



## WELCOME TO BORN CLINIC, P.C.

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Welcome to Born Clinic! Thank you for trusting us with your health care needs. We appreciate the opportunity to become your partner in improving your overall health and wellness. Our staff believes in the idea of challenging the "one-size-fits-all" model of medicine. We are passionate about preventing future health problems by adequately managing your current health issues. We are steadfast in our commitment to integrating unique, innovative practices with conventional medicine, as we cultivate a personalized approach to each patient's health care.

For over 30 years, Born Clinic has compassionately provided a whole-body approach for healing and improving our patient's well-being. Our integrated model of care includes detailed health examinations, supported by extensive laboratory testing and innovative therapies.

At the time of your first visit, please bring with you completed new patients forms, along with your insurance card and photo ID. Please also bring paper copies of your most recent testing (blood tests, imaging, biopsies, mammograms, cardiac tests, or any other test results that are relevant to your visit), as well as a list of your current medication and nutritional supplements.

If you have any questions or concerns, please call us for assistance at 616-656-3700.

Thank you,

*The Staff at Born Clinic*

Date: \_\_\_\_\_

**Welcome to Born Clinic! Please tell us: How did you first learn of our clinic?**

Born Clinic Website    Sign Outside Building    Friend or Family Member: \_\_\_\_\_  
 Healthcare Provider: \_\_\_\_\_    Book: \_\_\_\_\_    Other: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_

**Responsible Party:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Email:** \_\_\_\_\_

*Important: Born Clinic may need to call you to remind you of an appointment, provide test results, or make recommendations.*

**Primary Phone:** \_\_\_\_\_ **Secondary Phone:** \_\_\_\_\_  
 Cell    Home    Work    Other: \_\_\_\_\_    Cell    Home    Work    Other: \_\_\_\_\_

I consent to receive calls from Born Clinic for my protected healthcare and other services at the phone number(s) provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system. \_\_\_\_\_

*Patient or Guardian Signature*

**Family Information, including patient:**

First Name:	MI:	Last Name:	Sex:	DOB:	Age:	Employer:

**Emergency Contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Allergies to any medications:** \_\_\_\_\_  
\_\_\_\_\_

**Surgeries:** \_\_\_\_\_

**Allergy to Latex:**    Yes    No   **Date of most recent colonoscopy:** \_\_\_\_\_   **Date of most recent bone density:** \_\_\_\_\_

**Women:** **Date of most recent pap smear:** \_\_\_\_\_   **Date of most recent mammogram:** \_\_\_\_\_   **Dense Breasts:**    Yes    No

**Medications and/or Supplements you are currently taking:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Major medical problems:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# MEDICAL HISTORY REVIEW

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### Personal Medical History:

Please check all that apply to past and present medical conditions (if checked, please note onset/type):

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Anemia                            | <input type="checkbox"/> Blood Disorder                    | <input type="checkbox"/> Clots _____                  | <input type="checkbox"/> High Blood Pressure _____         |
| <input type="checkbox"/> Arthritis _____                   | <input type="checkbox"/> Autoimmune Disease _____          | <input type="checkbox"/> COPD                         | <input type="checkbox"/> Emphysema                         |
| <input type="checkbox"/> Breast Issues                     | <input type="checkbox"/> Dense Breasts _____               | <input type="checkbox"/> Asthma _____                 | <input type="checkbox"/> High Cholesterol _____            |
| <input type="checkbox"/> Cancer _____                      | <input type="checkbox"/> Dementia                          | <input type="checkbox"/> Alzheimer's _____            | <input type="checkbox"/> HIV                               |
| <input type="checkbox"/> COPD                              | <input type="checkbox"/> Emphysema                         | <input type="checkbox"/> Asthma _____                 | <input type="checkbox"/> Hepatitis                         |
| <input type="checkbox"/> Depression                        | <input type="checkbox"/> Anxiety _____                     | <input type="checkbox"/> Diabetes _____               | <input type="checkbox"/> TB _____                          |
| <input type="checkbox"/> Diabetes _____                    | <input type="checkbox"/> Digestive Issues                  | <input type="checkbox"/> IBS _____                    | <input type="checkbox"/> Kidney Disease _____              |
| <input type="checkbox"/> Digestive Issues                  | <input type="checkbox"/> IBS _____                         | <input type="checkbox"/> Enlarged Prostate _____      | <input type="checkbox"/> Liver Disease _____               |
| <input type="checkbox"/> Enlarged Prostate _____           | <input type="checkbox"/> GERD (Acid Reflux) _____          | <input type="checkbox"/> Heart Attack _____           | <input type="checkbox"/> Lyme Disease _____                |
| <input type="checkbox"/> GERD (Acid Reflux) _____          | <input type="checkbox"/> Glaucoma                          | <input type="checkbox"/> Other Eye Problems _____     | <input type="checkbox"/> Menopause                         |
| <input type="checkbox"/> Glaucoma                          | <input type="checkbox"/> Other Eye Problems _____          | <input type="checkbox"/> Heart Disease                | <input type="checkbox"/> Andropause _____                  |
| <input type="checkbox"/> Heart Attack _____                | <input type="checkbox"/> Heart Disease                     | <input type="checkbox"/> CHF                          | <input type="checkbox"/> CAD _____                         |
| <input type="checkbox"/> Heart Disease                     | <input type="checkbox"/> CHF                               | <input type="checkbox"/> CAD _____                    | <input type="checkbox"/> Migraines                         |
| <input type="checkbox"/> Heart Murmur                      | <input type="checkbox"/> Arrhythmia _____                  | <input type="checkbox"/> Heart Murmur                 | <input type="checkbox"/> Headaches _____                   |
| <input type="checkbox"/> Arrhythmia _____                  | <input type="checkbox"/> High Blood Pressure _____         | <input type="checkbox"/> Stroke _____                 | <input type="checkbox"/> Neuropathy _____                  |
| <input type="checkbox"/> High Blood Pressure _____         | <input type="checkbox"/> High Cholesterol _____            | <input type="checkbox"/> Thyroid Disease _____        | <input type="checkbox"/> Osteoporosis _____                |
| <input type="checkbox"/> High Cholesterol _____            | <input type="checkbox"/> Liver Disease _____               | <input type="checkbox"/> Other (please specify) _____ | <input type="checkbox"/> Peripheral Vascular Disease _____ |
| <input type="checkbox"/> Liver Disease _____               | <input type="checkbox"/> Osteoporosis _____                |   | <input type="checkbox"/> PMS                               |
| <input type="checkbox"/> Osteoporosis _____                | <input type="checkbox"/> Peripheral Vascular Disease _____ |   | <input type="checkbox"/> Heavy/Painful Menses              |
| <input type="checkbox"/> Peripheral Vascular Disease _____ | <input type="checkbox"/> Stroke _____                      |   | <input type="checkbox"/> Fibroids _____                    |
| <input type="checkbox"/> Stroke _____                      | <input type="checkbox"/> Thyroid Disease _____             |   | <input type="checkbox"/> Sleep Apnea                       |
| <input type="checkbox"/> Thyroid Disease _____             | <input type="checkbox"/> Other (please specify) _____      |   | <input type="checkbox"/> Insomnia _____                    |
| <input type="checkbox"/> Other (please specify) _____      |  |   | <input type="checkbox"/> Other (please specify) _____      |

### Family Medical History (Grandparents, Mother, Father, Siblings): Unknown Family History

Please check all that apply to family medical history (if checked, please specify which relative):

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Arthritis _____          | <input type="checkbox"/> Heart Murmur                      | <input type="checkbox"/> Arrhythmia _____ |
| <input type="checkbox"/> Autoimmune Disease _____ | <input type="checkbox"/> High Blood Pressure _____         |   |
| <input type="checkbox"/> Cancer _____             | <input type="checkbox"/> High Cholesterol _____            |   |
| <input type="checkbox"/> COPD                     | <input type="checkbox"/> Liver Disease _____               |   |
| <input type="checkbox"/> Emphysema                | <input type="checkbox"/> Osteoporosis _____                |   |
| <input type="checkbox"/> Asthma _____             | <input type="checkbox"/> Peripheral Vascular Disease _____ |   |
| <input type="checkbox"/> Dementia                 | <input type="checkbox"/> Stroke _____                      |   |
| <input type="checkbox"/> Alzheimer's _____        | <input type="checkbox"/> Thyroid Disease _____             |   |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Other (please specify) _____      |   |
| <input type="checkbox"/> Anxiety _____            |  |   |
| <input type="checkbox"/> Diabetes _____           |  |   |
| <input type="checkbox"/> Glaucoma                 |  |   |
| <input type="checkbox"/> Other Eye Problems _____ |  |   |
| <input type="checkbox"/> Heart Attack _____       |  |   |
| <input type="checkbox"/> Heart Disease            |  |   |
| <input type="checkbox"/> CHF                      |  |   |
| <input type="checkbox"/> CAD _____                |  |   |

### Social History/Habits:

- Tobacco Use?  Quit  Yes  No If yes, how much? \_\_\_\_\_ How often? \_\_\_\_\_
- Alcohol?  Yes  No If yes, how much? \_\_\_\_\_ How often? \_\_\_\_\_
- Caffeine (coffee/soda)?  Yes  No If yes, how much? \_\_\_\_\_ How often? \_\_\_\_\_
- Recreational Drugs?  Yes  No If yes, how much? \_\_\_\_\_ How often? \_\_\_\_\_
- Do you exercise?  Yes  No If yes, how much? \_\_\_\_\_ How often? \_\_\_\_\_
- Diet/Eating Habits (balanced, poor, vegetarian, gluten free, etc.): \_\_\_\_\_

I certify that the information given on this form is correct and accurate to the best of my knowledge. I understand that it is my responsibility to inform Born Clinic of any changes in my medical condition.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## BORN CLINIC FINANCIAL POLICY

Every effort is made to ensure that your visit to Born Clinic is a pleasant experience. We believe patients have a right to know, and that the Clinic has an obligation to provide, complete information about fee schedules and payment requirements. Unless you have Medicare\* or prior arrangements have been made for you, we appreciate total payment at the time services are rendered.

Payment may be made by cash, check, or credit card. You will be given an encounter form that you may send to your insurance company.

Born Clinic bills most Medicare plans but does not otherwise routinely file insurance claims. While we will cooperate to the fullest in providing you with accurate information so that you may bill your insurance company, you remain fully responsible for your account. If you have any questions regarding our financial policy, please feel free to speak with a receptionist or billing manager.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Insurance Information: If you are covered by more than one insurance company, please supply information from both carriers.**

Name of <i>Primary</i> Insurance:	Name of <i>Secondary</i> Insurance:
Name of the Insured (name on ID card):	Name of the Insured (name on ID card):
Insured's Date of Birth:	Insured's Date of Birth:
Patient's relationship to the insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Patient's relationship to the insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
Insured ID#:	Insured ID#:
Group # or Company Name:	Group # or Company Name:

**Please note:** Born Clinic does not file claims for Auto Accidents or Workers' Compensation.

**I authorize the release of my medical information or any other information necessary to process my claim(s):**

**Patient or Authorized Person's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Medicare Patients Only:** We are participating physicians with traditional Medicare and Medicare Plus Blue PPO. We are out of network for all other Medicare plans. We will file all covered Medicare services for you and accept Medicare's allowable charge.

We will bill you for any deductible and co-pays that you are responsible for. If you or your spouse are employed and have coverage through an employer, Medicare may be your secondary insurance. Born Clinic must know which insurance is primary and which is secondary.

I, \_\_\_\_\_ (*patient name*), hereby acknowledge by this statement that I have been fully informed that some and perhaps all of the medical services provided at Born Clinic, P.C., on or after this date by Tammy Born Huizenga, D.O.; Dorothy A. Pedtke, D.O.; Lory M. Read, D.O.; Mary L. Louder, D.O.; Robert E. Miller, P.A.-C.; Rachal L. Rossi, NP; Katherine Warner, NP, and their associates, may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other medical insurance. I realize that my insurance coverage, including Medicare, will not pay for such non-covered services, and I will be personally responsible for payments to the Born Clinic for such non-covered services.

I authorize payment of medical benefits be made on my behalf to Born Clinic, P.C., for any services furnished to me by Born Clinic. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents

any information needed to determine these benefits or the benefits payable for related services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

\*We do **not** participate with all Medicare plans. Please ask the receptionist or billing manager if you have any questions.



# AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Your medical information is confidential. Occasionally, it may be helpful or necessary for us to speak with a family member or friend on your behalf regarding an appointment, medications, test results, or to share medical advice. **Please note that this is not an authorization to release medical records.** In order to release a copy of your medical records, you will need to complete a separate records disclosure form.

I give Born Clinic permission to discuss my protected health information with the following person(s). This authorization will remain in effect until I withdraw my permission in writing to Born Clinic, attention operations director. I am aware that I am entitled to a copy of this form upon my request.

Name:	Relationship:	Phone Number:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# PREVENTIVE HEALTH CARE RECOMMENDATIONS FORM

Dear Patients,

The providers at Born Clinic are always striving to bring you the best in preventive care. Therefore, we would like to remind you that certain health examinations and screenings are recommended on a regular basis. Most of these examinations can be done at our office. Please review the recommendations below and then speak to your provider about which ones are right for you. In addition, please fill out the Medical History Review form.

### Recommended Periodic Health Examinations for Men and Women:

Age:	Recommended Screening:	Frequency:
18 Years & Older	Blood Pressure, Height, Weight, Nutritional and Toxicity Evaluation	Periodically or as recommended by your physician
35 Years & Older (or earlier if risk factors)	Lipid Profile, Thyroid Profile, Inflammation Markers, Blood Chemistry Profile, Complete Blood Count	Yearly, or more if abnormal or at high risk
40 Years & Older	ECG	Yearly or every other year
50 Years & Older	Sigmoidoscopy or Colonoscopy	Every 5-10 years, or as determined by risk factors

### Recommended Periodic Health Examinations for Women:

Age:	Recommended Screening:	Frequency:
25 Years & Older (or younger if sexually active)	Pap, Pelvic and Breast Exam  Self Breast Exam	Every year, especially if taking hormones Monthly
40 Years & Older (or at age 35 if strong family history of breast cancer)	Mammography, Thermography, or Breast MRI	Every 1-2 years, yearly if taking hormones
45-50 Years (or earlier if menopausal or family history)	Bone Density Measurement	Every 1-2 years

### Recommended Periodic Health Examinations for Men:

Age:	Recommended Screening:	Frequency:
50 Years & Older	PSA Blood Test Prostate Exam Bone Density Measurement	Yearly Yearly Every 1-2 years

I have read and understand the Preventive Health Care Recommendations Form. I will take the appropriate action to make arrangements for the necessary exams.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



PREFERRED PHARMACY, PRIMARY CARE,  
AND SPECIALTY PHYSICIAN(S)

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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Preferred Pharmacy:**

Pharmacy Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

\*If phone number and/or complete address are unknown, please provide street name and city.

**Primary Care Physician:**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

**Specialty Physician(s) - (Cardiology, Urology, etc.):**

1. Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Specialty: \_\_\_\_\_

2. Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Specialty: \_\_\_\_\_

3. Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Specialty: \_\_\_\_\_



WRITTEN ACKNOWLEDGMENT FORM,  
RECEIPT OF NOTICE OF PRIVACY  
PRACTICES

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I acknowledge that I have received a copy of Born Clinic's *Notice of Privacy Practices*.

**Patient's Name:** \_\_\_\_\_

**Patient's Date of Birth:** \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

***If signed by a personal representative:***

Name of personal representative: \_\_\_\_\_

Signature of personal representative: \_\_\_\_\_

Relationship: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Born Clinic Employee Witness Signature: \_\_\_\_\_





## PRESCRIPTION REFILL POLICY

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Dear Patient:

We strive to fulfill your prescription requests in a timely manner, as your health is very important to us. In order to do so, we are requesting that you please review the following:

1. We ask that you call in your prescription refill requests at least 3 days in advance; allow 1 to 2 business days for most refills. Bioidentical hormone and thyroid refills often take longer to process and may take up to 3 business days.
2. We require that you are seen here at least once per year for an examination. Please schedule your appointment far enough in advance to avoid running out of your medication before your appointment. This appointment may be scheduled with any of our providers.
  - a. **If you are a female taking hormones:**
    - Your annual exam will include a pelvic exam, breast exam, and possibly a Pap smear. At the time of your visit, you and your Born Clinic provider will discuss the most appropriate type of breast imaging such as thermography, mammogram, QT ultrasound or breast MRI. Our referral coordinator will schedule the breast imaging appointment and contact you with the details.
    - Routine Pap smear screenings are needed every 2 years and may be done at our office or elsewhere. Please note you will still need an annual pelvic exam performed here to check for abnormalities. This is necessary to prescribe your hormones.
    - If your breast exam and/or Pap smear are performed elsewhere, contact your provider and ask for a copy to be sent to our office. Please do so before you call us for a refill. ***Your prescription refills may be delayed if we do not have up-to-date copies in your chart.***
  - b. **If you are a male taking hormones:**
    - You will be required to have bloodwork done every 6 months, as well as an EKG with your annual visit.

We appreciate working with you to ensure high quality medical care. Thank you for choosing Born Clinic for your health care needs.



# WRITTEN ACKNOWLEDGEMENT FORM, RECEIPT OF PRESCRIPTION REFILL POLICY

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I acknowledge that I have received a copy of Born Clinic's Prescription Refill Policy.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*If signed by a personal representative:*

Name of Personal Representative: \_\_\_\_\_

Signature of Personal Representative: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date: \_\_\_\_\_



## PATIENT PORTAL SIGN-UP SHEET

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We are excited to invite you to join our patient portal. The patient portal will allow you access to parts of your medical record. It's an easy way to stay connected and communicate with us about your healthcare.

On the portal, you can:

- View your upcoming appointments, as well as request an appointment.
- Update demographic and insurance information.
- Securely communicate with our office and your provider.
- View your health information.

Please complete this form to sign up for the portal. You will receive an email invitation to the portal within 24 hours. Please click on the link and follow the prompts. The link will expire in 14 days. You will be asked for your first and last name, date of birth, and zip code, please make sure the information entered exactly matches the information on your fee ticket.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Email Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the requestor is different than the patient (e.g. parent or guardian), please enter the following information:

Name of Individual Requesting Portal Access: \_\_\_\_\_

Requestor's DOB: \_\_\_\_\_ Requestor's Phone Number: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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If you do not wish to participate in Born Clinic's patient portal, please check the box below and sign.

**I decline providing my email for access to Born Clinic's patient portal.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## LATE, NO SHOW, AND CANCELLATION POLICY

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To ensure every patient receives adequate care with his or her Provider, it is important to safeguard the scheduled time allotted with each patient. It is also imperative every Provider spends the length of the appointment to warrant quality care and service. If a patient arrives late, does not show, or cancels, it could not only affect the patient's care, but the care and service of other patients. We understand that there are situations that may arise that could lead to exceptions. These cases will be assessed at the discretion of Management and the patient's Provider. We will try to accommodate our patients as best we can with the possible circumstances that may present.

To promote an understanding between our patients and the practice, we ask that you thoroughly read the following policy guidelines and financial responsibility for any late, no show, or cancelled appointments.

- If you are running late to your appointment, we will try our best to accommodate you; however patients who arrive more than 20 minutes behind their scheduled appointment time may have a shortened visit or be required to reschedule
- Should you need to cancel or reschedule your appointment, we require a 24 hour notice in order to fill the appointment slot for another patient
  - For appointments that are cancelled or rescheduled with less than a 24 hour notice, a non-refundable fee of \$25 will be placed on your account
- Appointments that are missed with no call and no show, a non-refundable fee of \$35 will be placed on your account

We are committed to providing quality care and service. The understanding of your responsibilities are key aspects for Born Clinic to better serve you, as well as other patients.

**I have read and understand Born Clinic's Late, No Show, and Cancellation Policy and agree to its terms. I understand that such terms may be amended by the practice at any time.**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date