Angeli Maun Akey, MD, FACP, ABIHM/ABOIM, ABAARM, IFMCP
Dawn Brown, PA-C, IFMCP
Shawna Doran, ARNP-BC, MSN

6228 NW 43rd St. Suite B
Gainesville, FL. 32653
Phone: (352) 332-6680
Fax: (352) 332-6604
www.myNFIM.com

Dear New Patient,

I welcome you to our practice, North Florida Integrative Medicine. Our team is focused on whole-person healing; including body, mind and spirit. We like to take into account every facet of you that may impact your well-being so that we can partner with you to obtain optimal health.

Therefore, you are holding a 20-page New Patient Paperwork packet. You will find this packet extensive. It will provide us with valuable information to help us partner with you in excellent patient care so you can become the best version of yourself. ***In other words, we believe the investment of your time and effort will be worth it!***

We understand it can be overwhelming and tiresome to complete.

Here is a strategy that has worked for our other patients:

> **Plan on completing the packet over two days in two separate sweeps.**
>
> **Day One:** Fill out the paperwork without researching anything. Go with your first instincts when it comes to the metrics and questions that we ask. Mark with a sticky note areas that you need to research (such as data, doctor's address, dates, etc).
>
> **Day Two:** Look up the data marked with sticky notes and fill in the blanks.
>
> *If you need to take a break, please be sure to take a few deep breaths or laugh for a while!*
>
> **This paperwork takes about an hour to complete.**

We hope that you will find your experience at North Florida Integrative Medicine like none other you have experienced before.

Know that the efforts you've placed into giving us as much information as you can about your previous health journey will help us partner with you to assist you in obtaining optimal health hereforeward.

Most Sincerely,

Angeli Maun Akey, MD, FACP, ABIHM/ABOIM, ABAARM, IFMCP

Founder of this practice in the year 2000 in Gainesville-Florida , Owner, and Medical Director

Angeli Maun Akey, MD, FACP, ABIHM/ABOIM, ABAARM, IFMCP
Dawn Brown, PA-C, IFMCP
Shawna Doran, ARNP-BC, MSN

6228 NW 43rd St. Suite B
Gainesville, FL. 32653
Phone: (352) 332-6680
Fax: (352) 332-6604
www.myNFIM.com

Dear New Patient,

We would like to take this opportunity to welcome you to our practice and to thank you for choosing our physician and healthcare professionals to participate in your healthcare. We look forward to providing you with personalized, comprehensive healthcare focusing on wellness and prevention. As continuity and coordination of patient care is essential in meeting your healthcare needs, our healthcare team consists of Dr. Angeli Akey, a physician assistant (Dawn Brown) , a nurse practitioner (Shawna Doran), medical assistants and office staff who work closely in a "team approach" to support your patient care.

Our office is open Monday through Thursday from 7:00am-4:00pm, Friday from 8:30am-12:00pm. Our phones are "on service" daily from 12:00pm-1:00pm for lunch and after normal business hours. Any message left on our answering service during the above times, will be returned as soon as possible. Every effort is made to see our patients for medical problems during daytime hours. Please note that our schedulers are available every day and will do their best to accommodate you. Booking an appointment is essential to ensuring all patients receive the time they require for quality medical care.

In addition, all office visits are scheduled in advance, and we will make every effort to meet your needs. ***Note that we require 48 business hours for medication refills***. It is not always possible to fit urgent or emergency issues into our schedule. If this is the case, we encourage you to use the outstanding services offered by Dr. Steven Yucht's team at Emergency Physician Medical Centers located at:

9181 NW 39th Avenue Gainesville, Florida 32606 (next to Sonny's) 352-727-7755 emergencypmc.com ***or***

2445 SW 76th Street, Suite 110 Gainesville, Florida 32608
352-872-5111 emergencypmc.com

If this is a severe or life threatening medical condition, please proceed to North Florida Regional Medical Center or call 911. Dr. Akey is on staff at NFRMC and utilizes the services of Hospital Internal Medicine.

Once again, we would like to thank you for choosing us as your Primary Healthcare medical home. We look forward to partnering with you for your optimal health utilizing a functional, integrative, regenerative, restorative, internal medicine approach which you will find unique and effective.

Sincerely,

Healthcare Professionals (HCPs) and Staff of North Florida Integrative Medicine

Angeli Maun Akey, MD, FACP, ABIHM/ABOIM, ABAARM, IFMCP
Dawn Brown, PA-C, IFMCP
Shawna Doran, ARNP-BC, MSN

6228 NW 43rd St. Suite B
Gainesville, FL. 32653
Phone: (352) 332-6680
Fax: (352) 332-6604
www.myNFIM.com

Thank you for choosing NORTH FLORIDA INTEGRATIVE MEDICINE as your healthcare provider. We are committed to fulfilling our responsibilities in your successful treatment. However, in order for our relationship to be successful, it is important that you understand your responsibilities as a patient.

Patient Responsibilities:
Please initialize each statement.

_____ I understand that extensive preparation is made for my New Patient Appointment and it is important I keep this scheduled appointment. However, if for some reason I cannot attend, it is my responsibility to give a minimum of forty-eight (48) business hours notice. I understand that failure to do so will result in a $150 New Patient No Show/Late Cancellation fee.
_____ I need to keep my scheduled follow up appointments. However, if for some reason I cannot attend, it is my responsibility to give a minimum of twenty-four (24) business hours notice. I understand that failure to do so will result in a $75 No Show fee/Late Cancellation. Repeated failure to give appropriate notice could result in NFIM discharging me from the practice.
_____ It is my responsibility to give true and complete information about my health status, medical history, medications, and any other matters about my health. If I do not understand my care plan, I can inform NFIM medical assistants so they can clarify any questions I may have.
_____ It is my responsibility to make NFIM aware of changes in my care, illnesses, caregivers and safety.
_____ It is my responsibility to provide the front office with my up to date/current insurance information. It is my responsibility to pay patient co-pays, deductibles and other appropriate fees at the time of service. I understand that failure to pay previous balances could result in being sent to a collection agency or being discharged from NFIM.
_____ It is my responsibility to follow the treatment plan established by my practitioner and me. This includes attending appointments for tests, following recommended therapies and completing home activities recommended to me. I am responsible for my actions. If I refuse care or do not follow my practitioner's orders. I understand that failing to comply with my treatment plan could result in my practitioner discharging me.
_____ Prescription medicine might be part of my treatment. If so, it is my responsibility to follow instructions closely. I understand that no early refills on narcotics will be provided and that ***prescriptions can only be refilled during work days/hours: Monday through Thursday 7:00am-4:00pm with 48 business hours notice***.
_____ I will follow practice policies and procedures. I will be thoughtful of the rights of other patients and will treat the doctor, practitioners and staff with respect and consideration. I realize that bad language or behavior is not tolerated and may be grounds for discharge from the practice.

I pledge to fulfill my responsibilities as patient:

Signature: _____ Date: _____

Patient's Printed Name:_____

Patient's Date of Birth:_____

Angeli Maun Akey, MD, FACP, ABIHM/ABOIM, ABAARM, IFMCP
Dawn Brown, PA-C, IFMCP
Shawna Doran, ARNP-BC, MSN

6228 NW 43rd St. Suite B
Gainesville, FL. 32653
Phone: (352) 332-6680
Fax: (352) 332-6604
www.myNFIM.com

PATIENT INFORMATION (THIS PAGE MUST BE COMPLETED IN FULL)**:**

PATIENT NAME (LAST FIRST MIDDLE): _____
PREFERRED NAME: _____
SEX AT BIRTH: MALE ____ FEMALE ____
DATE OF BIRTH: _____
EMPLOYER/SCHOOL:_____
PHONE:_____
SOCIAL SECURITY:_____
DRIVER'S LICENSE:_____ STATE:_____

ADDRESS LINE 1_____
ADDRESS LINE 2 (LOT #, APT #)_____
CITY_____ STATE_____ZIP_____
HOME PHONE:_____ WORK PHONE:_____ CELL PHONE:_____
E-MAIL ADDRESS:_____

IN CASE OF EMERGENCY, CONTACT:
NAME:_____ PHONE:_____
RELATIONSHIP TO YOU: _____

PRIMARY INSURANCE INFORMATION:
INSURANCE _____
INSURANCE ID/POLICY #:_____ GROUP #:_____
INSURED PARTY'S NAME_____ DOB _____
RELATIONSHIP TO PATIENT:_____ PHONE:_____ SS#:_____
ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____
INSURED PARTY'S EMPLOYER:_____
EMPLOYER ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

SECONDARY INSURANCE INFORMATION:
INSURANCE _____
INSURANCE ID/POLICY #:_____ GROUP #:_____
INSURED PARTY'S NAME_____ DOB _____
RELATIONSHIP TO PATIENT:_____ PHONE:_____ SS#:_____
ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____
INSURED PARTY'S EMPLOYER:_____
EMPLOYER ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

**IS THIS AILMENT RELATED TO YOUR EMPLOYMENT? YES_____ NO_____*
**ACCIDENT? AUTO___ HOME___ WORK___ OTHER_____*
**NFIM does not manage auto insurance or workman's compensation insurance.*

Angeli Maun Akey, MD, FACP, ABIHM/ABOIM, ABAARM, IFMCP
Dawn Brown, PA-C, IFMCP
Shawna Doran, ARNP-BC, MSN

6228 NW 43rd St. Suite B
Gainesville, FL. 32653
Phone: (352) 332-6680
Fax: (352) 332-6604
www.myNFIM.com

Name (Print): _____

To whom can we thank for your referral? _____

Patient Concerns

What are you here to discuss today?

1._____
2._____
3._____
4._____
5._____

Past Medical History

Check beside all that apply.

_____Alcoholism/Substance Abuse
_____Anemia
_____Arrhythmia
_____Arthritis/Joint Disease
_____Autoimmune Disease
_____Blood Clots/ Phlebitis
_____Breast Cancer
_____Chronic Sinusitis
_____Colon Cancer
_____COVID-19
_____Depression
_____Diabetes
_____Epilepsy/ Seizures
_____Environmental Allergies
_____Fibromyalgia
_____Food Allergies
_____Gout
_____Hay Fever
_____Headaches/ Migraines
_____Heart Attack
_____Heart Disease
_____Heart Failure
_____High Blood Pressure
_____High Cholesterol
_____History of Infertility
_____ HIV/AIDS
_____Irritable Bowel Syndrome
_____Kidney Stones
_____Liver Disease
_____Lung Cancer
_____Lung Disease
_____Lyme Disease
_____Menstrual Dysfunction
_____Multiple Sclerosis
_____Parkinson's
_____Prostate Cancer
_____Rheumatic Fever
_____Serious Injury or Accident
_____Sexually Transmitted Disease
_____Stroke/ TIA's
_____Thyroid Disease
_____Tuberculosis
_____Ulcer
_____OTHER (please specify):
_____
_____

Past Surgical History

Please list any surgeries/operations or major injuries that you have had at any point in your life, along with the year it was performed, and if there were any complications that occurred as a result from your surgery.

1._____
2._____
3._____
4._____
5._____

Health Care Team

*Please list any other doctors you are seeing for any other medical problem. Providing this information will help us expeditiously obtain your old records. Make sure to list the **doctor's name, their specialty, phone and fax number**.*

1._____
2._____
3._____
4._____
5._____

Angeli Maun Akey, MD, FACP, ABIHM/ABOIM, ABAARM, IFMCP
Dawn Brown, PA-C, IFMCP
Shawna Doran, ARNP-BC, MSN

6228 NW 43rd St. Suite B
Gainesville, FL. 32653
Phone: (352) 332-6680
Fax: (352) 332-6604
www.myNFIM.com

Medications and Supplements

Preferred Local Pharmacy Name: _____

Address (include zip code): _____

Phone Number: _____

What medications are you currently taking? Please include both prescriptions and over-the-counter drugs (attach separate list if necessary).

Medication/Supplement/OTC	Date Started and Prescribing Doctor	Reason for Taking	Dosage per Day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Angeli Maun Akey, MD, FACP, ABIHM/ABOIM, ABAARM, IFMCP
Dawn Brown, PA-C, IFMCP
Shawna Doran, ARNP-BC, MSN

6228 NW 43rd St. Suite B
Gainesville, FL. 32653
Phone: (352) 332-6680
Fax: (352) 332-6604
www.myNFIM.com

Allergies

Do you have any allergies to medications, foods, or environmental causes?

Drug allergies:_____ Reaction:_____

Food allergies:_____ Reaction:_____

Environmental allergies:_____ Reaction:_____

Family Medical History

Fill all that apply with the following initials: (M)Mother, (F)Father, (B)Brother, (S)Sister, (C)Child, (MG)Maternal Grandparent, (PG)Paternal Grandparent, (MA)Maternal Aunt, (PA)Paternal Aunt, (MU)Maternal Uncle, (PU)Paternal Uncle.

_____Alcoholism/Substance Abuse
_____Allergies
_____Anxiety
_____Arthritis/ Joint Disease
_____Autoimmune Disease
_____Blood Disorder/Anemia
_____Cancers or tumors (please specify below)
_____Celiac Disease
_____Depression
_____Diabetes
_____Eilepsy/ Seizures
_____Glaucoma
_____Headaches/ Migraines
_____Heart Attack
_____Heart Disease
_____Heart Failure
_____High Blood Pressure
_____High Cholesterol
_____Liver Disease (Hepatitis etc)
_____Lung Disease (Asthma, COPD, etc)
_____Mental Illness
_____Multiple Sclerosis
_____Parkinson's
_____Stroke
_____Stomach or Intestinal Ulcer
(Crohn's Disease, Ulcerative Colitis, etc)
_____Suicide
_____Thyroid Disease
_____Other:_____
_____
_____
_____
_____
Cancer/Tumor types: _____
_____
_____
_____
_____

Angeli Maun Akey, MD, FACP, ABIHM/ABOIM, ABAARM, IFMCP
Dawn Brown, PA-C, IFMCP
Shawna Doran, ARNP-BC, MSN

6228 NW 43rd St. Suite B
Gainesville, FL. 32653
Phone: (352) 332-6680
Fax: (352) 332-6604
www.myNFIM.com

Vaccination History

For the year, please provide the most recent year of injection.

Childhood Vaccinations: up to date _____ refused_____
Influenza (flu): (Year) _____ (NO) _____
Hepatitis B: (Year) _____ (NO) _____
Screened for Hepatitis C: (YES)____(NO)____
Tetanus: (Year) _____ (NO) _____
Gardasil: (1st) _____ (2nd) _____ (3rd) _____ (NO) _____
Shingrix: (Year) _____ (NO)__NO___
Pneumovax: (Year) _____ (NO)_____
Prevnar 13: (Year) _____(NO)_____
Prevnar 20: (Year) _____(NO)_____
COVID-19: (Year)_____ TYPE_____ (NO)_____(YES AND # OF BOOSTERS)_____ #_____

Preventative and Diagnostic Testing

Please list any preventative or diagnostic testing that you have had done, along with the date it was performed, the location or ordering physician, and indicate whether the testing results were normal or abnormal.

Testing	Date	Location	Normal or abnormal results?
Colonoscopy			
Endoscopy			
Mammogram			
Pap Smear			
Prostate Exam			
DEXA (bone density scan)			
CT Scan/Imaging			
Cardiac Testing			
Chest X-Ray			
Lab Testing/Blood work			
Eye Exam			
Hearing Exam			

Angeli Maun Akey, MD, FACP, ABIHM/ABOIM, ABAARM, IFMCP
Dawn Brown, PA-C, IFMCP
Shawna Doran, ARNP-BC, MSN

6228 NW 43rd St. Suite B
Gainesville, FL. 32653
Phone: (352) 332-6680
Fax: (352) 332-6604
www.myNFIM.com

Social History

What kind of work do you do/did you do?_____

Marital Status: Single_____ Married_____ Divorced_____ Separated_____ Widowed_____ Other_____

Do you have children?_____

TOBACCO: (YES) _____ (NO) _____

If yes: how many cigarettes/week _____ or how many packs/day_____

If no: Never used _____ or Former smoker: Year quit _____

ALCOHOL: (YES) _____ (NO) _____

If yes: about how many drinks per week_____

RECREATIONAL DRUGS: (YES) _____ (NO) _____

If yes: about how many times per week _____

Nutritional History

What do you do for exercise? _____ How many times per week?_____

What type of diet do you follow? _____ Any restrictions?_____

How much caffeine do you have per day? _____

Review of Symptoms

Checkmark if you are currently experiencing any of these symptoms.

GENERAL: _____fatigue _____weight change

HEENT: _____headache _____change in vision _____change in hearing _____nasal obstruction _____nasal discharge _____hoarseness _____tooth pain _____mouth sores/lesions _____ringing in ears

NECK: _____stiffness _____pain

BREAST: _____lumps _____tenderness _____swelling _____nipple discharge

CARDIOVASCULAR: _____chest pain _____palpitations _____fainting _____edema/swelling of extremities

LUNGS: _____shortness of breath _____wheezing _____cough

ABDOMEN: ____change in appetite ____difficulty swallowing____acid reflux ____pain ____diarrhea ___constipation ___bowel habit changes ____vomiting ____dark stools ___bright red blood around rectum ____bloating ___indigestion.

GENITOURINARY: _____urgency _____frequency _____nighttime urination _____painful urination _____incontinence

MUSCULOSKELETAL: _____joint pain _____muscle pain _____joint swelling _____recent injuries

SKIN: _____rash _____changing moles _____itching

NEUROLOGICAL: ____generalized weakness ____localized weakness ____tremor ____memory loss ___balance problems

PSYCHOLOGICAL: _____depression _____anxiety _____insomnia

WOMEN ONLY: ____painful periods ____vaginal discharge ____painful intercourse ____decreased sexual desire ____pelvic pain ____menstrual irregularity ____severe PMS____postmenopausal *(at what age? _____)*

MEN ONLY: _____prostate problems _____testicular cancer _____hernia _____treatment for genital problems _____vasectomy _____discharge from penis _____loss of sexual activity

Angeli Maun Akey, MD, FACP, ABIHM/ABOIM, ABAARM, IFMCP
Dawn Brown, PA-C, IFMCP
Shawna Doran, ARNP-BC, MSN

6228 NW 43rd St. Suite B
Gainesville, FL. 32653
Phone: (352) 332-6680
Fax: (352) 332-6604
www.myNFIM.com

MSQ – MEDICAL SYMPTOM QUESTIONNAIRE

NAME:_____DATE:_____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are taking it after the first time, record your symptoms for the last 48 hours only.

POINT SCALE
0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

DIGESTIVE TRACT
___Nausea or vomiting
___Diarrhea
___Constipation
___Bloated feeling
___Belching, or passing gas
___Heartburn
___Intestinal/Stomach pain
*Total*_____

EARS
___Itchy ears
___Earaches, ear infections
___Drainage from ear
___Ringing in ears, hearing loss
Total _____

EMOTIONS
___Mood swings
___Anxiety, fear, or nervousness
___Anger, irritability, or aggressiveness
___Depression
*Total*_____

ENERGY/ACTIVITY
___Fatigue, sluggishness
___Apathy, lethargy
___Hyperactivity
___Restlessness
*Total*_____

EYES
___Watery or itchy eyes
___Swollen, reddened or sticky eyelids
___Bags or dark circles under eyes
___Blurred or tunnel vision (does not include near-or-far-sightedness)
*Total*____

HEAD
___Headaches
___Faintness
___Dizziness
___Insomnia
*Total*_____

HEART
___Irregular or skipped heartbeat.
___Rapid or pounding heartbeat
___Chest pain
*Total*_____

JOINTS/MUSCLES
___Pain or aches in joints
___Arthritis
___Stiffness or limitation of movement
___Pain or aches in muscles
___Feeling of weakness or tiredness
*Total*_____

LUNGS
___Chest congestion
___Asthma, bronchitis
___Shortness of breath
___Difficulty breathing
*Total*_____

MIND
___Poor memory
___Confusion, poor comprehension
___Poor concentration
___Poor physical coordination
___Difficulty in making decisions
___Stuttering or stammering
___Slurred speech
___Learning disabilities
*Total*_____

MOUTH/THROAT
___Chronic coughing
___Gagging, frequent need to clear throat
___Sore throat, hoarseness, loss of voice
___Swollen/discolored tongue, gum, lips
___Canker sores
*Total*_____

NOSE
___Stuffy nose
___Sinus problems
___Hay fever
___Sneezing attacks
___Excessive mucus formation
*Total*_____

SKIN
___Acne
___Hives, rashes, or dry skin
___Hair loss
___Flushing or hot flushes
___Excessive sweating
*Total*_____

WEIGHT
___Binge eating/drinking
___Craving certain foods
___Excessive weight
___Compulsive eating
___Water retention
___Underweight
*Total*_____

OTHER
___Frequent illness
___Frequent or urgent urination
___Genital itch or discharge
*Total*_____

GRAND TOTAL_____

Angeli Maun Akey, MD, FACP, ABIHM/ABOIM, ABAARM, IFMCP
Dawn Brown, PA-C, IFMCP
Shawna Doran, ARNP-BC, MSN

6228 NW 43rd St. Suite B
Gainesville, FL. 32653
Phone: (352) 332-6680
Fax: (352) 332-6604
www.myNFIM.com

The WHO-Five Well-being Index (WHO-5)

Over the last two weeks	All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
1. I have felt cheerful and in good spirits	5	4	3	2	1	0
2. I have felt calm and relaxed	5	4	3	2	1	0
3. I have felt active and vigorous	5	4	3	2	1	0
4. I woke up feeling fresh and rested	5	4	3	2	1	0
5. My daily life has been filled with things that interest me	5	4	3	2	1	0
Column Totals	_____	+_____	+_____	+_____	+_____	+_____
						Grand Total: _____

Angeli Maun Akey, MD, FACP, ABIHM/ABOIM, ABAARM, IFMCP
Dawn Brown, PA-C, IFMCP
Shawna Doran, ARNP-BC, MSN

6228 NW 43rd St. Suite B
Gainesville, FL. 32653
Phone: (352) 332-6680
Fax: (352) 332-6604
www.myNFIM.com

THE PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals: _____ + _____ + _____

Grand Total: _____

If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Angeli Maun Akey, MD, FACP, ABIHM/ABOIM, ABAARM, IFMCP
Dawn Brown, PA-C, IFMCP
Shawna Doran, ARNP-BC, MSN

6228 NW 43rd St. Suite B
Gainesville, FL. 32653
Phone: (352) 332-6680
Fax: (352) 332-6604
www.myNFIM.com

Generalized Anxiety Disorder Scale (GAD-7)

Over the last 2 weeks, how often have you been bothered by the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Column Totals:		_____	+ _____	+ _____

Grand Total: _____

If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Angeli Maun Akey, MD, FACP, ABIHM/ABOIM, ABAARM, IFMCP
Dawn Brown, PA-C, IFMCP
Shawna Doran, ARNP-BC, MSN

6228 NW 43rd St. Suite B
Gainesville, FL. 32653
Phone: (352) 332-6680
Fax: (352) 332-6604
www.myNFIM.com

WOMEN ONLY Hormone Balance Inventory

This inventory is a tool for assessing hormone imbalance. Circle the answer that best describes you.

During the past 3 months, how often have you experienced:					
Difficulty concentrating and remembering?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Hot flashes and/or night sweats?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Lack of sexual desire?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Feeling anxious?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Mood swings?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Feeling depressed, sad or unhappy?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Difficulties with sleep?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Irritability or nervousness?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Heart palpitations?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Changes in the length of your menstrual cycle?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Changes in the amount of menstrual bleeding?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Breast tenderness?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Bloating or fluid retention?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Weight gain?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Vaginal dryness?	Always 5	Many times 4	Sometimes 3	A few times 2	Never 1
Column Totals:	_____	+_____	+_____	+_____	+_____
					Grand Total: _____

Angeli Maun Akey, MD, FACP, ABIHM/ABOIM, ABAARM, IFMCP
Dawn Brown, PA-C, IFMCP
Shawna Doran, ARNP-BC, MSN

6228 NW 43rd St. Suite B
Gainesville, FL. 32653
Phone: (352) 332-6680
Fax: (352) 332-6604
www.myNFIM.com

MEN ONLY A.D.A.M

(Androgen Deficiency in the Aging Male) Screening Questionnaire

	Check YES or NO for each of the following questions:	YES	NO
1.	Do you have a decrease in libido (sex drive)?		
2.	Do you have a lack of energy?		
3.	Do you have a decrease in strength and/or endurance?		
4.	Have you lost height?		
5.	Have you noticed a decrease in “enjoyment of life”?		
6.	Are you sad and/or grumpy?		
7.	Are your erections less strong?		
8.	Have you noticed a recent deterioration in your ability to play sports?		
9.	Are you falling asleep after dinner?		
10.	Has there been a recent deterioration in your work performance?		

Angeli Maun Akey, MD, FACP, ABIHM/ABOIM, ABAARM, IFMCP
Dawn Brown, PA-C, IFMCP
Shawna Doran, ARNP-BC, MSN

6228 NW 43rd St. Suite B
Gainesville, FL. 32653
Phone: (352) 332-6680
Fax: (352) 332-6604
www.myNFIM.com

CONSENT FOR PURPOSES OF: TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by North Florida Integrative Medicine (NFIM), for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations by NFIM. I therefore authorize NFIM, by my signature on this document, to evaluate and treat my condition.

I give NFIM (Dr. Akey and/or staff) my authorization to photocopy all portions of my medical records and provide copies of those medical records to any individual or company which requests those records if the requesting party provides this office with either: a subpoena which requires that production, a court order which requires that production, or a release or authorization which appears to be signed by the patient or the patient's court appointed representative.

I understand I have the right to request a restriction on how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. NFIM is not required to agree to restrictions that I request. However, if NFIM agrees to a restriction I request, the restriction is binding on NFIM and any employee.

My "protected health information" means health information, including any demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical, and mental health condition and identifies me, or there is reasonable basis to believe the information may identify me.

Recipients have the right to receive security breach notification; Health plans may not use genetic information for underwriting purposes; Covered entities must obtain patient authorization before using PHI for marketing purposes and before selling PHI.

I have the right to revoke this consent, in writing, at any time, except to the extent that NFIM has taken action in reliance to this consent.

I understand that I have the right to review NFIM's notice of privacy practices prior to signing this document. The notice of privacy practices is posted in the North Florida Integrative Medicine lobby.

NFIM reserves the right to change the privacy practices that are described in the notice of privacy practices. I may obtain a revised notice by calling the office administrator and requesting a revised copy.

Signature of Patient or Personal Representative: _____

Name of Patient or Personal Representative: _____

Date:_____

Description of Personal Representative Authority: _____

Angeli Maun Akey, MD, FACP, ABIHM/ABOIM, ABAARM, IFMCP
Dawn Brown, PA-C, IFMCP
Shawna Doran, ARNP-BC, MSN

6228 NW 43rd St. Suite B
Gainesville, FL. 32653
Phone: (352) 332-6680
Fax: (352) 332-6604
www.myNFIM.com

HIPAA AUTHORIZATION

STATEMENT OF INTENT

I understand that Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits disclosure of my protected medical information. This authorization is being signed because it is crucial that my medical providers readily give my protected medical information to the persons designated in this authorization in order to allow me the advantage of being able to discuss and obtain advice from my family and/or friends.

Therefore, pursuant to 45 CFR 164.50 (a)(1)(iv)a covered entity (being a health care provider as defined by HIPAA) is permitted to disclose protected health information pursuant to and in compliance with this valid authorization under 45 CFR Sec. 164.508.

AUTHORIZATION

I, _____, an individual, hereby authorize all covered entities as defined in HIPAA, including but not limited to a physician, podiatrist, chiropractor, osteopath, psychiatrist, psychologist, dentist, therapist, nurse, hospital, clinic, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, medical insurance company or any other health care provider or affiliate, to disclose the following information:

All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization of ANY protected medical information to the persons named in this authorization. (This is normally family members, very close friends and <u>not</u> other physicians).

I authorize the following person(s) full authorization and ANY protected medical information:

Name:_____
Relationship:_____
Address:_____
Telephone:_____
Name:_____
Relationship:_____
Address:_____
Telephone:_____
Name:_____
Relationship:_____
Address:_____
Telephone:_____

You may leave a message on my answering machine and/or cell phone. (Yes)_____ (No)_____
I would like to be added to Dr. Akey's Health Newsletter via email*. (Yes)_____ (No)_____

*Monthly at the most, unless there's an emergency.

Angeli Maun Akey, MD, FACP, ABIHM/ABOIM, ABAARM, IFMCP
Dawn Brown, PA-C, IFMCP
Shawna Doran, ARNP-BC, MSN

6228 NW 43rd St. Suite B
Gainesville, FL. 32653
Phone: (352) 332-6680
Fax: (352) 332-6604
www.myNFIM.com

TERMINATION

This authorization shall terminate on the first to occur of: (1) two years following my death or (2) upon my written revocation actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the covered entity. This revocation shall be effective upon the actual receipt of the notice by the covered entity except to the extent that the covered entity has taken action in reliance on it. This authorization is not affected by my subsequent disability or incapacity.

RE-DISCLOSURE

By signing this Authorization, I acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the person or persons whose name(s) is/are written above, and the information once disclosed will no longer be protected by the rules created in HIPAA. No covered entity shall require my authorized persons to indemnify the covered entity or agree to perform any act in order for the covered entity to comply with this authorization.

INSTRUCTIONS FOR MY AUTHORIZED PERSONS

My authorized persons shall have the right to bring legal action in any applicable form against any covered entity that refuses to recognize and accept this authorization for the purposes I have expressed. Additionally, my authorized persons are authorized to sign any documents that the authorized persons deem appropriate to obtain the protected medical information.

VALID DOCUMENT

A copy or facsimile of this original authorization shall be accepted as though it were an original document.

WAIVER AND RELEASE (mandatory consent)

I hereby release any covered entity that acts in reliance on this authorization from any liability that may accrue from releasing my protected medical information and for any actions taken by my authorized persons.

Signed on the_____ day of _____ *year*_____

*Signature:*_____

*Printed Name:*_____

*Witness Signature:*_____

*Witness Printed Name:*_____

Angeli Maun Akey, MD, FACP, ABIHM/ABOIM, ABAARM, IFMCP
Dawn Brown, PA-C, IFMCP
Shawna Doran, ARNP-BC, MSN

6228 NW 43rd St. Suite B
Gainesville, FL. 32653
Phone: (352) 332-6680
Fax: (352) 332-6604
www.myNFIM.com

RELEASE OF MEDICAL RECORDS*

Patient Name: _____
Date of Birth: _____ Telephone:_____

I hereby authorize and request you to (check both boxes):

- o Release my file from all previous providers
- o Release my file to North Florida Integrative Medicine (NFIM)

List previous providers (note one release per provider) we will need records from (include phone number and/or fax):

_____
_____
_____

Purpose of Release (select one):

- o Continued care
- o Referred to another doctor
- o Leaving practice
- o Personal copy

Specific items or dates needed (leave blank if all): _____

This is an authorization for release of medical records and information including diagnosis, treatment, and/or examination related to mental health (psychiatry or psychology), drug and/or alcohol abuse, HIV testing or AIDS, and sexually transmissible diseases. As required by state and federal law, North Florida Integrative Medicine may not use or disclose your health information, except as provided in our HIPAA policy, without your authorization.

I understand that this authorization will remain in effect for one year or until a revoke is in writing. I further understand that such a revocation does not apply to information already released in response to this authorization. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization. I understand that I have a right to inspect and to obtain a copy of any information disclosed. I understand that I may be charged a fee of up to $1.00 per page up to 25 pages. Over 25 pages is a charge of $0.50 per page thereafter. This fee is waived for copies provided to a health care provider for continuing medical care. I understand this fee is within the limits allowable by Florida law.

If you are leaving the practice, please, sign this informed consent notification that you are hereby assuming responsibility for your medical care effective the date of this release.

Patient Signature: _____ Date: _____
Witness Signature: _____ Date: _____

**Please make copies and fill out one per physician on your health care team to date*

This document conforms to all regulations stipulated by the Health Information Portability and Accountability Act - HIPAA

Angeli Maun Akey, MD, FACP, ABIHM/ABOIM, ABAARM, IFMCP
Dawn Brown, PA-C, IFMCP
Shawna Doran, ARNP-BC, MSN

6228 NW 43rd St. Suite B
Gainesville, FL. 32653
Phone: (352) 332-6680
Fax: (352) 332-6604
www.myNFIM.com

LIFETIME AUTHORIZATION

INSURANCE ASSIGNMENTS AND AUTHORIZATIONS TO RELEASE INFORMATION FORM

I. **RELEASE OF INFORMATION**: I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payor (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. **PHYSICIAN INSURANCE ASSIGNMENT:** I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

III. **MEDICARE/MEDICAID:** Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. **I PERMIT A COPY OF THESE AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE.**

V. This assignment will remain in effect until revoked by me in writing.

VI. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third party payor within a reasonable period of time not to exceed 60 days.

VII. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

Date: _____

Patient Signature: _____

Subscriber Signature (if different from patient): _____

(Original signature on file at Physician's office)

MEDIGAP (SECONDARY INSURANCE) SIGNATURE

I request that payment of authorized MEDIGAP benefits be made on my behalf to North Florida Integrative Medicine or any services furnished me by (physician/supplier). I authorize any holder of medical information about me to release to (name of Insurance Company) _____ any information needed to determine these benefits or the benefits for related services.

Medigap Policy Number: _____

Name of Beneficiary Health: _____

Insurance Company: _____

Angeli Maun Akey, MD, FACP, ABIHM/ABOIM, ABAARM, IFMCP
Dawn Brown, PA-C, IFMCP
Shawna Doran, ARNP-BC, MSN

6228 NW 43rd St. Suite B
Gainesville, FL. 32653
Phone: (352) 332-6680
Fax: (352) 332-6604
www.myNFIM.com

ADVANCED DIRECTIVE

The law of Florida recognizes the right of a competent adult to make an Advance Directive regarding instructions for his or her medical care. An adult can instruct his or her physician to provide, withhold, or withdraw life- prolonging procedures (using a Living Will), or to designate another person to make those decisions for him or her if they are unable to (using a Designation of Health Care Surrogate form) should the adult be suffering from a terminal condition.

There is no requirement that our patients have an Advance Directive. The decision to have an advance directive is a personal one, and one that should be made after discussing this matter with one's family, friends, attorney, and/or spiritual advisor.

However, whether you do, or do not have an Advance Directive, we would like to document that fact in your medical record. If you do have an Advance Directive, we would like to keep a copy in your medical record.

Please contact your legal advisor or the Florida Bar Association at www.floridabar.org if you need any further information. On the website www.floridabar.org are free Advanced Care planning forms.

I have a Living Will (Yes) _____(No)_____

I have an Advanced Directive (Yes) _____ (No)_____

I have a Designation of Health Care Surrogate (Yes) _____(No)_____

My Attorney's name who has these documents:

Name:_____

Phone Number:_____

I certify the above is true and correct.

Name:_____Date:_____

Signature:_____Date:_____