Integrative Family Medicine of Asheville, PLLC

Comprehensive • Affordable • Primary & Urgent Care

Thank you for scheduling an appointment with Integrative Family Medicine. Please complete the intake form to the best of your ability. If at all possible, fill out these forms before coming for your visit.

If for any reason you need to cancel your appointment, we ask that you give us 24 hours notice. We reserve the right to charge you for your appointment if less than 24 hours notice is given. **Full payment is due at time of service**

For Medicare and Medicaid Patients Only:
The services we provide are currently not reimbursable under Medicare or Medicaid. At this time, you may not submit our invoices for reimbursement. However, referrals to specialists, hospitals, and for procedures such as x-rays or MRI would still be covered by Medicare or Medicaid.

We would like to take this opportunity to acquaint you with our payment procedure. We intentionally do not file insurance at our clinic. Not filing insurance allows us to focus on you as our #1 priority. This allows us to dramatically reduce fees, have longer visits, and increase the your quality of care. It is our goal to exceed your expectations, and make financial aspects of your healthcare as convenient and simple as possible.

We will provide you with the paperwork necessary to file insurance on your own, though we cannot guarantee reimbursement.

Privacy and confidentiality of personal health information is important to us. We have HIPAA polices in place to ensure your personal health information is available only to authorized persons who need access to this information to provide medical care. No patient information leaves our office either electronically, by fax, or paper record without specific authorization by you. A copy of our policy on privacy is posted at the front desk and you may receive a copy if you would like one.

I have read and understand the payment procedures and privacy policy of Integrative Family Medicine of Asheville. I agree to pay my bill in full at the end of my visit. I also authorize release of necessary medical records to Integrative Family Medicine of Asheville and to send any referrals on my behalf.

Signed:_____ Date _____

PLEASE PRINT AND COMPLETE IN FULL

Name: _____Nickname: _____
Last First M

Sex: Male_____ Female_____ Other_____ Birth date_____ Age_____

Social Security Number: _____

Is the patient enrolled in Medicare?_____

If Patient is a minor, Parent/Guardian's Name_____

Patient's Street Address_____ Zip Code_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email Address_____

Name and Relationship of Emergency Contact _____

Phone number of Emergency Contact_____

How did you learn of our office?_____

Reason for visit_____

How will you pay today? Cash_____ Check_____ Credit Card_____

Full Payment is due at time of service

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Acute/Urgent Visit Intake

Name:_____ Date:_____

Welcome to our clinic. Please answer the questions below to the best of your knowledge. Your answers will help us provide the best possible care.

We can cover 1 *acute/recent* problem in a 20 minute urgent care visit.

If your problem is long-standing, ongoing, or there are multiple concerns, we recommend joining the Integrative Life Membership so that we have the opportunity to review your history in detail and provide a holistic treatment plan.

Please describe your concern below. This will help us use the time wisely. If you would prefer not to record a concern on paper, simply write 'Private.'

_____
_____
_____
_____

Please describe your typical diet:

_____
_____
_____

Please list any allergies to medications, foods, or supplements as well as the reaction:

_____
_____
_____
_____

Please list any medications or supplements (with dosages) that you may be taking:

_____
_____
_____
_____

Please list any other information that you would be helpful for your visit

_____
_____

PRESCRIPTION MEDICATIONS - Please list on the table below ALL of your prescription medication

Name of Medication (Brand name) and Strength	How were you told to take this medication?	How often do you take this medication?	How much do you take for each dose?	When did you begin taking this medication?	Condition treated with this medication	When did you stop taking this medication?	Why did you stop taking this medication?

NONPRESCRIPTION MEDICATIONS AND SUPPLEMENTS CURRENTLY OR RECENTLY TAKEN (Vitamins, Minerals, Herbs, Herbal products, Remedies, and Other health products)

Brand name of Product and list of Ingredients	Dosage	Amount per dose	Frequency	When did you begin?	Reason for this supplement	When did you stop?	Why did you stop taking this product?