Please fill out the following form as neatly as possible.
All your health information is kept confidential.

Name_____
E-mail_____
Address:_____
City: _____
Zip Code:_____

Height _____ Weight_____

Occupation_____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widow

Today's Date: _____
Date of Birth_____
Home Phone: _____
Cell Phone:_____

Emergency Contact:
Name:_____
Relationship:_____
Phone Number:_____

Are you on a special diet? ( ) Yes ( ) No
If yes please Specify:
_____

Do you have any allergies? (food, contact, environment)_____

Please Check Mark Your Main Reasons for Today's Visit:

- ☐ Regenerative medicine consult for:
  - ☐ Knee
  - ☐ Spine
  - ☐ Shoulder
  - ☐ Other
  - ☐ Hip
- ☐ Functional Medicine/ Nutrition Consult
- ☐ Spine/ Chiropractic Exam
- ☐ Sexual Wellness/ ED Consult
- ☐ Aesthetics Consult
  - ☐ EMFACE ™
  - ☐ EXION™
  - ☐ Botox/ Fillers
  - ☐ Microneedling
  - ☐ Hair Restoration
- ☐ Hormone Testing/ Bioidentical (hormone therapy)

Please give any details you wish (**Skip** here and fill out "narrative history" page if here for functional medicine or hormone testing/ therapy)

_____
_____
_____

Have you had or do you have any of the following conditions or diseases? Please check any that apply.

☐ Anxiety	☐ Depression	☐ Knee Surgery	☐ Digestive/bowel problems	☐ Cancer
☐ Bowel/bladder problems	☐ Fusions (spinal/joint)	☐ Rotator Cuff problem	☐ Carpal Tunnel Syndrome	☐ Gall Bladder Issue
☐ Hip replacement	☐ High blood pressure	☐ Hip replacement	☐ Diabetes	

☐ Other _____

Are there any conditions that run in your family? ☐ Yes ☐ No If yes, what condition(s) and which family members?

_____
_____
_____

Dr. Stephen R. Beyer
Beyer Functional Wellness 10012 W. 190th Place, Mokena IL 60448
Phone: 708.478.0690 Email: beyerfunctionalwellness@gmail.com

MEDICATIONS

Name: _____ Date: ____/____/____

List the name of each current prescribed and OTC (over-the-counter) medications, its prescribed use and any side effects/reactions/positive responses. (Example: birth control pills can be used to prevent pregnancy, manage menopause or acne, etc.). (Example of side effect could be Tylenol caused liver enzymes to increase).

Medication	**The name of the condition or purpose for taking this medication.** (i.e. birth control pills for acne or endometriosis) Note: We do not need the number of pills or the dosage-mg/day info)	**Any Side-Effects**

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PATIENT CONSENT FOR US AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____, hereby states that by signing this consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/ or disclosures of my protected health information (PHI) necessary for the practice to provide me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a.) telephoning my home and leaving a message on my answering machine or with the individual answering the phone or b.) an automated text message reminding me of my appointment.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for (7) seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I HAVE READ AND UNDERSTAND THE FOREGOING NOTICE, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY FULL SATISFACTION IN A WAY THAT I CAN UNDERSTAND.

_____ _____

Name of Individual (PRINT NAME) Signature of Individual

_____ _____

Signature of Legal Representative (e.g., Attorney-in-Fact, Guardian, Parent if a minor): Relationship

Date Signed: _____/_____/_____ Witness: _____

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Release of Information

You are authorized to release any information you deem appropriate concerning my medical condition to any insurance company, attorney, adjuster, or any other person necessary for you to process any claim for reimbursement of charges incurred by me at Beyer Functional Wellness

Right to Receive Payment

I authorize and assign to you, the medical provider, the right to receive direct payment from my attorney, insurance company, or any other party who became obligated to pay me any sums. I further authorize the endorsement of my name to any draft containing my name to which you are legally entitled. I hereby instruct and direct my Insurance Company to pay by check made out and mailed directly to Beyer Functional Wellness

Assignment of Right to Sue

In the event any insurance company, attorney, or other person obligated to contractual agreement to make payment to me for your service charges, refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company, attorney, or person authorize you to prosecute said action either in my name or your name and for you to resolve said claim as you see fit. I understand that I shall continue to remain responsible for any uncollected or unpaid balance on my account.

Attorney Direction

I hereby direct my attorney not to interfere with or claim any lien upon medical payment benefits to which I may be entitled from whether my health insurance or medical payment sources. If any said medical payment check include my attorney's name, I direct my attorney to sign his name to these checks for the benefit of Beyer Functional Wellness.

_____ _____

Name of Individual (PRINT NAME) Signature of Individual

_____

Date

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Appointment Cancellation No Show Policy

Beyer Functional Wellness is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. **Please call or text us at (708) 478-0690 by 12:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations.**

If prior notification is not given, you will be charged **$25.00** for the missed appointment.

For patients seeing our Nurse Practitioner, **we *require 1 (one) week notice* to notify us of any changes or cancellations.**

If prior notification is not given, you will be charged $75.00 for the missed appointment.

Please sign below that you understand the terms of the policy.

_____

Client Print and Sign Name
(Client's Parent/Guardian if under 18)

_____

Today's Date

BFW Personnel _____

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