TENPENNY™

INTEGRATIVE MEDICAL CENTER

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 participate with CareCredit and most HSA plans. At the time of your visit, you will be given a HCFA form as a receipt for your services; you can submit this form to your insurance carrier for possible reimbursement. The amount of reimbursement will vary based on the amount of out-of-network coverage your plan provides and if you have met your out-of-network deductible. **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.

HOW DID YOU HEAR ABOUT US?

Please help us know how to best reach others. Mark all that apply.

- ☐ Patient referral: _____
- ☐ Physicians referral:_____
- ☐ Tenpenny Integrative Medical Center website
- ☐ DrTenpenny.com website
- ☐ Other website _____
- ☐ Westlake Magazine
- ☐ Berea Community Guide
- ☐ Our eNewsletter
- ☐ Direct mail marketing piece
- ☐ Radio show _____
- ☐ TV show _____

Social Media Referral

- ☐ Facebook
- ☐ Twitter
- ☐ YouTube video
- ☐ Other: _____

WHO ARE YOU SEEING TODAY?

- ☐ Michael Furci, PA
- ☐ Sherri Tenpenny, DO
- ☐ Matthew Grant, DC
- ☐ Janet Levatin, MD
- ☐ Sandi Asazawa, PA
- ☐ Autumn Schaef, NP
- ☐ Thermographer
- ☐ Blake Hardy, NP
- ☐ other ---

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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 OsteoMed II, Inc D/B/A Tenpenny Integrative Medical Center.

NOTICE AS TO NATURE OF SERVICES: I understand that the care I receive at OsteoMed II, Inc D/B/A 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 OsteoMed II, Inc D/B/A 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 OsteoMed II, Inc D/B/A 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 appraised 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 OsteoMed II, Inc D/B/A 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 OsteoMed II, Inc D/B/A 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 OSTEOMEDII, INC D/B/A 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 OsteoMed II, Inc D/B/A 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 OsteoMed II, Inc D/B/A Tenpenny Integrative Medical Center to take action to secure payment of an outstanding balance owed.

Patient Name: _____ Date: _____

NOTICE TO MEDICARE PATIENTS: The physcians at OsteoMed II, Inc D/B/A 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 OsteoMed II, Inc D/B/A 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. OsteoMed II, Inc D/B/A 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: OsteoMed II, Inc D/B/A 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. OsteoMed II, Inc D/B/A Tenpenny Integrative Medical Center may provide records requested by my insurance company. If possible, OsteoMed II, Inc D/B/A Tenpenny Integrative Medical Center will advise whether my insurance will cover any particular expenses, but given the uncertainty that pervades insurance decisions, OsteoMed II, Inc D/B/A 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 OsteoMedII, Inc d/b/a Tenpenny Integrative Medical Center.

REVOCATION 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 OsteoMedII, Inc d/b/a Tenpenny Integrative Medical Center Authorizations and Acknowledgements.

Patient's Signature:	Date:
Witness's Signature	Date:

TENPENNY

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**	
☐ Use this number as my primary contact	☐ Use this number as my primary contact	☐ Use this number as my primary contact	
☐ OK to leave detailed message	☐ OK to leave detailed message	☐ OK to leave detailed message	
☐ Leave your name and call back number only	☐ Leave your name and call back number only	☐ Leave your name and call back number only	
Email address:	**May be add your email to our in-office email databaseand Constant Contact mailing list? ☐ YES ☐ NO**	**WE PROTECT YOUR EMAIL PRIVACY AND IS USE FOR IN-OFFICE ALERTS AND PROMOTIONS ONLY.**	
EMERGENCY CONTACT NAME	EMERGENCY CONTACT NUMBER	RELATIONSHIP:	

INSURANCE INFORMATION		
Insurance Company:		
Address:	City, State and zip	
Insurance ID number	Group Number	
Insurance Policy Holder	Policy holder date of birth:	

I give my permission to share my medical information with _____

My relationship to this person is _____

I attest to the best of my knowledge, the information above is true and accurate.

Signature:	**Date:**

HEALTH HISTORY

Name:	**Date of Birth:**	
Reason for Visit:		

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:**
OCCUPATION:	**HIGHEST LEVEL OF EDUCATION:**

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

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

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

☐ DTaP	☐ HiB	☐ Flu Short	☐ Gardasil	☐ Typhoid	☐ RhoGam	
☐ MMR	☐ Prevnar	☐ Flu Mist	☐ Meningitis (college)	☐ Cholera		
☐ Polio	☐ Rotavirus	☐ Flu Short: H1N1	☐ Tetanus Booster	☐ Yellow Fever		
☐ Hepatitis A		☐ Flu Mist (nasal)		☐ Smallpox		
☐ Hepatitis B				☐ Anthrax		

FAMILY HEALTH HISTORY

	GOOD	POOR	DECEASED	AGE DECEASED	MEDICAL- HEALTH PROBLEMS
Father	☐	☐	☐		
Mother	☐	☐	☐		
Sister (s)	☐	☐	☐		
Brothers (s)	☐	☐	☐		
	☐	☐	☐		
	☐	☐	☐		

Signature:	**Today's Date:**

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	
Cancer - current. Type?		Always hungry		Anorexia		Headaches - cluster	
		Bloating		Bulimia		Headaches - migraine	
Cancer - past. Type?		Blood/black stools		Chronic anxiety		Headaches - tension	
		Burping to excess		Compulsive behavior		Hip pain	
THYROID		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		**RESPIRATORY · LUNGS**		**NEUROLOGICAL**		**URINARY · REPRODUCTIVE**	
Unexplained wt gain		Asthma		History of Concussions		**MEN**	
		Recurent sinus infections		History of stroke		Difficulty urinating	
CARDIOVASCULAR		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		**DENTAL HISTORY**		**SKIN PROBLEMS**		**WOMEN**	
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: ___	

Past medical history - more than 6 months ago

Blood clots		Other:					
Blood transfusion		Other:					
Cancer		Other:					
Diverticulitis		Other:					
Heart attack							

Past surgical history

What type of surgery?		**DATES**					

ANYTHING ELSE YOU WOULD LIKE US TO KNOW?

Signature:	**Today's Date:**

MEDICATION HISTORY

Please list all of the prescription medications you are CURRENTLY taking, and the dosage strength. If you are taking a generic medication, please include the common name, (ex: Fluoxitine is Paxil; ex: Omeprazole is Prilosec).

	Medication name (generic)	Medication name (common)	Dosage Strength	# times/day	OVER THE COUNTER MEDICATIONS	Dosage Strength	# times/day	MEDICATIONS YOU HAVE TAKEN IN THE PAST (NAMES ONLY)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								

SUPPLEMENTS YOU ARE CURRENTLY TAKING

	Supplement		Dosage Strength	# times/day	Supplement	Dosage Strength	# times/day

DRUG, SUPPLEMENT, FOOD AND ENVIRONMENTAL ALLERGIES/INTOLERANCES

	MEDICATIONS ALLERGY	SUPPLEMENT ALLERGY	
1			
2			
3			
4			
5			
6			
7			
8			

ENVIRONMENTAL ALLERGIES

☐	Dogs	☐	Grass	☐	Smoke	☐	Dairy	☐	Rabbits	☐	Mold	Other:
☐	Cats	☐	Spring pollen	☐	Perfumes	☐	Wheat	☐	Guinea Pigs	☐	Sugars	
☐	Birds	☐	Fall pollen	☐	Chemicals	☐	Corn	☐	Rag Weed	☐	Food dyes	Other:
☐	Horses	☐	Dust			☐	Fructose	☐	Poison Ivy			

Signature: **Today's Date:**

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

What time of day are your symptoms worse?

Morning	Afternoon	Evening	Bad all day long

What makes your symptoms better?

What makes your symptoms worse?

How would you describe your sleep patterns?

	I sleep well and wake up rarely during the night.
	I sleep well. If I get up, I return to sleep easily.
	I sleep well. But if I get up, I have difficulty falling back to sleep.
	I have difficulty falling asleep, but once asleep, I sleep well.
	I fall asleep easily but I have difficulty staying asleep
	I wake up consistently at ___ AM several times a week.
	I snore loudly and often wake my partner up.
	Most mornings I wake up feeling exhausted and feel like I barely slept at all.
	I often wake up with a headache.

STOP	BANG	Score→		(by your practitioner) score of 4 or more is significant

The **Epworth Sleepiness Scale** 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.

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

Sitting and reading			
Watching TV			
Sitting inactive in public place			
Passenger in car for> 1 hour			
Sitting and talking to someone			
Sitting quietly after lunch			
Stopped at a traffic light while driving			
TOTAL SCORE →			
On scale of 1 to 10, what is your present stress level?			
TOTAL SCORE →			

Have you been diagnosed with **sleep apnea**? If so, do you use a **CPAP** machine every night?

What has been the most significant **medical** occurrence in your life?

What has been your most significant **emotional** occurrence in your life?

What is your greatest **fear?**

What really makes you **happy?**

What is your favorite **relaxation time activity?**

SOCIAL HISTORY

Do you smoke?	☐ Yes	☐ No	If yes, how much and for how long?	Do you drink alcohol?	☐ Yes	☐ No	If yes, how much and for how long?
Did you quit smoking?	☐ Yes	☐ No	When did you stop smoking?	Have you stopped drinking alcohol?	☐ Yes	☐ No	When did you stop drinking?
Do you exercise regularly?	☐ Yes	☐ No	What type of exercise do you enjoy? How often?				

Signature:

Date:

Save Reset