WELCOME TO BORN CLINIC, P.C.

Welcome to Born Clinic, we are so glad you're here! Thank you for trusting us with your health care needs. For over 30 years, Born Clinic has compassionately provided a whole-body approach to healing and wellness. We believe in treating the whole person—not just the symptoms—by combining innovative therapies with conventional medicine to create a personalized approach to better health.

Our office believes in challenging the "one-size-fits-all" model of medicine. We are passionate about preventing future health problems by carefully managing current concerns, and we are steadfast in our commitment to integrating unique, innovative practices with conventional medicine. 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 your completed new patient forms, insurance card, and photo ID. We also ask that you provide paper copies of your most recent test results (such as bloodwork, imaging, specialist notes, or other relevant medical records), along with a list of your current medications and supplements.

If you have any questions, please call us at 616-656-3700.

We look forward to partnering with you on your journey to improved health and wellness!

Sincerely,

Born Clinic Staff

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Date: _____

Personal Information:

First Name: _____ Middle Initial: _____ Last Name: _____

DOB: _____ Gender: _____ Marital Status: _____

Email Address: _____ Approved for messages? ❑ Yes ❑ No

Mobile Phone: _____ Approved for messages? ❑ Yes ❑ No

Home Phone: _____ Office Phone: _____

Responsible Party: _____ Relationship to Patient: _____

Address:

Street Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact:

Emergency Contact: _____ Relationship: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician:

Name: _____ Phone Number: _____

Address: _____

Specialist:

Name: _____ Specialty: _____

Address: _____ Phone Number: _____

Name: _____ Specialty: _____

Address: _____ Phone Number: _____

NOTICE OF PRIVACY PRACTICES

In compliance with federal law, we are required to provide you with our Notice of Privacy Practices, which explains your rights and our legal duties under HIPAA. A complete copy of our notice is available by request at the front desk.

I acknowledge that I have been provided access to Born Clinic's Notice of Privacy Practices and that I understand my rights regarding the privacy of my health information. I understand that if I have questions or concerns about my privacy rights, I may contact the designated HIPAA Privacy Officer at Born Clinic. I further understand that Born Clinic will provide updates to the Notice of Privacy Practices, should it be amended or modified, and that updated copies will be available by request at the front desk. I acknowledge my right to receive this information and confirm my understanding of the Notice of Privacy Practices.

Patient Signature: _____ Date: _____

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Symptoms: *Rank from 1 (none/never) to 5 (always/severe) or "X" if Not Applicable*

Energy and Weight:	1	2	3	4	5	X
Unexplained weight loss						
Weight gain - all over						
Change in appetite						
Fatigue, malaise, lethargy						
Frequent fever or chills						

Eyes and Vision:	1	2	3	4	5	X
Frequent double or blurred vision						

Ears/Nose/Mouth/Throat:	1	2	3	4	5	X
Frequent stuffy ears						
Ear pain						
Ringing in ears						
Hearing loss						
Frequent runny nose						
Frequent nose bleeds						
Sinus pain/infection						
Frequent sore throat						
Pain with swallowing						
Frequent trouble swallowing						

Breathing (Respiratory):	1	2	3	4	5	X
Frequent wheezing						
Frequent coughing						
Shortness of breath with minimal exercise						
Shortness of breath while lying flat						

Heart (Cardiovascular):	1	2	3	4	5	X
Chest pain at rest						
Chest pain with exertion						
Frequent irregular heartbeat						
Ankles swell significantly with standing or walking for a long time						
Frequent palpitations/heart skipping						

Digestion (Gastrointestinal):	1	2	3	4	5	X
Frequent heartburn						
Nausea or the feeling that you may vomit						
Vomiting						
Frequent bloating after eating						
Abdominal pain/cramping						
Change in bowel habits						
Frequent constipation						
Frequent loose stools						
Frequent mucus in stool						
Frequent undigested food in stool						
Frequent gas/flatulence/burping						
Frequent blood in your stools						
Hemorrhoids						

Hormonal (Endocrine):	1	2	3	4	5	X
Cold hands and feet						
Difficulty tolerating hot environments						
Difficulty tolerating cold environments						
Increased sweating						
Decreased sweating						
Increased thirst						
Sugar cravings						
Salt cravings						
Frequent poor appetite						
Night sweats						
Hot flushes/sweating						
Water retention						

Kidney (Genitourinary):	1	2	3	4	5	X
Frequent blood in urine						
Difficulty in starting to urinate						
Dribbling after you have stopped urinating						
After you urinate, you feel as though you still have to urinate more						
Decreased force of stream						
Incontinence with exercise or coughing						
Pain/burning with urination						
Frequent bladder infections						
Bladder problems/incontinence						
Frequent urination						

Brain and Nerves (Neurologic):	1	2	3	4	5	X
Tingling of hands or feet						
Vertigo or the sensation of the room spinning						
Headaches						
Get dizzy if you turn your head quickly						
Frequent lightheadedness						
Tremor or shaking of your hands						
Increased difficulty with memory						
Frequent fainting						
Numbness in hands or feet						

Mood (Psychiatric):	1	2	3	4	5	X
Foggy thinking/brain fog						
Mood swings						
Little interest or pleasure in doing things						
Frequently irritable						
Frequently anxious						
Stress						
Frequently sad/tearful						
Depressive moods						

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Symptoms - *Continued*:

Joint and Bone Problems:	1	2	3	4	5	X
Swelling of your joints						
Aching/painful joints						
Aching/painful muscles						
Frequent stiff muscles and joints in the morning						
Muscle cramps or spasms						
Physical exhaustion						

Skin/Hair:	1	2	3	4	5	X
Acne						
Thinning skin						
Dry scaly skin						
Oily skin and/or hair						
Itching						
Rash/rashes						
Growths on skin						
Bumps on back of upper arms						
Frequent dark circles under eyes						
Nails breaking or brittle						
Loss of scalp hair						
Increased facial and body hair						

Breasts:	1	2	3	4	5	X
Frequent breast pain/tenderness						
Frequent discharge from breast						

Bleeding (Hematologic/Lymphatic):	1	2	3	4	5	X
Excessive or easy bruising						
Frequent prolonged or excessive bleeding						
Enlarged lymph nodes						

Allergic/Immunologic:	1	2	3	4	5	X
Frequent recurrent infections						
Sensitivities to chemicals						
Allergies						
Hypersensitivity to medications, foods, environments, etc.						

Sexual:	1	2	3	4	5	X
Libido (desire to have sex) is diminished						
Painful intercourse						

Women – Have you recently experienced any of the following?

Menses & Vagina (Gynecologic):	Yes	No
Irregular periods		
Heavy periods		
Spotting between periods		
Painful periods		
Vaginal pain		
Dryness of vagina		
Vaginal discharge/odor		
Frequent vaginal infections		

Nutrition & Diet:

Diet:	Yes	No
Do you currently follow a special diet or nutrition plan as noted below?		
Mixed (animal and vegetable sources)		
Physician-assisted low calorie diet (HCG, Medi-Fast, etc.)		
Starch/carbohydrate restriction (Atkins type)		
Allergy restricted (gluten free/dairy free)		
High protein (Paleo type)		
Vegetarian/vegan		

Nutrition:	Yes	No
Do you dislike healthy food?		
Are you an emotional eater?		
Do you overeat under stress?		
Do you eat too little under stress?		
Do you eat mostly non-organic foods?		
Do you drink at least 8 glasses of water a day?		
Do you use caffeine (coffee, tea, soda, energy drinks, etc.)?		
If yes, how many servings per day? ❑ 1 ❑ 2 ❑ 3 ❑ 4 +		
Do you take antacids frequently?		
Do you take lactose intolerance pills frequently?		
Do you regularly use acid-blocking drugs (Tagamet, Zantac, Prilosec, etc.)?		

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Exercise/Workout Details/Job Intensity:

Average number of workouts per week: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10+

Average time per workout: ❑ No Workouts ❑ 0-30 ❑ 31-45 ❑ 46-60 ❑ 60+

Average intensity of workout: ❑ No Workouts ❑ Light ❑ Moderate ❑ Hard ❑ Very Hard

Job Intensity: ❑ Sedentary ❑ Not Sedentary ❑ Physical

Energy & Sleep: *Rank from 1 (none/never) to 5 (always/severe) or "X" if Not Applicable*

Energy Level - Rank from 1 (low) to 5 (high)	Typical Time:	1	2	3	4	5	X
Lunch	AM/PM						
Mid-day	AM/PM						
Dinner	AM/PM						
Late at night	AM/PM						
Bedtime	AM/PM						

Sleep Pattern:

Length of time to fall asleep (minutes): ❑ 0 ❑ 5 ❑ 10 ❑ 15 ❑ 30 ❑ 45 ❑ 60 ❑ 90+ minutes

Hours slept before waking for first time (hours): ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9+

Average hours slept each night (hours): ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9+

Sleep Problems:	Yes	No
Do you snore?		
Do you wake with a headache?		
Do you wake up feeling tired/not rested?		
Do you have trouble falling asleep?		
Do you wake up often throughout the night?		
Do you have trouble falling back to sleep once awakened?		
Do you use a sleep apnea device?		
Do you take herbal or over-the-counter medication to sleep?		
Do you take prescription medication to sleep?		
Have you been told that you stop breathing while asleep?		
Do you kick or jerk your legs and/or arms while asleep?		
Do you ever awake choking, gasping for air, or feeling smothered?		
Do you experience restlessness, tingling, or crawling in your arms or legs?		
Do you experience inability to keep your legs still prior to falling asleep?		
As an adult, have you had episodes of talking in your sleep?		
As an adult, have you had episodes of sleep walking?		
Does your heart pound at night?		

Stress:

Stressors: Rank from 1 (none/never) to 5 (always/severe)	1	2	3	4	5	N/A
Do your children cause you stress?						
Does your spouse/significant other cause you stress?						
Do financial concerns cause you stress?						
Does your job cause you stress?						
Do you feel you have an excessive amount of stress in your life?						
Do you handle stress poorly?						
Have you ever been abused, a victim of a crime, or had a significant trauma?						
Have you experienced major losses in your life?						

Stress Management: Check Yes, No, or Sometimes	Yes	No	S
Do you pray or meditate?			
Do you exercise?			
Do you get enough sleep?			

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Allergies:

Drug Allergies:	Yes	No
Do you have any known drug allergies?		

If yes, please list: _____

_____

Environmental Allergies:	Yes	No
Aerosol (cologne, smoke, cleaning fluids)		
Seasonal (ragweed, pollen, dust)		
Pet/animal (dogs, cats, etc.)		
Latex (gloves, tape)		
Other:		

Food Allergies:	Yes	No
Gluten		
Dairy/lactose		
Nuts (peanuts, Brazil nuts, walnuts, etc.)		
Shellfish (shrimp, lobster, crab)		
Soy		
Eggs		
Other:		

Exposure:

Exposure:	Yes	No
Radiation		
Radon		
Second-hand smoke		
Asbestos		
Lead		
Mercury		
Electronics (power lines, Wi-Fi, cell phone, EMF, etc.)		
Artificial sweeteners (Splenda, Equal, etc.)		
Toxic chemicals (e.g. dry-cleaning fluid, solvents, pesticides)		
Mold		
Other:		

Medications & Supplements:

Are you currently taking any Prescription Medications? ❑ Yes ❑ No

If yes, please list (including Name, Strength, and Dose): _____

_____

Are you currently taking any Over-the-Counter Medications? ❑ Yes ❑ No

If yes, please list (including Name, Strength, and Dose): _____

_____

Are you currently taking any Vitamins/Supplements? ❑ Yes ❑ No

If yes, please list (including Name, Strength, and Dose): _____

_____

Preferred Pharmacy:

Name: _____ Phone Number: _____

Address: _____

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Tests & Procedures:

Tests & Procedures - Have you ever had a:	Yes	No	If Yes, Date:	Result:	Please Explain:
Bone density/scan				❑ Normal ❑ Abnormal	
Mammogram				❑ Normal ❑ Abnormal	
Breast exam using thermography				❑ Normal ❑ Abnormal	
Colonoscopy				❑ Normal ❑ Abnormal	
Cardiac stress test				❑ Normal ❑ Abnormal	
Calcium coronary scan/test				❑ Normal ❑ Abnormal	
Carotid artery ultrasound				❑ Normal ❑ Abnormal	
Uterine ultrasound				❑ Normal ❑ Abnormal	
Pap smear				❑ Normal ❑ Abnormal	
Other:				❑ Normal ❑ Abnormal	
Other:				❑ Normal ❑ Abnormal	

Medical History:

Respiratory:	Yes	No	If Yes, Date:	Please Explain:
Asthma				
Chronic bronchitis				
Emphysema (COPD)				
Chronic sinusitis				
Sleep apnea				
Tuberculosis				
Mycoplasma				

Blood Pressure:	Yes	No	If Yes, Date:	Please Explain:
High blood pressure				
Low blood pressure				

Bleeding Problems:	Yes	No	If Yes, Date:	Please Explain:
Blood clots				
Hemophilia				
Factor V Leiden				

Cardiovascular:	Yes	No	If Yes, Date:	Please Explain:
Coronary artery disease				
Heart attack				
Congestive heart failure				
Carotid artery stenosis				
Arrhythmia				
Palpitations				

Cholesterol Problems:	Yes	No	If Yes, Date:	Please Explain:
High cholesterol				
High triglycerides				

Gastrointestinal:	Yes	No	If Yes, Date:	Please Explain:
Reflux (heartburn)				
Stomach ulcers				
Gall bladder disease				
Liver disease				
Crohn's disease				
Ulcerative colitis				
Celiac disease				

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Medical History - *Continued*:

Blood Sugar Problems:	Yes	No	If Yes, Date:	Please Explain:
Elevated blood sugar (pre-diabetic)				
Diabetes (onset in youth, treated with insulin)				
Diabetes (onset as adult, treated with diet)				
Diabetes (onset as adult, treated with medication)				

Weight Problems:	Yes	No	If Yes, Date:	Please Explain:
Overweight				
Underweight				

Thyroid Problems:	Yes	No	If Yes, Date:	Please Explain:
Low thyroid (hypothyroidism)				
Hashimoto's thyroiditis				
High thyroid (hyperthyroidism)				
Thyroid nodules				
Graves' disease				
Goiter (thyroid problems)				

Neurological History:	Yes	No	If Yes, Date:	Please Explain:
Stroke				
ADD/ADHD				
Brain injury/concussion				
Parkinson's disease				
Multiple sclerosis (MS)				

History of Mental Illness:	Yes	No	If Yes, Date:	Please Explain:
Depression				
Bipolar disorder				
Post-traumatic stress disorder				
Anxiety				

Joint and Bone Problems:	Yes	No	If Yes, Date:	Please Explain:
Rheumatoid arthritis				
Gout (arthritis)				
Osteopenia (weakening bones)				
Osteoporosis (weak bones)				
Osteoarthritis				

Immune System:	Yes	No	If Yes, Date:	Please Explain:
HIV				
Hepatitis				
Herpes				
Epstein-Barr virus (EBV)				
Autoimmune disease				
Mast cell activation syndrome				
Eosinophilic esophagitis				

Energy Problem:	Yes	No	If Yes, Date:	Please Explain:
Chronic fatigue syndrome				
Fibromyalgia				

Cancer History:	Yes	No	If Yes, Date:	Please Explain:
Breast cancer				
Colon cancer				
Thyroid cancer				
Other cancer:				

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Medical History - *Continued*:

Skin Disease:	Yes	No	If Yes, Date:	Please Explain:
Eczema				
Psoriasis				
Acne				
Vitiligo				
Rosacea				

Gynecological History - Have you ever:	Yes	No	If Yes, Date:	Please Explain:
Been diagnosed with ovarian cysts?				
Been diagnosed with endometriosis?				
Been diagnosed with uterine fibroids?				
Been diagnosed with PCOS?				
Been diagnosed with fibrocystic breast disease?				
Had PMS?				
If yes: ❑ Mild ❑ Moderate ❑ Severe				
Used birth control pills?				
If yes, how many years in total? Are you currently taking birth control? ❑ Yes ❑ No Any gap? ❑ Yes ❑ No				

Obstetric History:	Yes	No	If Yes, Date:	Please Explain:
Have you ever experienced postpartum depression?				
How many times have you been pregnant? ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5				
Have you ever had gestational diabetes?				

Urologic History:	Yes	No	If Yes, Date:	Please Explain:
Chronic Kidney Disease (CKD)				

Surgery & Hospital:

Surgery:	Yes	No	If Yes, Date:	Reason for Surgery:
Tonsils removed (tonsillectomy)				
Gall bladder removed (cholecystectomy)				
Fibroid of the uterus removed				
Cesarean section				
Ovary (one removed)				
Ovaries (both removed)				
Appendix removed (appendectomy)				
Total Hysterectomy				
Partial Hysterectomy				
Other:				

Hospitalizations:	Yes	No	If Yes, Date:	Length of Stay:
Heart attack (acute myocardial infarction)				
Stroke (acute cerebrovascular disease				
Other:				

Social History:

Occupation Status: ❑ Unemployed ❑ Employed ❑ Semi-retired ❑ Retired

Are you sexually active? ❑ Yes ❑ No

Marital Status: ❑ Single ❑ Married ❑ Partnered ❑ Significant Other ❑ Divorced ❑ Widowed

Name of Spouse/Partner/Significant Other: _____

Use tobacco? ❑ Yes ❑ No ❑ Quit

Use alcohol? ❑ Yes ❑ No ❑ In Recovery

Other substances? ❑ Yes ❑ No

Do you have a history of using recreational or street drugs? ❑ Yes ❑ No

Do you currently use recreational or street drugs? ❑ Yes ❑ No

Have you traveled outside the U.S? ❑ Yes ❑ No

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Children:

Do you have any children? ❑ Yes ❑ No

If yes, please list below:

Name:	Relationship:	DOB:	Gender:	Living at Home?
			❑ M ❑ F	❑ Yes ❑ No
			❑ M ❑ F	❑ Yes ❑ No
			❑ M ❑ F	❑ Yes ❑ No
			❑ M ❑ F	❑ Yes ❑ No
			❑ M ❑ F	❑ Yes ❑ No

Family History:

Family History (Biological Only):

Family Member:	Living:	Deceased:	Unknown:	Age:	Cause of Death:
Mother	❑	❑	❑		
Father	❑	❑	❑		
Maternal grandmother	❑	❑	❑		
Maternal grandfather	❑	❑	❑		
Paternal grandmother	❑	❑	❑		
Paternal grandfather	❑	❑	❑		

Are you adopted? ❑ Yes ❑ No

Family Medical History:

Relationship:	None	Unsure	Mother	Father	Brother	Sister	Grand-mother	Grand-father	Aunt	Uncle
Breast cancer	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Ovarian cancer	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Uterine cancer	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Prostate cancer	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Colon cancer	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Heart attack	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
High cholesterol	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
High blood pressure	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Obesity	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Lung disease	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Alzheimer dementia	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Mental illness	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Other:	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Other:	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

I certify that the information provided on this form is true, complete, and accurate to the best of my knowledge. I understand that it is my responsibility to notify Born Clinic of any changes to my health status or medical condition.

Patient (or Guardian) Signature: _____ Date: _____

BORN CLINIC, P.C. FINANCIAL POLICY

Patient Name: _____ DOB: _____

At Born Clinic, every effort is made to ensure that your visit is a pleasant experience. We believe patients have a right to know, and Born Clinic has an obligation to provide, complete information about fee schedules and payment requirements. Born Clinic does not participate with any insurance companies. We are considered an out-of-network provider for all insurance plans. Payment in full is required at the time services are rendered.

Payment may be made by cash, check, credit card, or CareCredit. You will be given an encounter form that you may send to your insurance company, if services are covered under your plan (see below for Medicare beneficiaries or Medicaid patients*). Contact your insurance provider for details on how to file your claim. While we will cooperate fully in providing accurate information so you may bill your insurance company, you remain fully responsible for your account. Born Clinic does not file insurance claims, including claims for auto accidents or workers' compensation.

If you have any questions regarding our financial policy, please feel free to call the office at 616-656-3700 to speak with a receptionist or the billing department.

***Medicare Beneficiaries:** Born Clinic providers have opted out of Medicare. Services at Born Clinic cannot be submitted to, and will not be reimbursed by, Medicare, resulting in full payment by the patient. See Physician-Patient Private Contract (Medicare Opt-Out Agreement).

***Medicaid Patients:** Born Clinic is not a Medicaid provider. Services at Born Clinic cannot be submitted and will not be reimbursed by Medicaid, resulting in full payment by the patient.

Please enter your insurance information below. If you are covered by more than one insurance plan, provide the details for each carrier. When you come in for your appointment, we will ask for a copy of your insurance card to keep on file in order to bill certain laboratory tests, schedule referrals as needed, and to complete prior authorizations.

Primary Insurance:	Secondary Insurance:
Name of the Insured:	Name of the Insured:
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
Policy ID #:	Policy ID #:
Group # or Company Name:	Group # or Company Name:

Additional Financial Policies:

- Outstanding Balances: All outstanding balances must be paid in full before future appointments may be scheduled, unless prior arrangements have been made with the billing department.
- Returned Payments: A $25 fee will be charged for any returned checks or declined payments.
- Missed/Late Cancellation Appointments: Appointments cancelled or rescheduled with less than 24-hour notice will incur a non-refundable $25 fee. Missed appointments without prior notice will incur a non-refundable $35 fee.
- Refunds: Refunds are not available for professional services already rendered. Refunds for supplements are available within 30 days of purchase if the product is unopened and unused. Refunds for prepaid services, if applicable, will be processed according to Born Clinic's refund guidelines.

Authorization to Release Information:
I authorize Born Clinic to release my medical information, or any other necessary information, to my insurance company when required to process claims for reimbursement or to complete prior authorizations. I understand that Born Clinic does not submit insurance claims for office visits or services provided directly by Born Clinic providers.

Patient Acknowledgment:
I hereby acknowledge that I have been fully informed that some, and perhaps all, of the medical services provided at Born Clinic, PC, on or after this date by Dorothy A. Pedtke, DO; Derek R. Rosol, DO; Abigail M. Matovich, PA-C; Robert E. Miller, PA-C; Dr. Arkadiy Sarkisov, D.Ac, LAc, LMT; and their associates, may be non-covered services and not considered reasonable and necessary under medical insurance. I understand that my insurance coverage will not pay for such non-covered services, and I accept full personal responsibility for payment to Born Clinic.

Patient (or Guardian) Signature: _____ Date: _____

AUTHORIZATION TO DISCLOSE INFORMATION

Patient Name: _____ DOB: _____

Your medical information is confidential. Occasionally, it may be helpful or necessary for us to communicate with a family member (spouse, parent, child, etc.) or friend on your behalf regarding an appointment, medications, test results, or other aspects of your medical care.

Scope of this Authorization:
This authorization allows Born Clinic to disclose or discuss your protected health information (PHI) with the person(s) listed below. Such disclosures may include both verbal communication and providing limited written information (such as a copy of a test result, medication list, or appointment instructions).

Important: This is **not** an authorization to release your medical records. To obtain copies of your records, a separate records disclosure form must be completed.

Duration & Revocation:
I authorize Born Clinic to discuss my protected health information with the person(s) listed below. This authorization will remain in effect until I revoke it in writing, or until the following date (if specified): _____. I understand that I may revoke this authorization at any time by submitting written notice to Born Clinic, Attention: Operations Director.

I understand that I am entitled to receive a copy of this form upon request.

Name:	Relationship:	Phone Number:

❒ I decline authorizing Born Clinic to disclose or discuss my medical information with any family member or friend.

Patient (or Guardian) Signature: _____ Date: _____

PREVENTIVE HEALTH RECOMMENDATIONS

At Born Clinic, P.C., our providers are committed to supporting your long-term health through thoughtful preventive care. Regular health examinations and screenings are an important part of maintaining your well-being, and many of these can be completed right here in our office. We encourage you to review the recommended screenings below and discuss with your provider which ones are most appropriate 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

Acknowledgment:
I have read and understand the Preventive Health Recommendations Form. I accept responsibility for arranging the recommended exams as advised. I also understand that if my Born Clinic, P.C. provider determines that my medical condition and/or medications require care beyond the scope of this office, I may be referred to an outside Primary Care Physician.

Patient (or Guardian) Signature: _____ Date: _____

PRESCRIPTION REFILL POLICY

Patient Name: _____ DOB: _____

We strive to process your prescription requests as quickly as possible, as your health is our top priority. To help us do so, please review the following guidelines:

Prescription Refill Requests:

- Please call in your refill request at least a week in advance.
- Most prescriptions are processed within two (2) business days.
- Bioidentical hormone and thyroid prescriptions may require three (3) or more business days to complete.

Office Visit Requirements:

- You must be seen in our office at least once per year for an examination.
- Depending on your diagnosis, more frequent visits may be required (for example, every 3 to 6 months).
- Please schedule appointments far enough in advance to avoid running out of medication. Prescriptions may not be refilled if you have not had a visit within the past year.

Bioidentical Hormone Replacement Therapy (BHRT) Prescription Refill Requirements:

- Female Patients:
    - Your annual exam may include a Pap smear/pelvic exam and breast exam.
        - These exams may be performed at Born Clinic or elsewhere. If completed elsewhere, please request that results be sent to our office before submitting your refill request, as refills may be delayed without updated records.
        - Please note: An annual pelvic exam performed at Born Clinic may still be required to prescribe BHRT.
    - Annual breast imaging (thermography, mammogram, ultrasound, or MRI) is required.
    - Annual bloodwork is required (every 6 months may be necessary for some patients).
    - Testosterone prescriptions must be updated every 6 months.
- Male Patients:
    - An EKG is required at your annual visit.
    - A PSA blood test is required every 12 months.
    - Bloodwork is required every 6 months.
    - Prescriptions must be updated every 6 months.

Thank you for working with us to provide you with the best possible care!

Written Acknowledgment - 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 of this policy and understand that the practice may amend these terms at any time.

Patient (or Guardian) Signature: _____ Date: _____