Integrative Physicians of Atlanta 4880 Lawrenceville Highway Tucker, GA 30084 (770) 864-9602

Today's Date:	

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Marital status: Single Mar Div Sep
Street address:	Birth date:	Social Security no.:	Home phone no.: ( )
P.O. box:	City:	State:	ZIP Code:
Referred to clinic by :			
Family	Friend	Insurance Plan	Yellow Pages	Work:	Hospital:	Other:
Other family members seen here:						

INSURANCE

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: ■ ■	Address (if different):	Home phone no.: ( )
Is this person a patient here?	Yes No		
Occupation:	Employer:	Employer address:	Employer phone no.: ( ) ■

Please indicate primary insurance	BCBS	United Healthcar	Cigna	Aetna	Other
If other please indicate:					

Subscriber's name:	Subscriber's S.S. no.: ■ ■	Birth date: ■	Group no.: ■	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	Self	Spouse	Child	Other	
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber:	Self	Spouse	Child	Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize INTEGRATIVE PHYSICIANS OF ATLANTA or insurance company to release any information required processing my claims.

Patient/Guardian signature *Date*

Health History

Name_____ **Date**_____
DOB_____

Check any of following medical problems that you have had.

☐ Abn Weight Loss	☐ Rheumatic Fever	☐ Arthritis or joint pain
☐ Abn Weight Gain	☐ High Cholesterol	☐ Gout
☐ Excessive Fatigue	☐ Heart Failure	☐ Broken Bones
☐ Insomnia	☐ Heart Attack	☐ Rashes
☐ Anemia	☐ High Blood Pressure	☐ Hives
☐ Cancer or Tumor	☐ Breathing Problems	☐ Moles
☐ Glasses/ Contacts	☐ Frequent Bronchitis	☐ Seizure
☐ Glaucoma	☐ Emphysema	☐ TIA
☐ Cataracts	☐ Pneumonia	☐ Stroke
☐ Vison problems	☐ Asthma	☐ Numbness
☐ Hearing Loss	☐ Heartburn	☐ Weakness
☐ Ear Problems	☐ Ulcer Disease	☐ Memory Loss
☐ Ringing in Ears	☐ Gallbladder Disease	☐ Headaches
☐ Allergies	☐ Blood in Stool	☐ Depression
☐ Frequent Sinus Infections	☐ Hepatitis	☐ Anxiety/Panic Attacks
☐ Dentures	☐ Diarrhea, Constipation	☐ Suicide Attempt
☐ Dental Problems	☐ Hemorrhoids	☐ Physical Abuse
☐ Recurrent Sores In mouth	☐ Abdominal Pain	☐ Sexual Abuse
☐ Angina	☐ Colon Polyp	☐ Mental Illness
☐ Frequent Chest Pain	☐ Urinary Frequency	☐ Diabetes
☐ Irregular Heartbeat	☐ Bladder Infections	☐ Thyroid Disease
☐ Heart Murmur	☐ Prostate Problems	☐ Sexually Transmitted Diseases
☐ Kidney Problems	☐ Urinary Frequency	
☐ Abnorrmal Pap Smear	☐ Bladder Infections	
☐ Abnormal Mammogram	☐ Prostate Problems	
☐ Breast Lump	☐ Urinary Incontinence	
___#Pregnancies ___Live Births ___Miscarriages ___Abortions	Have you been exposed to or do you have a close family member with… ☐ HIV/AIDS ☐ Hepatitis ☐ TB	

Please list the last year in which you have had any of the following:

Physical Exam_____	Sigmoidoscopy/Colonoscopy (Circle which one)____	Cholesterol___
Pap smear_____	Stool Cards for Colon Cancer____	Dental Visit___
Mammogram_____	Rectal/Prostate Exam____	Eye Exam____
Testicular Exam_____	Bone Density____	Stress Test____

Please describe your use of tobacco products. (Check all that apply)
None_____ Cigarettes_____ Smokeless Tobacco_____ Pipe_____ Cigars_____

How much do you or did you smoke_____ per day? How often _____?
Do you wish to quit? Now_____ Soon_____ Eventually_____ Never_____
Have you quit? _____ When? _____

How much alcohol do you drink weekly on average? _____
Do you have a problem with alcohol? Yes_____ No_____

Have you used illicit drugs (marijuana, heroin, cocaine, LSD, etc.)? Yes_____ No_____

How much caffeine do you drink daily (include coffee, tea, colas)?_____

Are you sexually active? ____ Are your partners male, female, or both? (Circle)
Do you use contraception? None__ Rhythm__ Condoms__ Pill__ Vasectomy__ IUD__
Diaphragm__ Tubal Ligation__
Do you practice safe sex? Never__ Sometimes__ Always__

Please check if there is a history of any of the following diseases in your family.
Heart Disease__ Diabetes__ Colon Cancer__ Osteoporosis__ Prostate Cancer__
Breast Cancer__ Ovarian Cancer__ High Cholesterol__ Skin Cancer__

Please fill in the following family history. Age (or age at death)
Mother_____
Father_____
Siblings_____
Children_____

Other medical problems:
1._____
2._____
3._____
4._____

List ***all*** surgeries you have had:
1._____
2. _____
3._____
4. _____

List ***all*** allergies:
1_____
2._____
3._____
4._____

List medications, vitamins, and supplements you are currently taking:
1._____
2._____
3._____
4._____

Patient's Signature_____ Date_____

INTEGRATIVE PHYSICIANS OF ATLANTA

4880 Lawrenceville Highway, Suite 13
Tucker, GA 30084
(770) 864-9602

AUTHORIZATION FOR RELEASE/DISCLOSURE OF PROTECTED MEDICAL RECORDS

TO: _____

At the request of the undersigned, you are hereby authorized, requested and directed to disclose protected health information about me as described below for the purpose of evaluation and/or treatment with a Doctor at INTEGRATIVE PHYSICIANS OF ATLANTA.

1. The following specific person or class of persons or facility is authorized to make the requested disclosure: any and all medical doctors, hospitals, emergency treatment centers, private health care facilities, chiropractors, physical therapists, or any other persons or facilities who have provided any health related treatment, diagnosing testing, or test analysis on behalf of the undersigned or who maintain any documentation pertaining to the physical and/or mental condition of the undersigned.

2. INTEGRATIVE PHYSICIANS OF ATLANTA may receive disclosure of protected health information about me.

3. The specific information that should be disclosed is: documentation pertaining to the physical and mental condition of the undersigned, including patient history, examination, diagnosis, treatment, prognosis, opinion, x-ray and complete treatment file. I understand that this disclosure may include psychiatric, drug/alcohol, and/or HIV testing results, and/or AIDS related information. You are further authorized, requested and directed to discuss any relevant knowledge you may have related to any of the above-referenced information with the Doctor(s) of INTEGRATIVE PHYSICIANS CENTERS OF ATLANTA.

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying INTEGRATIVE PHYSICIANS OF ATLANTA in writing of my desire to revoke it. However, I understand that any action already taken in reliance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that any medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign this authorization. This authorization shall remain in effect regardless of the lapse of time, unless revocation is submitter to INTEGRATIVE PHYSICIANS OF ATLANTA in writing as stated above.

6. This authorization and/or request to release information from my protected health information (PHI) is fully understood and is made voluntarily on my part and includes faxing of my PHI to/from INTEGRATIVE PHYSICIANS OF ATLANTA.

Patient's Name: _____ Date: _____

Guardian's Name: _____ For: ☐ Minor ☐ Mental/Physical disable

Patient/Guardian's Signature: _____

Patient's DOB: _____

Patient's SSN _____-_____-_____ Guardian's SSN: _____-_____-_____

Witness's: _____ Date: _____

INTEGRATIVE PHYSICIANS OF ATLANTA

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI to be made by alternative means, such sending correspondence to the individual's office instead of their home.

For appointment reminders, rescheduling or billing, I authorize the staff of INTEGRATIVE PHYSICIANS OF ATLANTA to contact me at any of the phone numbers given to them. For all other matters I wish to be contacted in the following manner (check all that applies):

CHECK AT LEAST ONE

☐ Home Telephone _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

☐ Work Telephone _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

☐ Cell Telephone _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

CHECK AT LEAST ONE

☐ Written Communication
- ☐ OK to mail to my home address
- ☐ OK to mail to my work/office address
- ☐ OK to fax to this number _____

☐ Email: _____
_____
_____

☐ Other: _____
_____
_____

_____
Patient Signature **Date** _____

_____
Patient Name (Print) **Date**_____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Addresses or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

Informed Consent for Allergy Testing and Immunotherapy Treatment

Do not sign this form until yon have read it and fully understand its contents.

Patient's Name: _____ Date: _____

The following consent is intended to improve communication with and education of patients. The following has been explained:

1. The **diagnosis** requiring this procedure: **Allergic Rhinitis**

2. The nature of this procedure is: Hypo-sensitization (trying to make you less sensitive to what you are allergic to). The procedure may also include testing of the skin for allergic reactions with a skin pick device.

3. The **purpose** of these procedures is: to test for allergy and help relieve allergic symptoms.

4. **Possible Risks** It is impossible to truly list all of the complications that may occur from any procedure. However, risks here have been carefully considered. There may be possible risks involved in these procedures including, but not limited to:

Local Reactions: Burning, itching, bleeding, swelling and/or hives, redness of skin, skin blistering/sloughing, and/or possible infection at the injection/puncture site.

Mild Systemic Reactions: Nasal congestions and/or "runny nose;' skin rash, diarrhea, headache, itching of ears, nose, throat and/or sneezing occurring within two hours of the injection/puncture and/or itchy, watery or red eyes.

More severe reactions: Wheezing, coughing, or shortness of breath; bronchial asthma, generalized hives (welts); swelling of tissue around the eyes, tongue or throat; stomach or uterine (menstrual-type) cramps, possible miscarriage (if pregnant).

Rare complications: Abnormalities of the heartbeat, delayed response, loss of ability to maintain blood pressure and pulse, anaphylactic shock, death.

- Severe: There is the possibility of severe reaction involving the heart, lungs and blood vessels which, if unrecognized and untreated, could be fatal.

5. **Precautions to be taken:** Experience has shown that the majority of reactions from allergy testing and/or immunotherapy which require emergency treatment occur within 20 minutes of an injection/puncture. It is for this reason that all patients who receive allergy injections must remain in our designated waiting area for no less than 20 minutes or until checked by one of our lab technicians. If you choose to leave prior to the 20 minute waiting time after your injection, you do so against medical advice and therefore accept all responsibility and liability for any subsequent reaction(s) from shot(s).

On occasion, patients may choose to self-administer their injections. This is not the preferred method and therefore, you accept liability for any subsequent reaction from your allergy shot.

There is a possibility of a reaction occurring after a patient who received their injection(s) or skin testing leaves our allergy office. It is vitally important that any such reaction be reported to the physician before receiving the next injection. If you are ever concerned about a reaction you have after leaving our office, you should return to our office or go to your local emergency room or immediate care facility for treatment

If you are having a life threatening emergency, immediately CALL 911!

6. Duration of Treatment: The average patient will be on allergy immunotherapy, whether shots or drops, for a minimum of two

(2) Years. This schedule is impossible to predict and will differ from patient to patient depending on what your allergies are, how severe they are, and how you tolerate treatment. Your treatment with immunotherapy will be more successful and pose less risk if you consistently receive your shots according to your dosage log, which will be communicated to you by the clinical laboratory specialist.

Note: If you are not consistent in arriving at the appointed time(s) for your allergy shots, you not only decrease the success of your treatment but also increase your risk of having adverse reaction(s) to your immunotherapy, including the risk of anaphylactic shock. If you cannot be consistent in arriving at the appointed time(s) for your allergy shots, you will be asked, for your own protection, to consider alternative forms of allergy treatment. A repeat offender who is unable to stick to their injection schedule may be prevented from receiving allergy shots and their treatment may be discontinued at the discretion of the physician and/or the allergy department.

- Immunotherapy treatment has up to an 85% success rate.
- The practical alternatives to these procedures include antihistamines and other medical treatments.
- Prognosis: If the patient chooses not to have the above procedures, the patient's prognosis (future medical condition) is unknown.

- I understand that the physician, medical personnel or other assistant will rely on statements about the patient, the patient's medical history, and other information· in determining whether to perform the procedures or the course of treatment for the patient's condition in recommending the procedures, which has been explained.

- I understand that the practice of medicine is not an exact science and that no guarantees or assurances have been made to me concerning the results of these procedures.

- I understand that during the course of the procedures described above it may be necessary or appropriate to perform additional procedures, which are unforeseen, or not known to be needed at the time this consent is given. I consent to and authorize the person described herein to make the decision concerning such procedures. I also consent to and authorize the performance of such additional procedures, as they deem necessary or appropriate.

- I consent to the presence of observers in the allergy lab for medical, scientific or educational purposes approved by my physician. I consent to the taking and publication of any photographs or video tapes taken during the course of the patient's procedure for medical, scientific or education purposes approved by my physician.

- By signing this form, I acknowledge that I have read or had this form read or explained to me and that I fully understand its contents. I have been given the opportunity to ask questions and all my questions have been answered satisfactorily. I have also received additional information including but not limited to the materials listed below, related to the procedure described herein.

- I am aware that taking beta-blockers can greatly increase the risk of severe reactions, asthma and possible death while taking allergy shots, drops, or skin tests. I agree to inform the allergy technician at any time that a physician places me on a beta-blocker.
- Female Patients: I agree to notify my physician and the lab technician immediately upon learning that I have become pregnant during the course of allergy Immunotherapy treatment.

- I voluntarily consent to allow Dr. Sampson and all medical personnel under the supervision and control of such physicians and all other personnel who may otherwise be involved in performing such procedures to perform the procedures described or otherwise referred to herein.

Please answer the following questions by circling **YES** or **NO**:

1. Have you read the above Informed Consent document? YES NO

2. Do you understand the nature, expected benefits, and risks of the above-described testing/treatment procedures as well as alternative treatment options? YES NO

3.Are you satisfied that all your questions have been answered? YES NO

4.Do you understand that there are no guarantees to the testing and/or treatment outcomes? YES NO

5. Do you understand that a parent or guardian must be present in order to perform testing for a patient under the age of 18 to receive a consultation and/or testing and/or treatment of any kind? YES NO

6.Do you understand that all patients who receive injections must remain in the office for observation for no less than 20 minutes after their injection(s), until checked by an allergy lab technician and that anyone leaving prior to this time does so against medical advice and thus accepts all liability for subsequent reaction(s)? YES NO

7. Do you understand that if you have any reaction(s) to your allergy injections in a timely manner to our allergy department and, that if you are concerned about reaction(s), you will either return to the office allergy department or go to the local emergency room or immediate care facility for treatment? YES NO

8.Do you understand that if you are unable to consistently arrive for injections according to your shot schedule, this increases your risk of having an adverse reaction to immunotherapy? YES NO

9.Do you understand that if you fail to consistently arrive for injections according to you dosage log, our office may discontinue your immunotherapy treatment, for your own safety? YES NO

We often communicate with patients via email regarding personal medical information. By allowing your physician to communicate with you using this method, you can receive appointment alerts as well as Immunotherapy updates. Please be assured that all information will be kept confidential. By filling out your email address below, you are giving us authorization to send you medical information via email.

Patient E-Mail Address: _____

I the undersigned have read all three (3) pages of this form in its entirety and/or have had this form explained to me and fully understand the contents of this authorization.

Consent to have allergy Immunotherapy medication vials prepared for me, under the supervision of **Dr. Craig Sampson.** Upon receipt of my lab results and/or allergy skin test results so that I may begin my Immunotherapy Medication as soon as possible. I understand that sublingual Immunotherapy is for cash paying patients only.

_____ _____ _____

Patient's Signature/ Legal Authority Relationship to Patient Date

_____ _____

Witness Date

Integrative Physicians of Atlanta

Blood Testing Consent Form

Craig Sampson M.D.

CONSENT TO DRAW BLOOD

DATE: _____

RE: _____

TO: **CRAIG SAMPSON M.D.**

I, _____, authorize the above treating physician to draw blood for testing.

Patient Signature: _____

Date: _____

Integrative Physicians of Atlanta

THINGS TO KNOW BEFORE ALLERGY TESTING

Patient Name: **Date of Birth:**	**Address:**
Daytime Phone:	**Evening Phone:**

ARE YOU CURRENTLY TAKING ANY BETA BLOCKERS, HEART MEDICATIONS, OR OTHER? (CIRCLE ONE)
YES NO

If yes, please list all medications below

DO YOU SUFFER FROM SEVERE ASTHMA? (CIRCLE ONE) YES NO

If yes, please list medication you take to control your asthma below

DO YOU HAVE A HIGH SUSCEPTIBILITY TO ANAPHYLAXIS? (CIRCLE ONE) YES NO EXPLAIN BELOW

ARE YOU PREGNANT? (CIRCLE ONE) YES NO

IS YOUR CHILD 2 YEARS OLD OR UNDER? (CIRCLE ONE) YES NO

ARE YOU TAKING ANY ANTIHISTAMINES OR ALLERGY MEDICATIONS? (CIRCLE ONE) YES NO

If yes, please list the medications below….(Benadryl, Flonase, Allegra)

PATIENT SIGNATURE:	**PHYSICIAN SIGNATURE**
Name: **Date:**	**Name:** **Date:**

Important: For Allergy testing, you must be off any and all Allergy medications 5-7 days prior to testing.