WELCOME TO BORN CLINIC, P.C.

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 office 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 medications and nutritional supplements.

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

Thank you,

Born Clinic Staff

3700 52nd Street SE • Grand Rapids, MI 49512 • 616-656-3700
www.bornclinic.com

Date: _____

Welcome! Please tell us: How did you first learn of Born 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

Patient and Family Information (*please list patient first*):

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

Emergency Contact: _____ Relationship: _____ Phone: _____

Allergies (medication/food/environmental): _____

Surgeries: _____

Allergy to Latex: ☐ Yes ☐ No Date of most recent colonoscopy: _____ Date of most recent bone density: _____

Women Only: 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*):

☐ Abdominal Aortic Aneurysm (AAA) _____
☐ Anemia ☐ Blood Disorder ☐ Clots _____
☐ Arthritis _____
☐ Autoimmune Disease _____
☐ Breast Issues ☐ Dense Breasts _____
☐ Cancer _____
☐ COPD ☐ Emphysema ☐ Asthma _____
☐ Dementia ☐ Alzheimer's _____
☐ Depression ☐ Anxiety _____
☐ Diabetes _____
☐ Digestive Issues ☐ IBS _____
☐ Enlarged Prostate _____
☐ GERD (Acid Reflux) _____
☐ Glaucoma ☐ Other Eye Problems _____
☐ Heart Attack _____
☐ Heart Disease ☐ CHF ☐ CAD _____
☐ Heart Murmur ☐ Arrhythmia _____
☐ High Blood Pressure _____
☐ High Cholesterol _____
☐ HIV ☐Hepatitis ☐TB _____
☐ HIV ☐Hepatitis ☐TB _____
☐ Kidney Disease _____
☐ Liver Disease _____
☐ Lyme Disease _____
☐ Menopause ☐ Andropause _____
☐ Migraines ☐ Headaches _____
☐ Neuropathy _____
☐ Osteoporosis _____
☐ Peripheral Vascular Disease _____
☐ PMS ☐ Heavy/Painful Menses ☐ Fibroids ____
☐ Sleep Apnea ☐ Insomnia _____
☐ Stroke _____
☐ Thyroid Disease _____
☐ 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*):

☐ Abdominal Aortic Aneurysm (AAA) _____
☐ Arthritis _____
☐ Autoimmune Disease _____
☐ Cancer _____
☐ COPD ☐ Emphysema ☐ Asthma _____
☐ Dementia ☐ Alzheimer's _____
☐ Depression ☐ Anxiety _____
☐ Diabetes _____
☐ Glaucoma ☐ Other Eye Problems _____
☐ Heart Attack _____
☐ Heart Disease ☐ CHF ☐ CAD _____
☐ Heart Murmur ☐ Arrhythmia _____
☐ High Blood Pressure _____
☐ High Cholesterol _____
☐ Liver Disease _____
☐ Osteoporosis _____
☐ Peripheral Vascular Disease _____
☐ Stroke _____
☐ Thyroid Disease _____
☐ Other (please specify) _____

Dental:

Please check if you have, or have had, the following:

☐ Metal Braces ☐ Crown(s) ☐ Root Canal(s) ☐ Amalgam Filling(s)
☐ Bracket Placement for Teeth Straightening

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

REVIEW OF SYSTEMS

Patient Name: _____ DOB: _____

Are you **currently** experiencing any of the following symptoms? If yes, please check box below.

General:
☐ Fever
☐ Chills
☐ Change in weight
☐ Fatigue

HEENT:
☐ Headache
☐ Sinus pressure
☐ Runny nose
☐ Stuffiness
☐ Difficulty swallowing

Cardiovascular:
☐ Chest pain or discomfort
☐ Palpitations

Pulmonary:
☐ Shortness of breath
☐ Cough
☐ Wheezing

Gastrointestinal:
☐ Abdominal pain
☐ Heartburn
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Bloating
☐ Gas

Neurologic:
☐ Dizziness
☐ Lightheadedness
☐ Fainting (syncope)
☐ Memory lapses or loss

Musculoskeletal:
☐ Muscle aches/pain (Myalgias)
☐ Joint pain

Dermatologic:
☐ Unusual skin lesion/growth

Genitourinary:
☐ Changes in urinary habits
☐ Blood in urine

Female only:
☐ Vaginal pain
☐ Stress incontinence
☐ Menopausal concerns
☐ Hot flashes
☐ Night sweats
☐ Vaginal dryness

Male only:
☐ Erectile dysfunction

Psychiatric:
☐ Anxiety
☐ Depression
☐ Insomnia

Toxin Exposure:
☐ Exposure to farm or pesticides
☐ Mercury/metal fillings
☐ Work(ed) at a foundry
☐ Factory exposure to toxic metals, chemicals, dusts
☐ Secondhand tobacco smoke in home

Water Intake:
☐ Consumption of city water
☐ Consumption of well water
☐ Consumption of purified water

Family Risks:
☐ Family history of cancer
☐ Family history of early deaths
☐ Family history of genetic disease
☐ Family history of autoimmune disease

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 Name: _____ **DOB:** _____

Patient Signature: _____ **Date:** _____

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

Name of *Primary* Insurance:	Name of *Secondary* 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: ☐ Self ☐ Spouse ☐ Child	Patient's relationship to the insured: ☐ Self ☐ Spouse ☐ 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.; Brandi Boone, WHNP-BC, CNM; Christy F. Johnson, NP; Abigail M. Matovich, P.A.-C; Robert E. Miller, P.A.-C, 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 (spouse, parents, children, etc.) 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:

❒ I decline giving Born Clinic permission to discuss my medical information with a family member or friend.

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.

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 Breast Self-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 understand that it is my responsibility to take the appropriate action in making arrangements for the necessary exams. I also understand that if my Born Clinic Provider is unable to manage my medical condition and/or medications, I may be referred to an outside Primary Care Physician.

Patient Signature: _____ Date: _____

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

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) - (e.g., 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

I acknowledge that I have received, or have the right to request, a copy of Born Clinic's *Notice of Privacy Practices*. I understand that Born Clinic has the right to change its Notice of Privacy Practices at any time.

Patient Name: _____ **DOB:** _____

Patient Signature: _____ **Date:** _____

If signed by a personal representative:

Name of Personal Representative: _____

Signature of Personal Representative: _____

Relationship: _____ Date: _____

PRESCRIPTION REFILL POLICY

Dear Patient:

We strive to fulfill your prescription request(s) 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 request(s) at least 3 days in advance. Please 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 in office at least once per year** for an examination. Based on your diagnosis, you may be required to be seen more frequently (e.g., every 3 months, 6 months, etc.). Please schedule your appointment far enough in advance to avoid running out of your medication before your appointment. Your prescription may not be refilled if you have not been seen in office within a year of your request.
3. Hormone Prescription Refill Requests
    a. **Female Patients on Bioidentical Hormone Replacement Therapy:**
        - Your annual exam may include a pap smear/pelvic exam and breast exam.
        - Routine pap smear/pelvic exam/breast exams may be done at our office or elsewhere. If performed elsewhere, we ask that you contact your provider and request a copy be sent to our office. Please do so before you call with a refill request. *Your prescription refill request(s) may be delayed if we do not have up-to-date copies in your file.*
            1. Please note: you may still need an annual pelvic exam performed by a Born Clinic Provider to check for abnormalities, as this is necessary to prescribe bioidentical hormone replacement therapy.
        - You will be required to have yearly breast imaging (such as thermography, mammogram, ultrasound, or breast MRI).
        - You will be required to have bloodwork annually (every 6 months may be necessary for some patients).
        - If you are prescribed Testosterone, you will be required to have an updated prescription every 6 months.
    b. **Male Patients on Bioidentical Hormone Replacement Therapy:**
        - You will be required to have an EKG with your annual visit.
        - You will be required to have a PSA drawn at your annual visit (or every 12 months).
        - You will be required to have bloodwork every 6 months.
        - You will be required to have an updated prescription every 6 months.

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

I have read and understand Born Clinic's *Prescription Refill Policy* and agree to its terms. I acknowledge that I have received a copy and understand that such terms may be amended by the practice at any time.

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

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: _____

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

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: _____ DOB: _____

Patient Signature: _____ Date: _____