.
5. When a patient misses or late cancels 4 or more appointments within a 12-month period, the financially responsible party will be required to put a credit card on file to schedule future appointments. A billing representative will reach out to the financially responsible party to obtain the credit card information to maintain on file. If a subsequent appointment is missed or late cancelled a \$100 fee will automatically be charged to the credit card on file.

| | |
|----------------------|--------------------------|
| PATIENT NAME: | PATIENT NUMBER: |
| GUARANTOR NAME | RELATIONSHIP TO PATIENT: |
| GUARANTOR SIGNATURE: | Date |

THE INSTITUTE FOR PERSONAL DEVELOPMENT

MEASUREMENT BASED CARE

Dear IPD Patients,

At The Institute for Personal Development we pride ourselves on being a state of the art mental health practice. With that in mind we are currently introducing the next advancement in behavioral health care called "Measurement Based Care."

In Measured Based Care, we use standardized tests in order to determine precisely how well patients are doing. The goal in treating patients is not just to help them get better but to try to treat their condition to remission (no longer having any significant symptoms which interfere with their life). In order to do this it is critical that your clinician not just get a sense of how you are doing but to specifically **measure** how you are doing based on scientifically validated tests.

In addition, patients looking to choose a doctor or therapist do not just want to know what doctors and clinicians "specialize in" but actually how effective they are in treating certain conditions by looking at their **outcomes**. Lastly, insurance companies are asking clinicians to demonstrate that they are cost-effective in treating patients and are asking us to demonstrate how effective our clinicians are in treating conditions.

WHAT THIS MEANS FOR OUR PATIENTS

For our patients this means in the beginning of your session your clinician may ask you to take a brief computerized test to determine how well your condition is doing on a standardized test. In addition, it means that there will be a charge associated with the test. Typically the test is paid for by your insurance company and **you may have a small copayment for the test**. If the test is not covered by the insurance company, please call our billing department and we will investigate this and assist you. The charge for the testing goes to pay for the cost of the technology and implementation of state of the art care in our practice.

The testing **is not optional** as we have to be able to know **objectively** how well we are caring for you.

Sincerely,

Ronald Wuest, MD

Medical Director

The Institute for Personal Development

INSTITUTE FOR PERSONAL DEVELOPMENT

Medicaid/Illinois Public Aid Acknowledgement

I, _____ understand that the Institute for Personal Development is not accepting Medicaid/Illinois Public Aid Insurance for primary or secondary insurance. If Medicaid/Illinois Public Aid insurance is needed to be obtained during treatment here at I.P.D., I understand that I will be accepted as a cash patient and agree to pay my account in full at time of service. **

Signature of Patient (or Legal Guardian) _____

Date _____

** In the event that services are not paid in full and we must pursue legal action, all attorneys' fees, court costs and filing fees will be the responsibility of the patient/guarantor.**

Note: ALL MENTAL HEALTH INFORMATION IS PRIVILEGED AND HIGHLY CONFIDENTIAL. The information you share is STRICTLY BETWEEN YOU AND YOUR DOCTOR OR THERAPIST! No information will ever be released without your written permission!

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

INSTRUCTIONS:

Please fill out this form completely. If you are the parent/guardian of the patient, please ask the patient any questions that he/she is able to answer according to his/her age. Otherwise, answer the questions below to the best of your knowledge of the patient. The answers to these questions are very important in allowing us to care for the patient. Some of these questions we ask may seem silly or that they don't apply to you. Regardless, answer all questions to the best of your ability.

Date: _____

| | |
|--|-----------------|
| Name: | Age: |
| Sex: | Date: |
| If you are the parent/guardian of the patient and completing this form for the patient listed above, please write your name: | |
| Relation to Patient: | |
| Who is your primary care physician? | |
| May we contact your primary care physician with our initial findings? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| In the event that you request us to contact your primary care physician to coordinate your care, please provide his or her: | |
| Address | |
| | |
| Phone Number | Age: Fax number |
| Sex: | Date: |

| | | | | | | |
|-------------------------------|---|--|--|--|--|--|
| Marital status: | <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | | | | | |
| Previous or referring doctor: | Date of last physical exam: | | | | | |

PERSONAL HEALTH HISTORY

| | | | | | | |
|--|--|--|--|--|--|--|
| Childhood illness: | <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio | | | | | |
| Immunizations and dates or ~year of infection: | <input type="checkbox"/> Tetanus | | <input type="checkbox"/> Pneumonia | | | |
| | <input type="checkbox"/> Hepatitis | | <input type="checkbox"/> Chickenpox | | | |
| | <input type="checkbox"/> Influenza | | <input type="checkbox"/> MMR Measles, Mumps, Rubella | | | |

List any medical problems that other doctors have diagnosed

Surgeries

| Year | Reason | Hospital |
|------|--------|----------|
| | | |
| | | |
| | | |
| | | |
| | | |

| Other hospitalizations | | |
|------------------------|--------|----------|
| Year | Reason | Hospital |
| | | |
| | | |
| | | |
| | | |
| | | |

Have you ever had a blood transfusion? Yes No

| Allergies/ medication reactions | |
|---------------------------------|------------------|
| Name the Drug | Reaction You Had |
| | |
| | |
| | |

| Food sensitivities | |
|--------------------|------------------|
| Name the Food | Reaction You Had |
| | |
| | |
| | |

| HEALTH HABITS AND PERSONAL SAFETY | |
|---|--|
| ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL. | |
| Exercise | <input type="checkbox"/> Sedentary (No exercise) |
| | <input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf) |
| | <input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30min.) |
| | <input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30minutes) |
| Other Modalities (ex: massage, yoga, meditation, etc) <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Diet | Are you dieting? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | If yes, are you on a physician prescribed medical diet? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | # of meals you eat in an average day? |
| | Rank salt intake <input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low |
| | Rank fat intake <input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low |
| Caffeine | <input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> • Tea <input type="checkbox"/> • Cola |
| | # Of cups/cans per day? |
| Alcohol | Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | If yes, what kind? |
| | How many drinks per week? |
| | Are you concerned about the amount you drink? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Have you considered stopping? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Are you prone to "binge" drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Do you drive after drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No |

| | | |
|------------------------|---|--|
| Tobacco | Do you use tobacco? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | <input type="checkbox"/> Cigarettes _____ pks/day <input type="checkbox"/> Cigars -#/day <input type="checkbox"/> Chew _____/day <input type="checkbox"/> # of years <input type="checkbox"/> Pipe _____/day <input type="checkbox"/> Or year quit | |
| Drugs | Do you currently use recreational or street drugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Have you ever given yourself street drugs with a needle? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sex | Are you sexually active? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | If yes, are you trying for a pregnancy? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | If not trying for a pregnancy list contraceptive or barrier method used: | |
| | Any discomfort with intercourse? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Personal Safety | Do you live alone? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Do you have frequent falls? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Do you have vision or hearing loss? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Do you have an Advance Directive or Living Will? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Would you like information on the preparation of these? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? | |

| FAMILY HEALTH HISTORY | | | | | |
|--|--|-----------------------------|---|--|-----------------------------|
| | AGE | SIGNIFICANT HEALTH PROBLEMS | | AGE | SIGNIFICANT HEALTH PROBLEMS |
| Father | | | Do you have any children? <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | <input type="checkbox"/> M <input type="checkbox"/> F | |
| Mother | | | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| Siblings | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| Where are you in your family's birth order? # _____ of _____ children | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| | <input type="checkbox"/> M <input type="checkbox"/> F | | | Grandmother Maternal | |
| | <input type="checkbox"/> M <input type="checkbox"/> F | | Grandmother Maternal | | |
| | <input type="checkbox"/> M <input type="checkbox"/> F | | Grandmother Paternal | | |
| | <input type="checkbox"/> M <input type="checkbox"/> F | | Grandmother Paternal | | |

| MENTAL HEALTH | | |
|---|------------------------------|-----------------------------|
| Is stress a major problem for you? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you feel depressed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you panic when stressed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have problems with eating or your appetite? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you cry frequently? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever attempted suicide? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever seriously thought about hurting yourself? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have trouble sleeping? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

| WOMEN ONLY | | |
|---|------------------------------|-----------------------------|
| Age at onset of menstruation: | | |
| Date of last menstruation: | | |
| Period every _____ days | | |
| Heavy periods, irregularity, spotting, pain, or discharge? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Number of pregnancies _____ Number of live births _____ | | |
| Are you pregnant or breastfeeding? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had a D&C, hysterectomy, or Cesarean? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any urinary tract, bladder, or kidney infections within the last year? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any blood in your urine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any problems with control of urination? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any hot flashes or sweating at night? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Experienced any recent breast tenderness, lumps, or nipple discharge? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Date of last pap and rectal exam? | | |

| MEN HEALTH | | |
|---|------------------------------|-----------------------------|
| Do you usually get up to urinate during the night? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, # of times | | |
| Do you feel pain or burning with urination? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any blood in your urine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you feel burning discharge from penis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has the force of your urination decreased? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had any kidney, bladder, or prostate infections within the last 12 months? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have any problems emptying your bladder completely? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any difficulty with erection or ejaculation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any testicle pain or swelling? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Date of last prostate and rectal exam? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

METABOLIC ASSESSMENT FORM

| | |
|-------|-------|
| Name: | Age: |
| Sex: | Date: |

PART I

Please list the 5 major health concern in your order of importance:

| |
|----|
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |

PART II

Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.

| Category I | | | | |
|--|---|---|---|---|
| Feeling that bowels do not empty completely | 0 | 1 | 2 | 3 |
| Lower abdominal pain relief by passing stool or gas | 0 | 1 | 2 | 3 |
| Alternating constipation and diarrhea | 0 | 1 | 2 | 3 |
| Diarrhea Constipation | 0 | 1 | 2 | 3 |
| Hard dry or small stool | 0 | 1 | 2 | 3 |
| Coated tongue of "fuzzy" debris on tongue | 0 | 1 | 2 | 3 |
| Pass large amount of foul smelling gas | 0 | 1 | 2 | 3 |
| Category II | | | | |
| Excessive belching burping or bloating | 0 | 1 | 2 | 3 |
| Gas immediately following a meal | 0 | 1 | 2 | 3 |
| Offensive breath | 0 | 1 | 2 | 3 |
| Difficult bowel movements | 0 | 1 | 2 | 3 |
| Sense of fullness during and after meals | 0 | 1 | 2 | 3 |
| Difficulty digesting fruits and vegetables; undigested foods found in stools | 0 | 1 | 2 | 3 |

| Category III | | | | |
|--|---|---|---|---|
| Stomach pain, burning or aching 1- 4 hours after eating | 0 | 1 | 2 | 3 |
| Do you frequently use antacids | 0 | 1 | 2 | 3 |
| Feeling hungry an hour or two after eating | 0 | 1 | 2 | 3 |
| Heartburn when lying down or bending forward | 0 | 1 | 2 | 3 |
| Temporary relief from antacids, food, milk, carbonated beverages | 0 | 1 | 2 | 3 |
| Digestive problems subside with rest and relaxation | 0 | 1 | 2 | 3 |
| Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine | 0 | 1 | 2 | 3 |
| Category IV | | | | |
| Roughage and fiber cause constipation | 0 | 1 | 2 | 3 |
| Indigestion and fullness lasts 2-4 hours after eating | 0 | 1 | 2 | 3 |
| Pain, tenderness, soreness on left side under rib cage bloated | 0 | 1 | 2 | 3 |
| Excessive passage of gas | 0 | 1 | 2 | 3 |
| Nausea and/or vomiting | 0 | 1 | 2 | 3 |
| Excessive passage of gas | 0 | 1 | 2 | 3 |
| Stool undigested, foul smelling, mucous-like, greasy or poorly formed | 0 | 1 | 2 | 3 |
| Frequent urination | 0 | 1 | 2 | 3 |
| Increased thirst and appetite | 0 | 1 | 2 | 3 |
| Difficulty losing weight | 0 | 1 | 2 | 3 |

| Category V | | | | |
|---|---|---|---|---|
| Greasy or high fat foods cause distress | 0 | 1 | 2 | 3 |
| Lower bowel gas and or bloating several hours after eating | 0 | 1 | 2 | 3 |
| Bitter metallic taste in mouth, especially in the morning | 0 | 1 | 2 | 3 |
| Unexplained itchy skin Yellowish cast to eyes | 0 | 1 | 2 | 3 |
| Stool color alternates for clay colored to normal brown | 0 | 1 | 2 | 3 |
| Reddened skin, especially palms | 0 | 1 | 2 | 3 |
| Dry or flaky skin and/or hair | 0 | 1 | 2 | 3 |
| History of gallbladder attacks or stones Have you had your gallbladder removed | 0 | 1 | 2 | 3 |
| Category VI | | | | |
| Crave sweets during the day | 0 | 1 | 2 | 3 |
| Irritable if meals are missed | 0 | 1 | 2 | 3 |
| Depend on coffee to keep yourself going or started | 0 | 1 | 2 | 3 |
| Get lightheaded and if meals are missed | 0 | 1 | 2 | 3 |
| Eating relieves fatigue | 0 | 1 | 2 | 3 |
| Feel shaky, jittery, tremors | 0 | 1 | 2 | 3 |
| Agitated, easily upset, nervous | 0 | 1 | 2 | 3 |
| Poor memory, forgetful | 0 | 1 | 2 | 3 |
| Blurred vision | 0 | 1 | 2 | 3 |
| Category VII | | | | |
| Fatigue after meals | 0 | 1 | 2 | 3 |
| Crave sweets during the day | 0 | 1 | 2 | 3 |
| Eating sweets does not relieve cravings for sugar | 0 | 1 | 2 | 3 |
| Must have sweets after meals | 0 | 1 | 2 | 3 |
| Waist girth is equal or larger than hip girth | 0 | 1 | 2 | 3 |
| Frequent urination | 0 | 1 | 2 | 3 |
| Increased thirst & appetite | 0 | 1 | 2 | 3 |
| Difficulty losing weight | | | | |
| Category VIII | | | | |
| Cannot stay asleep | 0 | 1 | 2 | 3 |
| Crave salt | 0 | 1 | 2 | 3 |
| Slow starter in the morning | 0 | 1 | 2 | 3 |
| Afternoon fatigue | 0 | 1 | 2 | 3 |
| Dizziness when standing up quickly | 0 | 1 | 2 | 3 |
| Afternoon headaches | 0 | 1 | 2 | 3 |
| Headaches with exertion or stress | 0 | 1 | 2 | 3 |
| Weak nails | 0 | 1 | 2 | 3 |

| Category IX | | | | |
|---|---|---|---|---|
| Cannot fall asleep | 0 | 1 | 2 | 3 |
| Perspire easily | 0 | 1 | 2 | 3 |
| Under high amounts of stress | 0 | 1 | 2 | 3 |
| Weight gain when under stress | 0 | 1 | 2 | 3 |
| Wake up tired even after 6 or more hours of sleep | 0 | 1 | 2 | 3 |
| Excessive perspiration or perspiration with little or no activity | 0 | 1 | 2 | 3 |
| Category X | | | | |
| Tired, sluggish | 0 | 1 | 2 | 3 |
| Feel cold – hands, feet, all over | 0 | 1 | 2 | 3 |
| Require excessive amounts of sleep to function properly | 0 | 1 | 2 | 3 |
| Increase in weight gain even with low-calorie diet | 0 | 1 | 2 | 3 |
| Gain weight easily | 0 | 1 | 2 | 3 |
| Difficult, infrequent bowel movements | 0 | 1 | 2 | 3 |
| Depression, lack of motivation | 0 | 1 | 2 | 3 |
| Morning headaches that wear off as the day progresses | 0 | 1 | 2 | 3 |
| Outer third of eyebrow thins | 0 | 1 | 2 | 3 |
| Thinning of hair on scalp, face or genitals or excessive falling hair | 0 | 1 | 2 | 3 |
| Dryness of skin and/or scalp | 0 | 1 | 2 | 3 |
| Mental sluggishness | 0 | 1 | 2 | 3 |
| Category XI | | | | |
| Heart palpitations | 0 | 1 | 2 | 3 |
| Inward trembling | 0 | 1 | 2 | 3 |
| Increased pulse even at rest | 0 | 1 | 2 | 3 |
| Nervousness and emotional | 0 | 1 | 2 | 3 |
| Insomnia | 0 | 1 | 2 | 3 |
| Night sweats | 0 | 1 | 2 | 3 |
| Difficulty gaining weight | 0 | 1 | 2 | 3 |
| Category XII | | | | |
| Diminished sex drive | 0 | 1 | 2 | 3 |
| Menstrual disorders of lack of menstruation | 0 | 1 | 2 | 3 |
| Increased ability to eat sugars without symptoms | 0 | 1 | 2 | 3 |
| Category XIII | | | | |
| Increased sex drive | 0 | 1 | 2 | 3 |
| Tolerance to sugars reduced | 0 | 1 | 2 | 3 |
| "Splitting" type headaches | 0 | 1 | 2 | 3 |

| Category XIV | | | | |
|--|---|---|---|---|
| Urination difficulty or dribbling | 0 | 1 | 2 | 3 |
| Urination frequent | 0 | 1 | 2 | 3 |
| Pain inside of legs or heels | 0 | 1 | 2 | 3 |
| Feeling of incomplete bowel evacuation | 0 | 1 | 2 | 3 |
| Leg nervousness at night | 0 | 1 | 2 | 3 |
| Category XV (Males Only) | | | | |
| Decrease in libido | 0 | 1 | 2 | 3 |
| Decrease in spontaneous morning erections | 0 | 1 | 2 | 3 |
| Decrease in fullness of erections | 0 | 1 | 2 | 3 |
| Difficulty in maintain morning erections | 0 | 1 | 2 | 3 |
| Spells of mental fatigue | 0 | 1 | 2 | 3 |
| Inability to concentrate | 0 | 1 | 2 | 3 |
| Episodes of depression | 0 | 1 | 2 | 3 |
| Muscle soreness | 0 | 1 | 2 | 3 |
| Decrease in physical stamina | 0 | 1 | 2 | 3 |
| Unexplained weight gain | 0 | 1 | 2 | 3 |
| Increase in fat distribution around chest and hips | 0 | 1 | 2 | 3 |
| Sweating attacks | 0 | 1 | 2 | 3 |
| More emotional then in the past | 0 | 1 | 2 | 3 |
| Category XVI (Menstruating Females Only) | | | | |
| Are you a menopausal | 0 | 1 | 2 | 3 |
| Alternating menstrual cycle lengths | 0 | 1 | 2 | 3 |
| Extended menstrual cycle, greater than 32 days | 0 | 1 | 2 | 3 |
| Shortened menses, less than every 24 days | 0 | 1 | 2 | 3 |
| Pain and cramping during periods | 0 | 1 | 2 | 3 |
| Scanty blood flow | 0 | 1 | 2 | 3 |
| Heavy blood flow | 0 | 1 | 2 | 3 |
| Breast pain and swelling during menses | 0 | 1 | 2 | 3 |
| Pelvic pain during menses | 0 | 1 | 2 | 3 |
| Irritable and depressed during menses | 0 | 1 | 2 | 3 |
| Acne break outs | 0 | 1 | 2 | 3 |
| Facial hair growth | 0 | 1 | 2 | 3 |
| Hair loss/thinning | 0 | 1 | 2 | 3 |

| Category XVII (Menopausal Females only) | | | | |
|--|---|---|---|---|
| How many years have you been menopausal? | 0 | 1 | 2 | 3 |
| Do you ever have uterine bleeding since menopause? | 0 | 1 | 2 | 3 |
| Hot flashes | 0 | 1 | 2 | 3 |
| Mental fogginess | 0 | 1 | 2 | 3 |
| Disinterest in sex | 0 | 1 | 2 | 3 |
| Mood swings | 0 | 1 | 2 | 3 |
| Depression | 0 | 1 | 2 | 3 |
| Painful intercourse | 0 | 1 | 2 | 3 |
| Shrinking breast | 0 | 1 | 2 | 3 |
| Facial hair growth | 0 | 1 | 2 | 3 |
| Acne | 0 | 1 | 2 | 3 |
| Increased vaginal, pain, dryness or itching | 0 | 1 | 2 | 3 |

AUTHORIZATION TO RELEASE INFORMATION PART ONE

_____ I authorize Institute for Personal Development to request records from the following office: _____

_____ I authorize Institute for Personal Development to release records to the following office: _____

_____ I give Ardent permission to speak verbally with the following individual/office: _____

_____ I authorize Ardent (CLE) and The Institute for Personal Development to request and release records to each other.

(Name of Facility or Clinician)/Nature or Relationship to Patient

(Address)

(City, State, Zip)

(Phone Number)

(Fax Number)

The following information on _____

(Patient's Name)

(Date of birth)

Please release the following information (or specify):

_____ Verbal Information

_____ **ALL INFORMATION**

_____ Medical Records

_____ Lab Results

_____ Medical History/Physical

_____ Treatment Plan/Patient Progress Discharge Summary

_____ Psychologist Evaluation

_____ Results of Drug and Alcohol Treatment or Testing

_____ Social History

_____ Other (specify) _____

If "Other", for the Purpose of: _____

Approximate Dates of Service: _____

Release Expiration Date: _____ **Not to exceed 90 days** (Consent subject to revocation at any time.)

AUTHORIZATION TO RELEASE INFORMATION PART TWO

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to this authorization may be subject to re disclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed.
- I will receive a copy of this completed authorization form showing when my records have been sent.

| | |
|---|---------------|
| _____ Signature of Patient/ Responsible Party if Minor | _____ Date |
| _____ Signature of Witness | _____ Date |
| _____ Signature of Clinician #1 | _____ Date |
| _____ Signature of Clinician #2 | _____ Date |
| _____ Signature of Clinician #3 | _____ Date |

*** There is a standard processing fee of \$30.00 for any medical records that are released

All patients 12 years of age or older need to sign this authorization to release.***

Date Records Sent: _____ Initials of Records Keeper _____

*** There is a standard processing fee of \$30.00 for any medical records that are released outside of physician offices.

Also, all patient responsibility balances must be paid in full before any medical records are released. ***

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

| | |
|---------------|----------------|
| Patient Name: | Date of Birth: |
|---------------|----------------|

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Type of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
 - The rights to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
 - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
 - The right to receive confidential communications of protected health information.
 - The right to inspect and copy protected health information.
 - The right to amend protected health information
 - The right to receive an accounting of disclosures of protected health information
 - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

| | |
|---|------|
| Signature: | Date |
| Relationship to patient (if signed by a personal representative of patient): | |
| You may request a copy of this Privacy Practice from our staff, or find it on our website at ipdhealth.com | |

CREDIT CARD AUTHORIZATION

To Our Patients:

We have implemented a payment on file policy at ARDENT (The Center for Life Enrichment). You will be asked for a credit card number at the time you schedule your appointment. Your information will be held securely until your insurance(s) have paid their portion and notified us of any amount you may owe. At that time, any remaining balance owed will be charged to your credit card and a copy of the charge will be made available to you.

This will be an advantage to us both, as it will create more efficient payment processing and will decrease the number of paper statements to generate and mail. The combination will benefit everybody in helping to keep the cost of health care down. The American Medical Association estimates it costs \$7 to \$12 to collect \$20 dollars.

This in no way will compromise your ability to dispute a charge or question your insurance company 's determination of payment.

Co-Pays due at the time of the visit will be collected at the time of the visit.

In addition, appointments with ARDENT are in high demand. For this reason, we have policy in place related to "missed" appointments. A "missed" appointment is one where someone does not show up for an appointment and does not cancel the appointment at least 24 hours in advance of the scheduled date and time. For each missed appointment, ARDENT will charge 100% of the visit cost, and each late cancellation will be 50% of the visit cost. This fee will not be submitted to your health plan and will be your sole financial responsibility.

Missed and cancelled appointment fees will be charged automatically to your credit card on file.

If you have any questions about this payment method, please do not hesitate to ask.

Sincerely,

Ronald Wuest, MD

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ THE IPD CREDIT CARD AUTHORIZATION POLICY AND GIVEN AN OPPORTUNITY TO ASK QUESTIONS. I AUTHORIZE IPD TO CHARGE MY CREDIT CARD ON FILE IN ACCORDANCE WITH SUCH POLICY. I AGREE TO UPDATE MY CREDIT CARD ON FILE UPON REQUEST OR AS OTHERWISE NECESSARY.

Signature: _____

| | |
|---|---------------|
| Printed Name: | Date: |
| If signed by other than patient, relationship to patient: | |
| | |
| Credit Card Information | |
| Credit Card Number | |
| Expiration Date | Security Code |