



Welcome:

Please arrive 30 minutes prior to your scheduled appointment time.

Please bring the following to your first appointment:

- **New patient paperwork completely filled out!**
- **License or ID card**
- **Insurance card (if applicable)**
- **Lab work from the last 6 months (if applicable)**
- **Medical records pertaining to your current or past diagnosis'**

We will call to confirm your new patient appointment 2 days in advance. If we do not reach you, we must receive a call back within 24 hours of the appointment to confirm that you wish to keep your appointment.

Young Foundational Health Center
7241 Bryan Dairy Rd.
Largo, FL 33777
(727)545-4600

*If utilizing GPS for directions, use the city of Pinellas Park.

Directions from Tampa/I275

1. Take I275 S towards St. Petersburg. Take Exit to 118th St.
2. Make a right on 72nd St.
3. Turn left on 112th Ave.
4. Take 1st left into parking lot
5. We are building just to your left. Neon green columns on brick building.

Directions from St. Petersburg Area

1. Head North on US 19 / 34th St.
2. Make a left turn on 118th / Bryan Dairy Rd.
3. Bryan Dairy Business Park is on the North side of Bryan Dairy.
4. Continue past 66th St. and make a right turn onto 72nd St. (Wheelchair store on rt. called Custom Mobility)
5. Make a left at the first street on your left 112th Ave.
6. Take first left into parking lot. Our office is to the left next to law office.

INITIAL HEALTH ASSESSMENT

The following information is CONFIDENTIAL. It is used to evaluate your health profile and risk factors.

IDENTIFICATION DATA

DATE: _____

Full name: _____
 First Middle Last

Male Female

Address: _____
 Street Apt#

 City State Zip

Single Divorced

Married Separated

Social Security Number: _____ DOB: _____ Driver's License#: _____

Home Phone#: _____ Cell Phone#: _____ Work Phone#: _____

E-mail: _____ Employer: _____

How did you hear about us? _____

What Pharmacy do you use? _____ Pharmacy Phone#: _____

Emergency Contact/Relation: _____ Phone#: _____

PRESENT ILLNESSES

Please list all illnesses or concerns that you would like to address with the doctor today:

1. _____
2. _____
3. _____

4. _____
5. _____
6. _____

CURRENT MEDICATIONS:

Please list ALL medicines you are taking, including any over the counter medicines and vitamins.

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

6. _____
7. _____
8. _____
9. _____
10. _____

DRUG ALLERGIES

List all drug, food and environmental allergies:

1. _____
2. _____
3. _____

4. _____
5. _____
6. _____

Name: _____ DOB: _____

PAST MEDICAL HISTORY

List all serious medical problems you have had such as diabetes, cancer, heart disease, lung disease etc...

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

PERSONAL HISTORY Please list who lives with you:

Name, First & Last	Age	Relation to You	Name, First & Last	Age	Relation to You
1.			4.		
2.			5.		
3.			6.		

- Have you ever smoked? Yes No How long? _____
- Do you presently smoke? Yes No How much? _____
- Do you use alcoholic beverage? Yes No How much? _____
- Do you use recreational drugs? Yes No Type? How often? _____
- Do you have pets? Yes No If so, what type? _____
- Is religion or spiritual belief important to you? Yes No If so, what religion? _____
- Do you exercise at least 3 times a week? Yes No What type? _____
- Have you had a colonoscopy? Yes No When? _____
- How would you describe your overall health? (check one) Excellent Very Good Good Fair Poor

HEALTH SCREENING QUESTIONS FOR WOMEN

- Have you had a mammogram? Yes No Date of last mam _____
- Do you do self-breast exams? Yes No
- Have you had a pap smear? Yes No Date of Last Pap _____
- Any history of abnormal Pap smear? Yes No When? _____
- Please list dates of any pregnancy and outcomes _____

Have you ever been a victim of sexual or physical abuse? Yes No When? _____

HEALTH SCREENING QUESTIONS FOR MEN

- Do you examine your testicles for lumps? Yes No
- Have you had a prostate exam? Yes No When? _____
- Have you had a PSA test? Yes No When/Results? _____
- Have you had trouble achieving or maintaining an erection? Yes No

Name: _____ DOB: _____

IMMUNIZATIONS & TESTS

Please give the date of your last immunization/test:

Tetanus: _____ Flu shot: _____ TB test: _____ Cholesterol Check: _____

Over age 50 only: Pneumonia shot: _____ Stool blood test: _____ Colonoscopy: _____

FAMILY HISTORY

Please check or list any diseases that your relatives have now or have had:

	Age if Alive	Age at Death	Diabetes	High Blood Pressure	Heart Disease	Cancer	Other
Mother							
Father							
Brother(s)							
Sister(s)							
Grandparents (Maternal)							
Grandparents (Paternal)							

SURGICAL HISTORY

Please list all surgeries you have had and dates performed.

Operation	Year	Operation	Year
1.		4.	
2.		5.	
3.		6.	

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient's Signature: _____ Date: _____

INSURANCE INFORMATION: INSURANCE SELF-PAY

Primary Carrier: _____ Secondary Carrier: _____

ID/Policy #: _____ ID/Policy #: _____

Group#: _____ Group#: _____

Ins Party's Date of Birth: _____ Ins Party's Date of Birth: _____

Ins Party's SSN#: _____ Ins Party's SSN#: _____

Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay a fixed allowance for certain procedures and others pay a percentage of the charge. Please remember it is your responsibility to pay any deductible amount, co-insurance and any other balance not paid for by your insurance. If your insurance company does not respond to our billing within 60 days, you are responsible for the charges. **Self-pay and co-pays are due at the time of service.** If this account is assigned to an attorney for collection and or suit, the prevailing party shall be entitled to reasonable Attorney's fees and cost of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records.

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize the Providers (and its entities) to furnish information to the insurance carriers, and I hereby assign to all physicians all payment for medical services. I understand that I am responsible for non-covered fees.

Signed: _____ Date: _____ DOB: _____

Young Foundational Health Center
7241 Bryan Dairy Rd., Largo, FL 33777

NUTRITIONAL ADJUNCTIVE SUPPORT FOR ACUTE & CHRONIC DISEASES

To Our Patients:

In order to make it possible for you to choose from all effective health care options available to you. Including those that complement or substitute for prevailing conventional treatments, we are making the following information available to you. You have the right of access to any mode or treatment that in your and our judgement is in your best interests.

The Orthomolecular/Budwig Nutritional Program involves the use of vitamins, minerals, ions, nutraceuticals and whole foods as well as an educational program on how to incorporate them into a healthy lifestyle. Orthomolecular Therapy is considered to be in the category of complementary and alternative medicine. Complementary and alternative medicine involves the use of medical services and procedures which are not usually and customarily performed by the general medical community, or as usually and customarily performed by the medical community but for different conditions.

Theoretically, Orthomolecular Therapy puts nutrients into the blood and Gastro-intestinal (GI) system that enhances the body's immune system, cell-wall structure and function, and to supplement that patient's nutritional needs not otherwise obtained by the patient through their usual dietary intake. This biochemical process is thought to enhance the patient's general physical condition. Potential risks are allergic/hypersensitivity reactions, rashes, numbness, and local irritation.

Although much evidence exists supporting the belief that Orthomolecular Therapy is effective. Orthomolecular Therapy is not generally recognized as proven by various professional medical organizations, governmental agencies such as FDA (Food and Drug Administration), and the medical establishment at large. Therefore, Orthomolecular Therapy is considered experimental, investigative, and medically unnecessary by these entities and third party payers (insurance companies, Medicare, Worker's Compensation, etc.). Thus, not all of our program may be covered by insurance or reimbursable.

Dr. Young practices alternative medicine and he has recommended that I maintain other physicians to oversee and coordinate my various healthcare needs.

Based upon all of the information available to us, my health care provider and I agree that I will be treated with Orthomolecular Therapy. I choose and request Orthomolecular Therapy.

PLEASE SIGN BELOW

Patient/Guardian Signature

Date

Print Name of Person Signing

Date

Name: _____ DOB: _____

Compliance Consent Form

I _____ understand that the success of any treatment plan we offer; including Weight management, Hormone therapy, Diabetes, Thyroid, Chronic Disease etc. depends on my active participation, compliance and full disclosure of lifestyle, eating habits, medications, etc. Full disclosure and compliance is the utmost importance to my success. If I omit something or am not completely transparent with the doctors about what I am eating, medications I'm taking or about something in my life, it may throw off my success. My compliance with the treatment plan advised is also vital. I understand that the doctors cannot guarantee or assure treatment success or any definite outcomes. I understand that many issues, i.e. Hormone problems, Diabetes, Thyroid, Weight problems, etc. are considered chronic conditions that may require permanent changes in my eating habits, treatment and lifestyle to attempt symptom relief.

Print Patient's Name: _____ Date: _____

Signature of Patient or Patient's Legal Representative: _____

Print Name of Legal Representative (if applicable): _____

**PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT,
PAYMENT, OR HEALTHCARE OPERATIONS, PER HIPAA REGULATIONS**

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care of treatment. I understand this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care, such as referrals,
- A source of information for applying my diagnosis and treatment information to my bill,
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff.

I have been provided with a “Notice of Patient Practices” that provides a more complete description of information uses and disclosures. I understand that I have the rights and privileges:

- The right to review the “Notice” prior to acknowledging this consent.
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

Restrictions: (Please Print)

**I request the following restrictions to the use or disclosure of my health information:

****Please tell us with whom we may discuss your protected health information:**

Example: spouse name, children name(s), other relatives name(s), friends or caregivers name(s).

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

****Messages or Appointment Reminders:**

May we leave a message at your home using doctor’s/practice name:	Yes	No
May we leave a message at your work using doctor’s/practice name:	Yes	No

Messages will be of a non-sensitive nature, such as, appointment reminders.

We require 24 hour notice for cancellations or changes to appointment date / time or a \$25 fee will be charged.

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e. referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

I fully understand and accept decline (please check one) the information in this consent.

Patient/Guardian Signature Date

Print Name of Person Signing Date

*If other than the patient (Patient Name) _____ is signing, are you the legal guardian, custodian or do you have Power of Attorney for this patient, for treatment, payment or healthcare operations? Yes No

Name: _____ DOB: _____

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

NAME OF PATIENT: _____	DOB: _____
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Requesting Office

Name: Young Foundational Health Center Phone: 727-545-4600 Fax: 727-545-4611
Address: 7241 Bryan Dairy Road
City/State/Zip Largo, Florida 33777

RECORDS FROM: (Who is releasing the records?)

Name: _____ Phone #: _____
Address: _____ Fax #: _____
City/State/Zip _____

For the Following Purposes:

- Continued Medical Care** Personal Information Legal Follow-up
 Disability Insurance Other:

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, if such information And/or Records Exist:

- Please send the entire Medical Record (all information) to the above named recipient.
- Office Notes and Reports** **Most recent one-year history** Most recent 3-year history
 Rx History Transcribed hospital reports **Laboratory reports**
 Billing Statements **Diagnostic Reports** Diagnostic Films
 Others Listed Here:

The Following Items Must Be initialed to Be Included in the Use and/or Disclosure:

- ____ HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases
____ Mental Health information and/or Records
____ Domestic Violence
____ Genetic Testing information and/or records
____ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe: _____

I understand that, if the person entity receiving the information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality requirements. Authorization will expire in Six (6) Months from date of signing.

Print Patient's Name: _____ Date: _____

Signature of Patient or Patient's Legal Representative: _____

Print Name of Legal Representative (if applicable): _____

Relationship to patient: _____