



Welcome! And thank you for choosing Tenpenny Integrative Medical Center as part of your journey to optimal health.

**Financial Information:**

Payment in full is due at the time of service. We accept cash, check, and most major credit cards.

While we do not participate with any insurance company directly, we do accept CareCredit and most HSA plans. Some patients may receive a HCFA form at the time of service as a receipt for their visit. This form can be submitted to your insurance carrier for possible reimbursement. Reimbursement amounts vary depending on your out-of-network benefits and whether your deductible has been met. **Please note: HCFA forms cannot be submitted to Medicare or Medicaid.**

We do not participate with Medicare. We do not participate with Medicaid, CHIPS or military insurance programs.

Our goal is to identify the underlying cause(s) that lead to your current condition using unique testing and assessments. Many of our specialized tests are not covered by medical insurance. Most of the laboratories we use require a co-payment to be sent, with your blood samples, directly to the laboratory.

**PLEASE ARRIVE AT LEAST 15 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT WITH YOUR FORMS COMPLETED.**

**Completed forms are very important for your assessment. If the forms are not with you or are not completed prior to your scheduled appointment, it may be necessary to reschedule your appointment and enforce our cancellation policy to respect the time of other patients scheduled after your appointment.**



T E N P E N N Y

INTEGRATIVE MEDICAL CENTER

AUTHORIZATION & ACKNOWLEDGEMENTS

INITIAL  ANNUAL UPDATE

**TREATMENT AUTHORIZATION:** I (print name) \_\_\_\_\_ authorize medical treatment of myself or my minor child by physicians, nurse practitioners, physician assistants, nurses, chiropractors, acupuncturists and medical assistants and staff by Tenpenny Integrative Medical Center.

**NOTICE AS TO NATURE OF SERVICES:** I understand that the care I receive at Tenpenny Integrative Medical Center may be nontraditional or unconventional. Such services are commonly referred to as complementary or alternative or holistic medicine, or innovative services. Many of these services may not be recognized as standard medical practices, and may be considered investigational or experimental. Medications prescribed may be approved by the FDA for a different condition than that for which it is prescribed for me. I understand my physician may request laboratory testing which may include venipuncture, analysis of stool, urine, saliva and breath.

**NOTICE THAT SERVICES ARE NOT PRIMARY CARE:** I understand that no physician or any other practitioner I see at Tenpenny Integrative Medical Center is acting as my primary care physician unless otherwise agreed to by a physician in writing. As such, emergency services are not offered. I understand that even though my physician(s) and Tenpenny Integrative Medical Center practitioners may address issues affecting my general health, the practice is focused on a complementary, holistic approach to care and it is in my best interest to have a primary care physician to ensure that I am fully apprised of all available conventional means to address any medical conditions I may have. This is also important because these practices are exclusively office-based and are not affiliated with a hospital. If I become so ill that I require hospitalization, it is vital that I have a primary care physician with hospital admitting privileges familiar with my health problems and history. I understand that in addition to a primary care physician, it may be in my best interest to have appropriate specialists, such as a cardiologist if I have cardiac problems or a hospital based pediatrician if I am seeking treatment for my children. I also understand that it is my responsibility to inform Tenpenny Integrative Medical Center who my primary care physician and specialists are, to let my physician know of any diagnoses I have received, and of any treatments I have had or am now undergoing for current conditions, and that I should keep my physicians and any practitioners I see informed on an ongoing basis. I also understand that it is very important to let my primary care physician know about any treatments performed at Tenpenny Integrative Medical Center in order to properly and safely coordinate my care. My primary care physician is:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ City State Zip Code: \_\_\_\_\_

I am also being treated for \_\_\_\_\_ by:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ City State Zip Code: \_\_\_\_\_

**FINANCIAL/INSURANCE RESPONSIBILITY FOR ALL TENPENNY INTEGRATIVE MEDICAL CENTER SERVICES:** I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at or before each visit, unless other specific arrangements have been made. I am responsible for charges incurred for all treatment rendered, unless otherwise agreed to in writing. I further understand Tenpenny Integrative Medical Center will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Tenpenny Integrative Medical Center to take action to secure payment of an outstanding balance owed.

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**NOTICE TO MEDICARE PATIENTS:** The physicians at Tenpenny Integrative Medical Center have opted entirely out of the Medicare program, which means that Medicare will not cover any services or procedures performed at Tenpenny Integrative Medical Center. I understand that I will not be able to submit any claims to Medicare and that if I have a secondary insurance carrier that carrier may or may not choose to reimburse claims. I understand that I will need to sign a contract (Medicare Private Contract Agreement) agreeing not to submit to Medicare, that Medicare limiting fees do not apply, and that I will be financially responsible for any services received. I understand that Medicare will not be reviewing any claims, and that an opinion by Medicare that a service is not medically necessary in their view of care would not discharge my responsibility for payment of said services(s).

**CLAIM MANAGEMENT:** My treating practitioner(s) may respond to insurance requests for information, but will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I understand I may be charged for responding to requests for information. Insurance claim forms and information will be provided to patients at the time of visit or sent to you upon the availability of the appropriate documentation. Tenpenny Integrative Medical Center does not typically send information directly to insurance carriers due to problems we have experienced with carriers misplacing claims.

**FURTHER NOTICES AS TO POLICIES REGARDING INSURANCE:** Tenpenny Integrative Medical Center will provide claim forms for submission to insurance; submission shall be the patient's responsibility. Claim submissions may or may not be for covered services and may or may not include procedural codes or other data sufficient to support my insurer's determination as to what services it will reimburse. Tenpenny Integrative Medical Center may provide records requested by my insurance company. If possible, Tenpenny Integrative Medical Center will advise whether my insurance will cover any particular expenses, but given the uncertainty that pervades insurance decisions, Tenpenny Integrative Medical Center cannot be responsible for any information that turns out to be incorrect.

**NO GUARANTEES:** I am aware that no practice of medicine is an exact science, and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnosis or treatments that I receive at Tenpenny Integrative Medical Center.

**REVOCAION OF AUTHORIZATIONS:** These authorizations may be revoked by me in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

**PATIENT ACKNOWLEDGMENT:** I certify that the information I provide to my practitioners and my insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party.

By signing and dating this form, I acknowledge that I have received a copy of Tenpenny Integrative Medical Center Authorizations and Acknowledgements.

Patient's Signature:	Date:
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T E N P E N N Y  
INTEGRATIVE MEDICAL CENTER

7380 ENGLE ROAD  
MIDDLEBURG HEIGHTS, OHIO 44130  
440.239.3438

## CANCELLATION POLICY

When you schedule an appointment, we reserve time just for you. Upon scheduling your first appointment, we will process your credit card over the phone for \$50.00 to hold your appointment time. The \$50.00 will be applied towards your first appointment unless you fail to give proper notice to cancel or reschedule. TIMC reserves the right to keep the \$50.00 as your cancellation fee for a no show or failure to follow our cancellation policy.

All scheduled appointments require a minimum of two-day notice, excluding Saturdays and Sundays. You must call the office to make schedule changes. Email and text are unacceptable. Patients who cancel without proper notice or fail to show for any scheduled appointment will be subject to a \$50.00 charge. We appreciate your understanding and respect of our policy.

I, \_\_\_\_\_, hereby authorize Tenpenny Integrative Medical Center to charge my credit card for \$50.00 in the event that I do not adhere to TIMC's cancellation policy, as outlined above. This authorization will remain in effect indefinitely; I reserve the right to cancel this authorization at any time. It is my responsibility to notify TIMC of any changes regarding this credit card authorization, including change of numbers, expiration dates, etc. My signature below confirms that I understand and agree to this authorization.

Credit Card Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

CVV Code: \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_

Name On Card: \_\_\_\_\_

**I have read and agree to adhere to this policy.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Last Name			DATE
First Name			DOB
Address			Age
			MALE   FEMALE
City	State	Zip	
HOME TELEPHONE:	WORK TELEPHONE:	MOBILE PHONE	
<input type="checkbox"/> Use this number as my primary contact	<input type="checkbox"/> Use this number as my primary contact	<input type="checkbox"/> Use this number as my primary contact	
<input type="checkbox"/> OK to leave detailed message	<input type="checkbox"/> OK to leave detailed message	<input type="checkbox"/> OK to leave detailed message	
<input type="checkbox"/> Leave your name and call back number only	<input type="checkbox"/> Leave your name and call back number only	<input type="checkbox"/> Leave your name and call back number only	
Email address:	May be add your email to our in-office email database? YES NO <input type="checkbox"/> <input type="checkbox"/>	WE PROTECT YOUR EMAIL PRIVACY AND IS USE FOR IN-OFFICE ALERTS AND PROMOTIONS ONLY.	
EMERGENCY CONTACT NAME	EMERGENCY CONTACT NUMBER	RELATIONSHIP:	
<b>INSURANCE INFORMATION</b>			
Insurance Company:			
Address:		City, State and zip	
Insurance ID number		Group Number	
Insurance Policy Holder		Policy holder date of birth:	
<input type="checkbox"/> I give my permission to share my medical information with <input type="checkbox"/> My relationship to this person is <input type="checkbox"/> I attest to the best of my knowledge, the information above is true and accurate.			
Signature:			Date:

# HEALTH HISTORY

<b>Name:</b>	<b>Date of Birth:</b>	
<b>Reason for Visit:</b>		

Please list all major illnesses, surgeries, emotional traumas, etc.  
Please list issues of concern you but have been brushed aside by healthcare practitioners.

Pre-term to birth to 1yo:	19yo to 29yo:
2yo to 5yo (pre school)	30yo to 39yo:
6yo to 9 yr (grade school)	40yo to 49yo:
10 yr to 12 yr (middle school)	50yo to 59yo:
13 to 18yo (high school)	60yo and older:
<b>OCCUPATION:</b>	<b>HIGHEST LEVEL OF EDUCATION:</b>

**Please indicate the approximate year (or date) of your last:**

Complete physical exam:	<b>Cardiovascular Evaluation</b>
<b>Gastrointestinal evaluation:</b>	EKG
Upper GI (endoscopy)	Echocardiogram
Lower GI (colonoscopy)	Stress test
<b>Ultrasound</b>	<b>Xrays - Imaging</b>
Thyroid	CT scan
Pelvis	MRI
Gall bladder	Chest Xray
Abdomen	Mammogram
Other	Other

**VACCINE HISTORY - \*\*Check  \*\* ALL THAT APPLY**

<input type="checkbox"/> DTaP		<input type="checkbox"/> Hib	<input type="checkbox"/> Flu Short	<input type="checkbox"/> Gardasil	<input type="checkbox"/> Typhoid	<input type="checkbox"/> RhoGam
<input type="checkbox"/> MMR		<input type="checkbox"/> Pevnar	<input type="checkbox"/> Flu Mist	<input type="checkbox"/> Meningitis (college)	<input type="checkbox"/> Cholera	
<input type="checkbox"/> Polio		<input type="checkbox"/> Rotavirus	<input type="checkbox"/> Flu Short: H1N1	<input type="checkbox"/> Tetanus Booster	<input type="checkbox"/> Yellow Fever	
<input type="checkbox"/> Hepatitis A		<input type="checkbox"/> Covid Shot	<input type="checkbox"/> Flu Mist (nasal)		<input type="checkbox"/> Smallpox	
<input type="checkbox"/> Hepatitis B		<input type="checkbox"/> Covid Booster			<input type="checkbox"/> Anthrax	

## FAMILY HEALTH HISTORY

	GOOD	POOR	DECEASED	AGE DECEASED	MEDICAL- HEALTH PROBLEMS
<b>Father</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Mother</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Sister (s)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Brothers (s)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

<b>Signature:</b>	<b>Today's Date:</b>
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# PHYSICAL HISTORY - SYMPTOMS

Please put an X next to all symptoms you are currently experiencing.

GENERAL COMPLAINTS	GASTROINTESTINAL	MENTAL- EMOTIONAL	MUSCULOSKELETAL
Alcohol problems	Abdominal pain	ADD	Ankle pain
Drug addiction	Alt diarrhea/constipation (IBS)	ADHD	Foot pain
<b>Cancer - current. Type?</b>	Always hungry	Anorexia	Headaches - cluster
	Bloating	Bulimia	Headaches - migraine
<b>Cancer - past. Type?</b>	Blood/black stools	Chronic anxiety	Headaches - tension
	Burping to excess	Compulsive behavior	Hip pain
<b>THYROID</b>	Constipation	Depression	Knee pain
Constipation	Daily diarrhea	Excessive fatigue	Low back pain
Dry hair	Excessive gas	Excessive irritability	Neck pain
Dry skin	GERO or reflux	Insomnia	Shoulder pain
Feel cold	Hemorrhoids	Nervousness	Osteoarthritis
Goiter	Jaundice	Poor memory	Osteopenia
Hair loss	Pain after eating	Sleep difficulties	Osteoporosis
High cholesterol	Stomach pain after eating		Rheumatoid arthritis
Hyperthyroid diagnosis			
Hypothyroid diagnosis			
Unexplained wt gain	<b>RESPIRATORY · LUNGS</b>	<b>NEUROLOGICAL</b>	<b>URINARY · REPRODUCTIVE</b>
	Asthma	History of Concussions	<b>MEN</b>
	Recurrent sinus infections	History of stroke	Difficulty urinating
<b>CARDIOVASCULAR</b>	Hay fever/seasonal allergies	Lightheaded - continual	Elevated PSA level: _____
Ankle swelling	Frequent colds	Lightheaded - periodical	Enlarged prostate
Cannot sleep lying flat	Emphysema	Neuropathy - feet	Erectile dysfunction
Chest pain with activity	COPD	Neuropathy - other	Incontinence
Heart murmur	Chronic bronchitis	Vertigo - room spins	Kidney stones
High blood pressure			Testicular pain
High cholesterol	<b>DENTAL HISTORY</b>	<b>SKIN PROBLEMS</b>	<b>WOMEN</b>
High Triglycerides	Braces	Dermagraphia	Bleeding after intercourse
Leg cramps with walking	Jaw locking/popping	Eczema	Irregular menses cycle
Palpitations	TMJ pain	Hives - chronic	Painful intercourse
	Extractions	Hives - occasional	PMS symptoms
	Dentures	Psoriasis	Urinary incontinence
	Wear day time mouth guard?	Rashes	Vaginal dryness
	Wear night time mouth guard?	Sun sensitivity	Number of pregnancies: __
			Age first menses: _____
			Date last pap: _____
			Date last mammogram: __
			Date last thermogram: ____
<b>Past medical history - more than 6 months ago</b>			
Blood clots	Other:		
Blood transfusion	Other:		
Cancer	Other:		
Diverticulitis	Other:		
Heart attack			
<b>Past surgical history</b>			
<b>What type of surgery?</b>	<b>DATES</b>		
<b>ANYTHING ELSE YOU WOULD LIKE US TO KNOW?</b>			
<b>Signature:</b>		<b>Today's Date:</b>	





## NUTRITION HISTORY

How often do you consume the following foods?

1 = Daily		2 = 3-4 times/week		3 = Occasionally		4 = Never	
Alcohol - liquor		Wheat/gluten		Eggs		Fast Food	
Alcohol - wine		Non-gluten grains		Red Meat		Restaurant food	
Coffee - regular		White rice		Chicken		Pkg/proc food	
Coffee - decaf		Brown rice		Fish		White flour	
Black Tea		Cheese		Pork		White sugar	
Green Tea		Milk - cows milk		Beans		Canned Fruit	
Other types of tea		Yogert		Fresh Fruit		Frozen fruit	
Soda pop		Butter		Fresh Veggies		Frozen veggies	
		Margarine					

What do you crave to eat?

What diets have you tried before? (ex: Weight Watchers, Physician Weight Loss, HCG, etc)

Were you successful in losing weight? If so, were you able to keep the weight off? Why or Why not?

**List typical daily diet:**

BREAKFAST	LUNCH	DINNER	SNACKS

**Signature:**

**Today's Date:**

## SLEEP - ENERGY HISTORY

<b>What time of day are your symptoms worse?</b>					STOP	BANG	Score→		(by your practitioner) score of 4 or more is significant																																																											
Morning	Afternoon	Evening	Bad all day long																																																																	
<b>What makes your symptoms better?</b>					The <b>Epworth Sleepiness Scale</b> is used to determine your daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy and significant, indicating the need for either more sleep, better sleep hygiene, and/or a screening test for sleep apnea.																																																															
<b>What makes your symptoms worse?</b>																																																																				
<b>How would you describe your sleep patterns?</b>					0 = would never doze or sleep		3 = moderate chance I would doze or sleep																																																													
					1 = slight chance I would doze or fall asleep		4 = high chance I would doze or sleep																																																													
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 10%;"></td><td style="width: 40%;">I sleep well and wake up rarely during the night.</td><td style="width: 10%;">Sitting and reading</td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td></tr> <tr><td></td><td>I sleep well. If I get up, I return to sleep easily.</td><td>Watching TV</td><td></td><td></td><td></td></tr> <tr><td></td><td>I sleep well. But if I get up, I have difficulty falling back to sleep.</td><td>Sitting inactive in public place</td><td></td><td></td><td></td></tr> <tr><td></td><td>I have difficulty falling asleep, but once asleep, I sleep well.</td><td>Passenger in car for &gt; 1 hour</td><td></td><td></td><td></td></tr> <tr><td></td><td>I fall asleep easily but I have difficulty staying asleep</td><td>Sitting and talking to someone</td><td></td><td></td><td></td></tr> <tr><td></td><td>I wake up consistently at __ AM several times a week.</td><td>Sitting quietly after lunch</td><td></td><td></td><td></td></tr> <tr><td></td><td>I snore loudly and often wake my partner up.</td><td>Stopped at a traffic light while driving</td><td></td><td></td><td></td></tr> <tr><td></td><td>Most mornings I wake up feeling exhausted and feel like I barely slept at all.</td><td style="text-align: center;"><b>TOTAL SCORE →</b></td><td></td><td></td><td></td></tr> <tr><td></td><td>I often wake up with a headache.</td><td>On scale of 1 to 10, what is your present stress level?</td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td style="text-align: center;"><b>TOTAL SCORE →</b></td><td></td><td></td><td></td></tr> </table>						I sleep well and wake up rarely during the night.	Sitting and reading					I sleep well. If I get up, I return to sleep easily.	Watching TV					I sleep well. But if I get up, I have difficulty falling back to sleep.	Sitting inactive in public place					I have difficulty falling asleep, but once asleep, I sleep well.	Passenger in car for > 1 hour					I fall asleep easily but I have difficulty staying asleep	Sitting and talking to someone					I wake up consistently at __ AM several times a week.	Sitting quietly after lunch					I snore loudly and often wake my partner up.	Stopped at a traffic light while driving					Most mornings I wake up feeling exhausted and feel like I barely slept at all.	<b>TOTAL SCORE →</b>					I often wake up with a headache.	On scale of 1 to 10, what is your present stress level?						<b>TOTAL SCORE →</b>				<b>TOTAL SCORE →</b>		<b>TOTAL SCORE →</b>	
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Have you been diagnosed with <b>sleep apnea</b> ? If so, do you use a <b>CPAP</b> machine every night?
What has been the most significant <b>medical</b> occurrence in your life?
What has been your most significant <b>emotional</b> occurrence in your life?
What is your greatest <b>fear</b> ?
What really makes you <b>happy</b> ?
What is your favorite <b>relaxation time activity</b> ?

### SOCIAL HISTORY

Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how much and for how long?	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how much and for how long?
Did you quit smoking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When did you stop smoking?	Have you stopped drinking alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When did you stop drinking?
Do you exercise regularly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	What type of exercise do you enjoy? How often?				
<b>Signature:</b>				<b>Date:</b>			

## How Did You Hear About Us?

Patient referral, who can we thank? \_\_\_\_\_

Physician Recommendation:  Yes Physician Name: \_\_\_\_\_

### Please select all that apply (check all that apply):

#### Social Media:

- Instagram  Facebook  Twitter  TikTok  Telegram  CloutHub  GAB  
 GTTR  Truth Social  Rumble  BitChute  Internet Search  Google Search

#### Email:

- DrTenpenny.com
- Tenpenny Integrative Medical Center (TenpennyIMC.com)
- ECP Studio in Ventura, CA (TenpennyECP.com)

#### Podcast / Interview:

- Happy Hour with Guest
- This Week with Dr. T
- Happy Hour Bible Study
- On Your Health with Dr. Tenpenny (Brighteon)
- Morning Coffee with Dr. T
- Deep Dive
- Critically Thinking

Advertisement: (Please indicate where you saw the ad)

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Church: (Church name)

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