CENTER FOR WELLNESS AND HEALING, P.A.

P O Box 8406 ✷ Houston, Texas 77288 ✷ 713 520 9611 ✷ 713 456 2929 Fax ✷cwh2004@aol.com

NEW PATIENT INFORMATION

Thank you for choosing the Center for Wellness and Healing. We strive to make your experience a fruitful one and your feedback is welcomed.

Please complete these forms and fax or email back to our office as soon as possible and ***PLEASE CALL*** *to confirm the receipt of your information.*

We will contact you within 24 hours to discuss what preliminary testing you will need in order to schedule your appointment.

Voice Number: (713) 520 9611

Fax Number: (713) 456 2929

Email address: info@centerforwellnessandhealing.com

Thanks again for your confidence in us!

Pamela B. Atkins, MD

CENTER FOR WELLNESS AND HEALING

PAMELA B. ATKINS, MD

PATIENT INFORMATION

PLEASE COMPLETE AS FULLY AS POSSIBLE

DATE:_____

PATIENT NAME_____

ADDRESS_____
(STREET) **(CITY)** **(STATE)** **(ZIP)**

SOC SEC_____**DATE OF BIRTH**_____**MARITAL STATUS**_____

PHONE [Day] _____**[Evening]** _____**[Mobile]**_____

FAX NUMBER_____**EMAIL ADDRESS**_____

OCCUPATION_____

GUARDIAN / NEAREST RELATIVE/ CONTACT:_____

CONTACT NUMBER: _____ **2nd NUMBER:** _____

RESPONSIBLE PARTY_____
(NAME) **(ADDRESS)**

_____
(CITY) **(STATE/ZIP)**

Are you under a doctor's care? _____**Reason**_____

_____

PHYSICIAN'S NAME and ADDRESS_____

_____

Health Insurance:_____ **PPO**_____ **HMO**_____ **HSA**_____

I hereby give my permission to be examined and treated by Dr. Pamela Atkins.

DATE_____**PATIENT SIGNATURE**_____

****Referred by:**_____

HISTORY QUESTIONAIRE

DATE:_____NAME_____DOB:_____

Height:_____ Weight:_____

WHAT IS THE PRIMARY REASON FOR YOUR VISIT? _____

_____

(CIRCLE ALL THAT APPLY)

ROS:	Constitutional Symptoms:	fever	weight loss	fatigue	headaches	weight gain	sweating
	Eyes:	blurred vision	double vision	blindness	cataracts	pain	
	Ears,Nose,Mouth,Throat:	ringing ears	hearing loss	congestion	cavities	soreness	infection
	Cardiovascular:	chest pain	palpitations	leg edema	varicose veins	leg pain on ambulation	
	Gastrointestinal:	heartburn	stomach ulcers	constipation	liver problems	hemorrhoids	tumors
	Genitouninary:	urination:	painful frequent	during nighttime	kidney stones	recurrent infections	
	Musculoskeletal:	joint pain	stiff joints	cramps	muscle pain	amputation	fractures
	Integumentary	rashes	ulcers	lesions	dryness	recent mole changes	
	Neurological:	paralysis	numbness	tingling	burning feet	radiating pain	headache
	Psychiatric:	depression	anxiety	agitation	memory	difficulty sleeping	
	Endocrine:	night sweats	cold hands/feet	hot flashes	hyperactive	fatigue	dry skin
	Hematologic/Lymphatic:	bruises	pain	tenderness	masses	swelling	anemia
	Allergic/Immunologic:	allergies	sinusitis	frequent colds	influenza	hepatitis	HIV
	Respiratory:	asthma	emphysema	pneumonia	short of breath	chronic cough/bronchitis	

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING <u>CONDITIONS</u>....

DIABETES	STROKE	HEART DX	HYPERTENSION	ARTHRITIS	GOUT
CANCER	SEIZURES	ASTHMA	POOR CIRCULATION	BLEEDING DISORDER	ANEMIA
GLAUCOMA	RENAL DX	HEPATITIS B/C	TUBERCULOSIS	OSTEOPOROSIS	VARICOSE VEINS
TUMORS	PACEMAKER	STD's	HIV		

WHAT OPERATIONS OR INJURIES HAVE YOU HAD IN THE PAST?

1)_____ 2)_____
3)_____ 4)_____
5)_____ 6)_____

MEDICATIONS?

1)_____ 2)_____ 3)_____
4)_____ 5)_____ 6)_____
7)_____ 8)_____ 9)_____

ARE YOU ALLERGIC TO: PENICILLIN NOVACAINE IODINE SULFA CODIENE CORTISONE ASPIRIN FOODS: _____

FAMILY HISTORY:

	LIVING?	**HEALTH CONDITIONS**	**DECEASED?**	**CAUSE OF DEATH**
MOTHER	_____	_____	_____	_____
FATHER	_____	_____	_____	_____
MOTHER	_____	_____	_____	_____
FATHER	_____	_____	_____	_____
SIBLINGS	_____	_____	_____	_____
SIBLINGS	_____	_____	_____	_____

SOCIAL HISTORY:

		Usage:
TOBACCO:	**Packs/day_____ How many years?_____**	**Past_____Present_____**
ALCOHOL USE:	**Yes_____ No_____ How much?_____ drinks/day**	**Past_____Present_____**
SUBSTANCE ABUSE:	**Yes_____ No_____ How Long?_____**	**Past_____Present_____**

CENTER FOR WELLNESS AND HEALING

"Balancing Hormones Naturally"

FEMALE HORMONAL SYMPTOMS

Please indicate the symptoms you are experiencing as:

0 (none), 1 (mild), 2 (moderate), 3 (severe)

For example, if you are moderately stressed you would indicate this by darkening the "2" next to 'Stress' : ⓪ ① ② ③ Stress

⓪ ① ② ③ Hot Flashes
⓪ ① ② ③ Foggy Thinking
⓪ ① ② ③ Heart Palpitations
⓪ ① ② ③ Aches and Pains
⓪ ① ② ③ Allergies
⓪ ① ② ③ Sugar Craving
⓪ ① ② ③ Loss of Scalp Hair
⓪ ① ② ③ Tender Breasts
⓪ ① ② ③ Anxious
⓪ ① ② ③ Weight Gain-Hips
⓪ ① ② ③ High Cholesterol
⓪ ① ② ③ Hair Dry or Brittle
⓪ ① ② ③ Constipation
⓪ ① ② ③ Hoarseness
⓪ ① ② ③ Low Blood Pressure
⓪ ① ② ③ Vaginal Dryness
⓪ ① ② ③ Tearful
⓪ ① ② ③ Sleep Disturbed
⓪ ① ② ③ Morning Fatigue
⓪ ① ② ③ Stress
⓪ ① ② ③ Weight Gain-Waist
⓪ ① ② ③ Acne
⓪ ① ② ③ Nervous
⓪ ① ② ③ Fibrocystic Breasts
⓪ ① ② ③ Decreased Muscle Size
⓪ ① ② ③ Slow Pulse Rate
⓪ ① ② ③ Thinning Skin
⓪ ① ② ③ Hearing Loss
⓪ ① ② ③ Low Blood Sugar
⓪ ① ② ③ Other

⓪ ① ② ③ Night Sweats
⓪ ① ② ③ Memory Lapse
⓪ ① ② ③ Bone Loss
⓪ ① ② ③ Fibromyalgia
⓪ ① ② ③ Sensitivity to Chemicals
⓪ ① ② ③ Elevated Triglycerides
⓪ ① ② ③ Increase Facial or Body hair
⓪ ① ② ③ Bleeding Changes
⓪ ① ② ③ Water Retention
⓪ ① ② ③ Decreased Stamina
⓪ ① ② ③ Swelling or Puffy Eyes, Face
⓪ ① ② ③ Nails Breaking or Brittle
⓪ ① ② ③ Rapid Heart Beat
⓪ ① ② ③ Increased Urinary Urge
⓪ ① ② ③ Numbness-Feet and Hands
⓪ ① ② ③ Incontinence
⓪ ① ② ③ Depressed
⓪ ① ② ③ Headaches
⓪ ① ② ③ Evening Fatigue
⓪ ① ② ③ Cold Body temperature
⓪ ① ② ③ Decreased Libido
⓪ ① ② ③ Mood Swings
⓪ ① ② ③ Irritable
⓪ ① ② ③ Uterine Fibroids
⓪ ① ② ③ Rapid Aging
⓪ ① ② ③ Decreased Sweating
⓪ ① ② ③ Infertility Problems
⓪ ① ② ③ Goiter
⓪ ① ② ③ High Blood Pressure

Name_____Date_____

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MALE HORMONAL SYMPTOMS

Please indicate the symptoms you are experiencing as:

0 (none), 1 (mild), 2 (moderate), 3 (severe)

For example, if you are moderately stressed you would indicate this by darkening the "2" next to 'Stress' : ⓪ ① ② ③ Stress

⓪ ① ② ③ Burned Out Feeling	⓪ ① ② ③ Apathy
⓪ ① ② ③ Decreased Mental Sharpness	⓪ ① ② ③ Depressed
⓪ ① ② ③ Nervous	⓪ ① ② ③ Anxious
⓪ ① ② ③ Decreased Stamina	⓪ ① ② ③ Decreased Muscle Size
⓪ ① ② ③ Decreased Flexibility	⓪ ① ② ③ Neck/Back Pain
⓪ ① ② ③ Elevated Triglycerides	⓪ ① ② ③ Sugar Craving
⓪ ① ② ③ Headaches	⓪ ① ② ③ Ringing in Ears
⓪ ① ② ③ Sensitivity to Chemicals	⓪ ① ② ③ Decreased Erections
⓪ ① ② ③ Decreased Urine Flow	⓪ ① ② ③ Increased Urinary Urge
⓪ ① ② ③ Bone Loss	⓪ ① ② ③ Stress
⓪ ① ② ③ Swelling or Puffy Eyes, Face	⓪ ① ② ③ Slow Pulse Rate
⓪ ① ② ③ Nails Breaking or Brittle	⓪ ① ② ③ Thinning Skin
⓪ ① ② ③ Rapid Heart Beat	⓪ ① ② ③ Hearing Loss
⓪ ① ② ③ Low Blood Sugar	⓪ ① ② ③ High Blood Pressure
⓪ ① ② ③ Oily Skin or Hair	⓪ ① ② ③ Acne
⓪ ① ② ③ Difficulty Sleeping	⓪ ① ② ③ Increased Forgetfulness
⓪ ① ② ③ Mental Fatigue	⓪ ① ② ③ Irritable
⓪ ① ② ③ Morning Fatigue	⓪ ① ② ③ Evening Fatigue
⓪ ① ② ③ Sore Muscles	⓪ ① ② ③ Increased Joint Pain
⓪ ① ② ③ Weight Gain (Breasts/Hips)	⓪ ① ② ③ Weight Gain-Waist
⓪ ① ② ③ Heart Palpitations	⓪ ① ② ③ Dizzy Spells
⓪ ① ② ③ Cold Body Temperature	⓪ ① ② ③ Allergies
⓪ ① ② ③ Decreased Libido	⓪ ① ② ③ Prostate Problems
⓪ ① ② ③ Hot Flashes	⓪ ① ② ③ Night Sweats
⓪ ① ② ③ Rapid Aging	⓪ ① ② ③ High Cholesterol
⓪ ① ② ③ Decreased Sweating	⓪ ① ② ③ Hair Dry or Brittle
⓪ ① ② ③ Infertility Problems	⓪ ① ② ③ Constipation
⓪ ① ② ③ Goiter	⓪ ① ② ③ Hoarseness
⓪ ① ② ③ Low Blood Pressure	⓪ ① ② ③ Numbness-Feet or Hands
⓪ ① ② ③ Aggressive Behavior	⓪ ① ② ③ Other

Name_____Date_____

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LOW THYROID SCREENING

Do you have fatigue?	Yes____ NO____
Do you have elevated cholesterol?	Yes____ NO____
Do you have difficulty losing weight?	Yes____ NO____
Do you have cold hands and feet?	Yes____ NO____
Are you sensitive to the cold?	Yes____ NO____
Do you have difficulty thinking?	Yes____ NO____
Do you find it hard to concentrate?	Yes____ NO____
Do you experience brain fog?	Yes____ NO____
Do you have poor short term memory?	Yes____ NO____
Are your moods depressed?	Yes____ NO____
Are you experiencing hair loss?	Yes____ NO____
Do you have less than one bowel movement a day?	Yes____ NO____
Do you have dry skin?	Yes____ NO____
Does your skin itch in the winter?	Yes____ NO____
Do you have fluid retention?	Yes____ NO____
Do you have recurrent headaches?	Yes____ NO____
Do you sleep restlessly?	Yes____ NO____
Are you tired when you awaken?	Yes____ NO____
Do you have afternoon fatigue?	Yes____ NO____
Do you experience tingling/numbness in your hands or feet?	Yes____ NO____
Do you have decreased sweating?	Yes____ NO____
Have you had problems with infertility or miscarriages?	Yes____ NO____
Do you have recurrent infections?	Yes____ NO____
Do your muscles ache?	Yes____ NO____
Do you have joint pain?	Yes____ NO____
Do you have thinning of your eyebrows or eyelashes?	Yes____ NO____
Is your tongue enlarges with teeth indentations?	Yes____ NO____
Is your skin pasty, puffy or pale?	Yes____ NO____
Do you have decreased body hair?	Yes____ NO____
Is your voice hoarse?	Yes____ NO____
Do you have a slow pulse?	Yes____ NO____
Do you have low blood pressure?	Yes____ NO____
Does your body temperature run below the normal 98.6º?	Yes____ NO____
Do you have sleep apnea?	Yes____ NO____

Name_____Date_____

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YEAST OVERGROWTH SCREENING

Do you have fatigue? Yes____ NO____
Do you feel lethargic? Yes____ NO____
Do you have recurrent yeast infections? Yes____ NO____
Have you taken antibiotics multiple times during your life? Yes____ NO____
Do you have abdominal bloating, cramping or gas? Yes____ NO____
Do you have indigestion or heartburn? Yes____ NO____
Do you have abnormal bodily reactions to wine, beer or alcoholic beverages, such as flushing, headache, sinus congestion or itchy skin? Yes____ NO____
Do you crave sugar or bread products? Yes____ NO____
Do you have difficulty concentrating? Yes____ NO____
Do you have depressed moods? Yes____ NO____
Do you develop skin rashes or hives? Yes____ NO____
Do you have athlete's foot? Yes____ NO____
Do you have jock itch? Yes____ NO____
Do you have rectal itching? Yes____ NO____
Do you have fungal infections under the toenails or fingernails? Yes____ NO____
Do you have allergy symptoms? Yes____ NO____
Do you have recurrent respiratory infections? Yes____ NO____
Do you have joint pain? Yes____ NO____
Do you have muscle pain? Yes____ NO____

Name_____Date_____

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P O Box 8406 Houston, Texas 77288 713 520 9611 713 456 2929 Fax

PAMELA B. ATKINS, MD
CWH2004@aol.com

REQUEST FOR RELEASE OF RECORDS

(COMPLETE BY PATIENT OR GUARDIAN)

Patient Name_____SS#_____DOB:_____

Address_____Tel#_____

Physician/Facility_____ **Fax #_____**
Ph #_____

(OFFICE USE ONLY)
I hereby authorize _____to release
Facility Name

The Medical Records of_____ for the treatment dates
Patient Name

From _____To_____ for the following purposes:

_____Medical _____Legal _____Insurance _____Other(Specify)_____

_____ Complete Record (Yes/No) _____ Include HIV _____ Include Chemical Dependency

Records concerning the following:
_____ Imaging/Radiology Results_____
_____ Lab Studies _____
_____ Cardiac Studies _____
_____ Emergency Room _____
_____ Chart Documents _____ H & P _____ MD Orders _____ MD Progress Notes
_____ Summaries/Reports _____ Operative _____Admissions _____ Discharge
_____ Other _____

I, the undersigned, have read the above and authorize the staff of above-named facility to disclose such information as herein contained. I have the right to revoke the authorization in writing at any time except yo the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I thereby release and hold harmless the above-named facility and its parent company from all liability and damages resulting from the lawful release of my Protected Health Information.

_____	_____	_____
Date	Patient/Guardian Signature	Authority/Relationship to Patient

This authorization is valid until 180 days after it is signed unless it provides otherwise; not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above.

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OFFICE POLICY AND PROCEDURE

1. Thank you for choosing the Center for Wellness and Healing. Our strategy is to partner with you to get to the "root" of your problem rather than practicing "band-aid" medicine. Our office policy is designed to help you understand how our practice operates. It also provides structure and organization so that we can provide excellent healthcare service to every patient. We strive to make your experience a fruitful one and your feedback is welcomed.

2. Our office is an out of network fee for service provider which means we do not participate in any insurance plans. No medical or consulting services, nutritional supplements, etc. will be billed to any insurance company or third party payer. Patients are responsible for payment in full for services rendered to them. PPO insurance companies with "out of network benefits" usually cover a portion of the office visit and laboratory testing charges. We will prepare a statement to submit to your insurance company as a courtesy. Each insurance company has different policies, therefore, reimbursement is not guaranteed. All office services are non-refundable.

3. The payment for services provided by the **Center for Wellness and Healing** is due in full at the time services are provided. The methods of payment for services are cash, credit/debit cards, and checks by prior approval. A return check fee of $35 will be assessed in addition to the balance due on "insufficient funds" items.

4. A $200 deposit is required to schedule a new patient appointment which will be applied to the initial visit. **Appointment cancellation requires a 48 hour notification prior to your appointment time avoid forfeiture of deposit**. You will be billed according to our office fee schedule for the missed appointment. Please notify us immediately if you need to change your appointment.

5. Please call as soon as possible if you cannot keep your appointment. We are always willing to work with our patients in the event of an emergency and understand that there may be circumstances outside of your control. In order to provide better service to our patients we do not overbook to compensate for no shows; your appointment time is dedicated only to you, therefore, we must bill for missed appointments.

6. If you are late for an appointment you will be seen for the remainder of your appointment time in order to avoid delays for other patients.

7. If you go over your scheduled appointment time you will be charged for the additional time spent with the doctor. Please be sure to review our office fee schedule.

8. 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 out. Medical records are sent out within 3 weeks of a completed request. All outstanding bills must be paid in full before medical records are sent out.

9. Prescription refill requests should be submitted to our office a full 7 days prior to running out of medication in order to prevent a lapse in medication. Prescription refills are called in within 48 hours of their request. Patients who have not been seen recently may be required to get labwork or come in for an office visit before a prescription is called in. A fee of $15.00 for prescription requested within 48 hours may apply.

10. 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.

11. 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. See Fee Schedule.

12. 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.

13. 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. Insurance companies do not reimburse for phone consultations.

14. If you request to speak with the doctor by phone, a phone consult will be scheduled and you 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 emails that require time from the physician according to our fee schedule.

15. Products can be ordered from our website www.centerforwellnessandhealing.com. They will be shipped to you or you may request to pick them up at the office. Patients are billed for the postage and shipping charge for products sent by mail. If you plan to stop by to pick up your product, please call first before coming.

16. 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 purchased. 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 and it leaves the office.

17. Patients who show up for unscheduled appointments to speak with the doctor will be billed according to our fee schedule. We discourage patients from showing up unannounced without an appointment. You will be billed for the amount of time that you speak with the physicians even if you do not have an appointment. Please schedule an appointment to be considerate of other patients who have appointments so that the office can run smoothly and efficiently.

18. Patients who request credit card charge backs for any reason will be billed $50.00 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 the Center for Wellness and Healing for collections. Credit card charge backs will be immediately turned over for collections at the expense of the patient. Patients are responsible for all fees incurred by Center for Wellness and Healing for collections.

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

20. Our office specializes in bio-identical hormone replacement, thyroid balancing, functional medicine, natural or holistic approach to chronic conditions, wellness and prevention programs. We do not assume the responsibility for treatment of your overall medical care which may include cardiac conditions, psychiatric illnesses, traumatic injury, etc. Please continue treatment with your primary care or specialty physicians for such medical problems.

21. Patients are responsible for all costs, including legal fees, associated with collections on their accounts.

22. 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.

23. We reserve the right to immediately discharge a patient from our practice if he/she does not comply with office policies or does not conduct themselves in a respectful manner.

By signing below you acknowledge that you have read this document and agree to abide by our office policies.

_____

Patient Signature