THE CENTER FOR
FUNCTIONAL MEDICINE
Helping Healing Happen

Patient Information – Please Print and Complete All Sections

Name: Last _____ First _____
MI _____

Address_____
Zip_____

Sex: Female ____ Male ____ Social Security #_____ DOB_____
Age____

Home: _____ Work: _____ Cell: _____

***Which of these numbers is the best to reach you at all times?**
_____

Email Address _____

Marital Status _____ Occupation_____
Employer_____

Next of Kin _____ Relation _____Phone ( )_____

Emergency Contact _____ Phone ( ) _____
Relation_____

Referred by _____ Allergies _____

_____

_____ _____

Signature of Patient, Parent or Guardian Date

The Center for Functional Medicine
1011 High Ridge Road, Stamford, CT 06905
203-321-0200 ● Fax 203-321-0300

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The Center for Functional Medicine believes in the importance of the healing partnership between physician and patient. It is important that our patients are aware of our financial policies and procedures so that the "business side" of healthcare delivery does not intrude on or diminish the effectiveness of our collaboration.

Our office, like many others, charges for appointments that are not cancelled more than 24 **business** hours in advance. This policy is designed to defer the economic impact of empty, unscheduled time slots. Our cancellation fees are as follows: $175 for an appointment of 30 minutes, $300 for an hour appointment or ultrasound appointment and $ 100.00 for Thermography appointments. For this reason we request that you leave a credit card on file to cover these expenses, should they arise.

Please note that this information is not shared and is secure as we do not share any information with any other facility.

We accept all major credit cards and recommend that you use your HSA credit card (Health Savings Account) if you have one.
Thank you in advance for your cooperation and understanding.

Credit Card#_____ 3 digit code_____

Name on Card: _____ Exp date: _____

Patient Name (If different than card holder) _____

Type of card: Amex Visa MasterCard Discover

I understand the above information and give the Center for Functional Medicine authorization to charge my card for all charges as described above.

Signature of Patient: _____ Date: _____

_____
Print Name

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I understand that I have the right to request restrictions as to how my health information may be used and disclosed to carry out treatment, payment, or healthcare operations, and that The Center for Functional Medicine is not required to agree to the restrictions requested but if it does, it is bound by such restrictions.

I consent to the release of my private health information to parent or legal guardian, which may include test results. **YES or NO**

If yes, Please specify who has permission to receive information

_____

I request the following restrictions to the use or disclosure of my health information:_____

_____**I understand that I may request that certain information not be released to my parent or legal guardian and/or someone other than myself**.

Name and relationship: _____

I understand that I may revoke this consent in writing, except to the extent that The Center for Functional Medicine has already taken action in reliance thereon.

Signature of Patient: _____ Date: _____

_____
Print Name

Patient has been notified about the acceptance or denial of the restriction requested above.

Signature of Patient: _____ Date: _____

_____
Print Name

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Do you currently receive our Emails and newsletter?

YES NO

If NO would you like to receive them?

YES NO

Your Name:

Your Email Address:

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I, _____, understand that Dr. Joel M. Evans has opted out of Medicare and that I will be fully responsible for all charges and will pay in full at the time of service. I understand that Medicare limits do not apply to what Dr. Evans may charge for items or services provided. I agree not to ask Dr. Evans to submit claims to Medicare and I acknowledge that I do not expect reimbursement from Medicare. I understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

I also understand that I have the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare.

_____
Patient Signature

_____
Date

_____
Joel M. Evans, M.D.

_____
Date

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In order to inform you of your lab or test results in the most time-effective manner, we would like to call you on your cell phone to speak with you or to leave a message for you with the results.

☐ I authorize The Center for Functional Medicine to call me or to leave a message on my cell phone informing me of my lab or test results.

My cell phone is: _____

If we are unable to reach you by phone may we email you? **YES or NO**

E-mail:_____

☐ I do not authorize The Center for Functional Medicine to call me or to leave a message on my cell phone informing me of my lab or test results

_____
Patient Signature

_____
Date

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With my permission, The Center for Functional Medicine may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to The Center for Functional Medicine Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Center for Functional Medicine reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of The Center for Functional Medicine may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of The Center for Functional Medicine may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marker Personal and or Confidential.

With my permission, the office of The Center for Functional Medicine may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that The Center for Functional Medicine restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing The Center for Functional Medicine to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

** **PLEASE NOTE:** Patients who request their medical records be sent directly to them will be charged $0.67 per page*

_____

Signature of Patient/Legal Guardian

_____ _____

Print Name of Patient/Legal Guardian Date

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Patient Name:_____ Patient DOB:___/___/___

This questionnaire is designed to help us determine if you might benefit from testing for inherited forms of cancer. Please indicate if any of the following apply to you or your family members. ***Your family members include your biological parents, children, siblings, nieces/nephews, aunts/uncles, grandparents and first cousins.***

General Family Medical History

Have you or any of your family members been diagnosed with breast, colon/rectal or endometrial cancer BEFORE age of 50?	**YES**	**NO**
Have you or any of your family members been diagnosed with more than one breast cancer, triple negative breast cancer, ovarian cancer, or male breast cancer?	**YES**	**NO**
Are there two or more breast and/or pancreatic cancer diagnoses on the SAME side of your family BEFORE age 50?	**YES**	**NO**
Are there two or more colon/rectal, endometrial, gastric, ureter/kidney, biliary tract. Small bowel, pancreatic and/or brain cancer diagnoses on the SAME side of your family?	**YES**	**NO**
Have you or your family members had Ovarian Cancer at any age?	**YES**	**NO**
Are there two or more sarcoma, brain cancer, adrenocortical carcinoma, leukemia or lung cancer diagnoses BEFORE age 50 on the SAME side of your family?	**YES**	**NO**
Have you or any of your family members been diagnosed with medullary thyroid cancer, a tumor on the adrenal gland (pheochromocytoma) or tumors in the head and neck (paragangliomas)?	**YES**	**NO**
Is there a known inherited cancer gene mutation in your family?	**YES**	**NO**
Do you have **2 relatives** on the same side of the family with breast cancer **with one under the age of 50?**	**YES**	**NO**
Do you have **3 relatives** on the same side of the family with breast cancer **at any age?**	**YES**	**NO**
Has there been any male breast cancer in your family?	**YES**	**NO**
	YES	**NO**

Colon & Uterine Cancer History

Have you or any of your family members had 10 or more colon polyps?	**YES**	**NO**
Have YOU been diagnosed with uterine (endometrial) or Colorectal cancer before age 50?	**YES**	**NO**

Have **2 relatives** on the same side of the family been diagnosed **at any age before 50** with any of the following? **If YES, Please circle which:** COLON, UTERINE/ENDOMETRIAL, OVARIAN, STOMACH, SMALL BOWEL, BRAIN, KIDNEY/URINARY TRACT, URETER OR RENALPELVIS.	**YES**	**NO**
Have **3 or more relatives** on the same side of the family been diagnosed **at any age** with any of the following? **If YES, Please circle which:** COLON, UTERINE/ENDOMETRIAL, OVARIAN, STOMACH, SMALL BOWEL, BRAIN, KIDNEY/URINARY TRACT, URETER OR RENALPELVIS.	**YES**	**NO**
A family member has a known Lynch Syndrome mutation. ****If you are unfamiliar with Lynch Syndrome it is unlikely that is exists in your family.***	**YES**	**NO**

Non-Hereditary Breast Cancer History

Have you ever been diagnoses with any breast cancer or ductal carcinoma in situ (DCIS) or lobular carcinoma in situ (LCIS)?	**YES**	**NO**
Did you start your menstrual period before the age of 12 **OR** start menopause after age 50?	**YES**	**NO**
Did you have your first child AFTER age 30 **OR** never had children?	**YES**	**NO**
Have you ever been told you have DENSE BREASTS?	**YES**	**NO**
Have you ever been tested for BRCA?	**YES**	**NO**
Have you ever been tested for BREVAGen? (Saliva Test for Breast Cancer Risk)	**YES**	**NO**
Have you ever taken estrogen for hormone replacement therapy (HRT)?	**YES**	**NO**
Have you ever had a **(positive or negative)** breast biopsy?	**YES**	**NO**

I have been offered screening for inherited cancer. By signing below, I hereby **decline** to undergo screening, despite being advised of the benefits of this option.

Patient Signature:_____ Date:_____

MD Signature:_____ Date:_____

FOR OFFICE USE ONLY

- Patient not appropriate for testing
- Patient offered testing and accepted
- Patient offered testing and declined

NOTE: failure to meet the above criteria reduces but does not eliminate the risk for hereditary cancer. The above criteria do not account for all possible personal or family history factors that may be suggestive of hereditary cancer nor all possible scenarios in which insurance coverage for testing might be provided. Conversely, meeting the above criteria does not guarantee insurance coverage. This form is for informational purposes only and is not intended to provide legal advice or serve as a substitute for informed consent to be obtained by the ordering healthcare provider.

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