(The Center for Life Enrichment)

New Patient Information Sheet

Personal Information (must be filled out completely)

Doctor 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 ____________________

Driver's License # of the Responsible Party ____

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 ____

Reason For Your Visit ____

____

Family Physician ____________________________ Telephone Number ( ) ____________

Whom may we contact in an emergency? ____

Telephone number ( ) ____________________________ Relationship ____________________

FINANCIAL AGREEMENT

I, ________________________________ understand that I am being accepted as a cash only patient and that Ardent is a concierge service. I understand services are to be paid in full** at the time of service by cash/ credit or debit card/ or check and that Ardent is not contracted with any insurance company.

_____________________________________ _____________________________

Signature of Patient (or Legal Guardian) Date

_____________________________________ _____________________________

Witness (Ardent Staff Member) 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.

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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: Male/Female Date of birth: _____________

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? Yes 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 (_______) ______________________________ Fax number ____________________________

***Please make sure to sign an IPD Release of Information Form**

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Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates or ~year of infection:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

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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	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Other Modalities (ex: massage, yoga, meditation, etc)	☐ Yes, please list:_______________________________________	☐ No			
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you considered stopping?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to “binge” drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No

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Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	If yes, are you trying for a pregnancy?			☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?			☐ Yes	☐ 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?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of these?			☐ Yes	☐ 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?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Do you have any children?** Yes: ☐, #____ No: ☐	☐ M ☐ F	
Mother				☐ M ☐ F	
Siblings Where are you in your family's birth order? # ____ of____ children	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

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MENTAL HEALTH

Question	Yes	No
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

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

MEN ONLY

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

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OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

CURRENT MEDICATIONS/SUPPLEMENTS:

NAME:	DOSE:

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Authorization to Release Information

_____ I authorize Ardent to request records from the following office:

_____ I authorize Ardent to release records to the following office:

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

____
(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
___ Medical Records
___ Medical History/Physical
___ Psychologist Evaluation
___ Social History

___ ALL INFORMATION
___ Lab Results
___ Treatment Plan/Patient Progress
___ Discharge Summary
___ Results of Drug and Alcohol Treatment or Testing
___ Other (specify) ______________________________________

For the Purpose of: ____

Approximate Dates of Service: ____

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

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 redisclosure 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

______________________________ ____________________
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. ****

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Ardent
Administrative Policies

Thank you for choosing Ardent for your healthcare needs. We are committed to high quality, personalized and comprehensive care. We ask that you carefully read the following administrative policies so that the expectations of our organization are understood and we may care for you in the most efficient manner. Please initial underneath each policy acknowledging you have read, understood and agreed to these policies.

Patient / Guarantors Initials: ____

Consent for treatment:
I hereby authorize and acknowledge to work with physicians and other clinicians at Ardent to administer such medications and treatments as may be deemed necessary for the interest and care of me / and/or the child for whom I acknowledge that I am the official legal guardian.

Patient / Guarantors Initials: ____

Guarantee of payment:
I understand that I will solely be responsible to pay the charges of the scheduled visit time.
I understand insurance will not cover the cost of the visit.
I understand that I am responsible for the charge of the time of the visit which I scheduled even if I shorten my visit time.
I understand and agree to pay for the visit in full at a time of the appointment.

Patient / Guarantors Initials: ____

Delinquent Accounts:
I give permission to charge my credit card for any delinquent payments which are due.
All outstanding balances are due in full at the time the services are provided.
I understand if I have a delinquent account over 60 days that my account will be sent to a collection agency with a 30% Collection fee added to the outstanding balance. In the event that services are not paid in full and we must pursue legal action, all attorney fees, court costs and filing fees will be the responsibility of the patient/guarantor.
I understand that late payment or nonpayment of account balances may be grounds for termination of services rendered by Ardent.

Patient / Guarantors Initials: ____

(The Center for Life Enrichment)

Cancellations:
All appointments must be canceled 24 hours in advance of the appointment time. If an appointment is canceled less than 24 hours in advance, I understand that I will be responsible for the charge of the scheduled visit.
Please be advised that your clinician does not have the ability to waive this fee. If there is a circumstance that is out of the patient's control that caused him/her to miss his/her appointment, then appropriate documentation must be submitted for administrative review. The administrative director will have the sole discretion of whether this fee may be waived.

Patient / Guarantors Initials: ____

Phone consultations:
Phone consultations will be charged at the normal hourly rates. Phone calls without a scheduled appointment will be charged in five minute increments. All phone consultations will be the patient's responsibility. Charges for phone consultation will be due before, but no later than, at the time of the next scheduled visit.

Patient / Guarantors Initials: ____

Medical records charges:
We take time and consideration to ensure your records are kept confidential. There is a standard $30 fee per medical records that are released outside of physician offices. Please note that all medical record fees must be paid in full before any medical records will be released.

Patient / Guarantors Initials: ____

Completion of forms and letters:
There is no additional charge for forms and letters which are completed during the office visit. However, any forms or letters completed outside the normal visit hours may be charged starting at a thirty dollar service fee. More complex paperwork, such as FMLA, require an appointment to discuss such circumstances.

Patient / Guarantors Initials: ____

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Because insurance companies do not honor the time necessary for physicians to spend the necessary time involved in excellent patient care, Ardent has decided not to accept insurance. In order to provide specialty care, this requires your physician to spend sufficient time with you to accurately diagnosis, treat and educate our patients. Our hourly rates are as follows:

Rates:

Dr. Sarah Zielsdorf, MD, MS in person or on phone Initial Eval - 2 hours 500.00 Follow up - 1 hour 425.00 Follow up - 30 mins 275.00 **Roxana Calafos, FNP in person or on phone** Initial Eval 2 hours - 375.00 Follow up - 1 hour 300.00 Follow up- 45 minutes 250.00 Follow up - 30mins 200.00	**Jennifer Peterson, FNP in person or on phone** Initial Eval 2 hours - 375.00 Follow up - 1 hour 300.00 Follow up- 45 minutes 250.00 Follow up - 30mins 200.00 **Kelly Johnson, LCPC Health Coach in person or on phone** Initial Eval 1 hours- 140.00 Follow up - 1 hour 140.00 Follow up - 30mins 95.00 **Phone calls with Dr. Zielsdorf Assistants** $60 per hour *(discretionary)*

**Phone consultations are not covered by insurance. The rates for phone calls will be charged the same as the rates for self-pay patients.

**Appointments will be charged the amount of time that the appointment is scheduled for. To make sure everyone receives an appropriate amount of time with their provider, appointments will not go over in time. Appointments that require extra time will need to book an additional follow-up appointment shortly after (this can be in the form of an in person visit or phone consultation).

Please Sign Below to Authorize treatment that you acknowledge your full financial responsibility for services rendered at the time of the visit:

_________________________________ ________________________

Printed name of the patient date

_________________________________ _________________________

Signature of the patient date

_________________________________ _________________________

Signature of the guarantor date

_________________________________ _________________________

Signature of Ardent staff date

If the patient is unable to sign please state the reason below:

____

____

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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: X____ **Date:** ______________

Relationship to patient (if signed by a personal representative of patient): ________________________

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PATIENT COPY

Notice of Privacy Practices
Patient Acknowledgement

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- 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.
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  - 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.
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Signature: X____ **Date:** _______________

Relationship to patient (if signed by a personal representative of patient): ________________________