DISCOVER HEALTH
FUNCTIONAL MEDICINE CENTER

24 Pleasant Street
P.O. Box 244 Conway, NH 03818
Phone (603)447-3112
Fax (603) 447-3118
DiscoverHealthfmc.com

Welcome

This opening letter and packet of paperwork is meant to introduce you to our office and to inform you of our policies, as well as have you fill out paperwork prior to your appointment so that more time can be spent focusing on your health issue. Please read carefully and fill out all attached forms.

T Murray Wellness Center Inc. fosters independence and self-empowerment when working with patients. You are ultimately responsible for you own health and our physicians are here to assist you and guide you along your path to wellness. Using a holistic approach to healing and medicine, the focus of the visit may be on current or chronic conditions.

We are a "specialist" office and not a "primary care physician". With this in mind, it is important that you have a primary care provider for preventative care, emergency situations and ongoing medical care. If you should need to see Urgent Care or the Emergency Room, please refer to your primary care doctor as your doctor of record, not the physicians at T Murray Wellness Center.

What to Expect:

The initial visit often lasts for one hour. Follow-up visits will usually be scheduled for 30 minutes. Your visits may include a comprehensive medical history, Functional medicine intake, physical exam, osteopathic manipulative treatment, cranial treatment, injection treatment of joints, ligaments or tendons when necessary, or referral to other providers.

Please come prepared! If you are coming to the office for an Osteopathic Manipulative Medicine visit, be comfortable; wear a t-shirt and pants other than jeans. Sweat pants are preferred.

Holistic Care Planning:

Please be aware that depending on your injury or condition, it may be necessary to set up a holistic treatment plan that may include nutrition and herbal consults, physical therapy, or other bodywork to address your problem. Our Physicians will communicate with your primary care provider and other health care providers as is necessary. Additional studies, such as labs or x-rays may be ordered.

Cancellation Policy:
Your appointment is sacred; please honor this time. If you are unable to keep your commitment, please call the office at least 24 hours in advance. Each person will be allowed one cancellation without charge. For subsequent cancellations, **if less than 24 hours in advance, you will be responsible for a $50.00 fee.** This fee will be due at the time of service on your next visit; otherwise a bill will be mailed to you. Please be on time for your appointment. Each person is evaluated and treated efficiently and thoroughly. Any person more than 15 minutes late for their appointment will be asked to reschedule as not to affect the time allotted to the following patients.

Financial Policy:
Health Insurance is gladly billed as a courtesy to our patients when you provide us with current information. If your deductible has not been met we require payment for half of the amount of services rendered at the time of service. For 60 days while a claim is pending insurance payment, you may not receive statements. Once there is a "patient balance" a statement will be sent to you from our billing company. Payment is due on receipt of statement from our billing company. If claims are denied, you will be responsible for any outstanding debt.

- **Payment at the time of service** is required if you do not have health insurance or your insurance does not cover our services. We accept cash, check, Visa and Mastercard.
- **Co-payment** is due at the time of service.
- **Returned Checks** will be charged a $25.00 fee.
- **Copies:** Any copies of records will be charged $0.25 per page.

Note: For billing purposes, we may need to provide copies of your chart notes to your insurance company or to other payers to process claims. By signing this office policy, you are giving us permission to submit such records. If this is of concern to you, please do not sign the policy and discuss this with our office.

I have read, understand, and agree to the above mentioned office policy. If I have any questions or concerns regarding the office policy I will speak with the office prior to my first visit.

_____ _____

Printed name of Patient or Personal Representative Date

_____ _____

Signed name of Patient or Personal Representative Date

Notice of Privacy Practices

T. Murray Wellness Center Inc.
(Updated 09/01/2017)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information. We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment a health care operation;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised of your unprotected PHI is intentionally or unintentionally disclosed.

* If you have paid for services "out of pocket," in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.
* we are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

*This notice if effective as of September 1st 2017 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.
*You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer: Cherie Jewell (603) 447-3112 for more information, in person or in writing.

Receipt of Notice of Privacy Practices Written Acknowledgment Form

Discover Health Functional Medicine Center & T. Murray Wellness Center Inc.
I am a patient of T Murray Wellness Center Inc. DBA Discover Health Functional Medicine Center, I hereby acknowledge receipt of T. Murray Wellness Center's (DBA: Discover Health Functional Medicine Center Notice of Privacy Practices.

Name [please print): _____ **Date:** _____

Please Sign: _____

I am a parent or legal guardian of _____ **[patient name].** I hereby acknowledge receipt of T Murray wellness center's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____ **Date:** _____
Relationship to Patient: Parent Legal Guardian

☐ Documents of Good Faith Efforts: The patient presented for treatment on this date and was provided with a copy of the practice Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgment of receipt of the notice. However, an acknowledgment was not obtained for the following reasons:

*During the course of my treatment, I understand that certain tests, such as MRI, CAT scan, or consultations with other physicians, may be necessary. I authorize the release of any medical information for these purposes.

I authorize the release of any medical information necessary to process my disability and/or medical claim. ☐

Please sign here: _____

Authorization of Payment:
I authorize the payment of medical benefits to T Murray Wellness Center Inc. for services rendered. I understand that I am financially responsible in the event that payment is denied or rejected by the insurance company and for those charges not covered by the insurance company and for those charges not covered by policy benefits, as well as deductibles and co-insurance that are not covered by the assignment. ☐

Please sign here: _____

MEDICARE PATIENTS ONLY: I authorize any holder of medical or other information about me to be released to the Social Security Administration, Health Care Financial Administration or it's intermediaries/carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignments. I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare Assignment of benefits also apply. ☐

Please sign here: _____

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GENERAL INFORMATION

Date: _____

Legal Name (as listed on your insurance card): _____

Age: _____ Date of Birth: _____ Soc. Sec. # _____

Mailing Address: _____ City, State, and Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email address: _____

Pharmacy Phone: _____

Emergency Contact: _____ Emergency Phone: _____

Employer: _____ Employer Phone: _____

Referring Physician: _____

Phone: _____

Address: _____

Primary Care Physician: _____

Phone: _____

Address: _____

Please make sure your insurance is aware of any changes such as a new primary care Physician or an address changes

Insurance: _____

Referral Needed: Y N

Group Number: _____ BC: _____

Copay:

REASON FOR VISIT:

Name

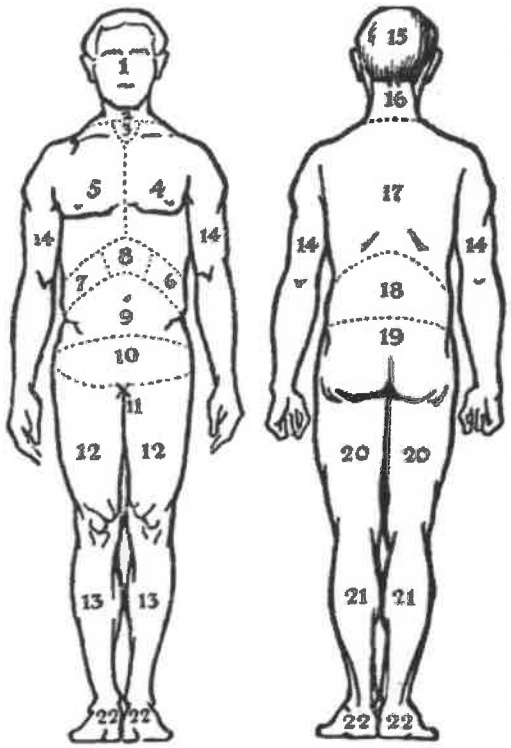
Date of Birth

Location of Pain

Use this diagram to indicate the location and type of pain. Write the number(s) based on the location of your symptoms and the following letters that best indicate your symptoms.

"N" = numbness
"S" = stabbing pain
"B" = burning pain
"P" = pins and needles
"A" = aching pain

Location Number:	Symptom Letters:



What does the pain feel like?

Check all the following that apply to the quality of your pain:

- ☐ Throbbing
- ☐ Shooting
- ☐ Stabbing
- ☐ Sharp
- ☐ Cramping
- ☐ Gnawing
- ☐ Hot-Burning
- ☐ Aching
- ☐ Heavy
- ☐ Tender
- ☐ Splitting
- ☐ Tiring-Exhausting
- ☐ Sickening Fearful
- ☐ Punishing, Cruel
- ☐

How Does Your Pain Change Over Time?

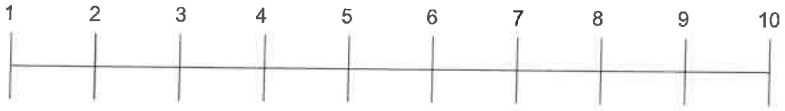
Check the word or words which best describe your pain:

- ☐ Continuous
- ☐ Steady
- ☐ Constant
- ☐ Rhythmic
- ☐ Periodic
- ☐ Intermittent
- ☐ Brief
- ☐ Transient
- ☐ Momentary

What kind of things relieve your pain?

What kind of things increase your pain?

How Bad is Your Pain?
Rate your pain in the boxes below (0 = No pain, 10 = Worst pain you've ever had)



	Which number (0-10) describes your pain right now?
	Which number (0-10) describes your pain at its worst?
	Which number (0-10) describes your pain at its least?
	Which number (0-10) describes the worst toothache you ever had?
	Which number (0·10) describes the worst headache you ever had?
	Which number (0-10) describes the worst stomach-ache you ever had?

Treatment for Your Pain
Please check all at the following physicians or specialists you have consulted

ONLY FOR PAIN RELIEF FOR THE CURRENT PROBLEM NOT FOR OTHER PROBLEMS

- ☐ Acupuncturist
- ☐ Allergist
- ☐ Anesthesiologist
- ☐ Chiropractor
- ☐ Dentist
- ☐ ENT Physician
- ☐ Endocrinologist
- ☐ Faith Healer
- ☐ General Physician
- ☐ Hypnotist
- ☐ Internist
- ☐ Neurologist
- ☐ Neurosurgeon
- ☐ Nutritionist
- ☐ Ophthalmologist
- ☐ Orthopedic Surgeon
- ☐ Osteopath
- ☐ Pain Clinic
- ☐ Physical Therapist
- ☐ Plastic Surgeon
- ☐ Podiatrist
- ☐ Psychiatrist
- ☐ Psychologist
- ☐ Rheumatologist

Please check all the following treatments you have used for pain relief and if they helped or not.

✓		Helped Pain	Worsened Pain	No Change
☐	Massage Therapy			
☐	Hot Packs			
☐	Ice			
☐	Physical Therapy			
☐	Chiropractic			
☐	Acupuncture			
☐	Traction			
☐	Brace Support			
☐	TENS			
☐	Injection Therapy			
☐	Oral Medication			

Other Details of Your Pain

How did your current episode begin? | Suddenly ☐ Gradually ☐

Describe the onset of the pain: _____

_____

_____

How long ago did your current episode begin? Please give the date. _____

Has the pain lessened, stayed the same, or worsened since it started? _____

Mark the effect of each of the following on your pain:

	Increase	Decrease	No Change
Sitting			
Standing			
Rising from sitting			
Bending forward			
Bending backward			
Walking			
Climbing stairs			
Lying on your back			
Lying on your stomach			
Driving			
Coughing/sneezing			
Lifting objects			

Please check the statement that best describes your sleep pattern:

	I sleep well
	Pain occasionally interrupts my sleep
	Pain interrupts my sleep half of the time
	Pain often interrupts my sleep
	Pain always Interrupts my sleep
	I never sleep well

Please choose the ONE item that best describes your current situation:

Married/living with significant other		Divorced	
Widowed		Single	
Do you have children?			
Do any children live at home?		If yes. What are their ages?	

Other Details of Your Pain:

Is this a work-related Injury?		If yes, date of injury:	
Is this a motor vehicle in jury?		If yes, date of injury:	
Is your problem due to an injury not state above?			
Accident Information:			

Accident Information:

If your injury/pain is the result of an accident or some other incident, please provide the following details:

Date of injury:	
Treatment at time of injury:	
Location of injury:	

Describe how the injury occurred:

Have you ever received Workers Compensation for past injury?

☐ **Yes** ☐ **No**

Please mark the ONE statement that best describes your current employment situation.

Currently Working		On paid leave	
On unpaid leave		Unemployment	
Homemaker		Student	
Retired (not due to health)		Disabled and or retired due to health	
Other, Please Specify			

ALLERGIES (Please List): _____

MEDICATIONS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

MEDICAL PROBLEMS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

SURGICAL HISTORY (Please list):

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

SOCIAL HISTORY

• Smoking	Do you smoke?		How many packs/day?		When did you quit?	
• Alcohol	Do you drink?		How many drinks/week?		When did you quit?	

• Recreational drugs:

• Coffee/Soda/Tea: How many cups per day?	
• Hobbies:	• Exercise:

FAMILY HISTORY

Father	Age if living:	Health Problems:
	Age at time of death:	Cause:
Mother	Age if living:	Health Problems:
	Age at time of death:	Cause:
	Number of Sisters:	Health Problems:
	Number of Brothers:	Health Problems:

Check the box if present in any blood relatives (include parents, grandparents, siblings, children, cousins, aunts, and uncles):

Arthritis ☐	Alcohol or Drug Abuse ☐	Blood Disease ☐	Cancer ☐	Diabetes ☐
Epilepsy ☐	Glaucoma ☐	Heart Disease ☐	High Blood Pressu ☐	Kidney Disea ☐
Lung Disea ☐	Migraine Headach ☐	Psychiatric Illne ☐	Tuberculosis ☐	Suicide ☐

Other Inherited Conditions: _____

_____

What tests and studies have been done (MRI, CAT scan, X-Rays, Ultrasound, etc)?

_____

_____

_____

When? _____

Results? _____

Directions

From the South:
Proceed North on Route 16 to Conway. At the second traffic light, take a right onto Pleasant Street. We are the second driveway (yellow building with maroon trim) on the right.

From the North:
Proceed South on Route 16 to Conway. At the first traffic light, take a right continuing to Route 16 South. At the second traffic light, take a left onto Pleasant Street. We are the second driveway (yellow building with maroon trim) on the right.

THE INSTITUTE FOR FUNCTIONAL MEDICINE®

Medical Symptoms Questionnaire (MSQ)

Patient Name_____ Date_____

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale

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

HEAD

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia

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 _____

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss

Total _____

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation

Total _____

MOUTH/THROAT

_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores

Total _____

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating

Total _____

HEART

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain

Total _____

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing

Total _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain

Total _____

JOINTS/MUSCLE

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness

Total _____

WEIGHT

_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight

Total _____

ENERGY/ACTIVITY

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness

Total _____

MIND

_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities

Total _____

EMOTIONS

_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression

Total _____

OTHER

_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge

Total _____

Grand Total _____

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL RECORDS

_____ _____
Patient Name (Please Print) Date of Birth

I hereby authorize Patricia Murray, DO to obtain/release records (Please circle one) from/to:

Physician/Other: _____

Address: _____

_____ _____ _____
City/Town State Zip Code

Phone: _____ Fax: _____

_____
Specific Information to be released

I Understand that my medical records could possibly contain information related to the diagnosis or treatment of one of the following conditions:

- Psychological or Psychiatric Problems
- Substance Abuse or Chemical Dependency
- Sexually transmitted disease or HIV infection or testing

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I Authorize release of the requested information to me only so that I may protect any sensitive information that they may contain.

☐ I authorize the release of the requested records directly to the party who requested this information regardless of content.

I've read this release and understand the information contained in this document. I understand that I may revoke this consent at any time except that the action has been taken reference to this request. I can also revoke this consent with proper notification of Patricia Murray, DO at any time this release is valid for this request only.

This Authorization will expire on (date or event) _____ If no date or event is stated, expiration is 60 days from the date this release was signed.

Signature of Patient or Legal Guardian: _____

Witness: _____ Date: _____