Pamela J. Costello, MD, PC
3915 Bristol Hwy. STE 103
Johnson City, TN 37601

PATIENT NAME: **DATE OF VISIT:**
DATE OF BIRTH:

FAMILY/REFERRING MD: **Allergies:**

CURRENT SYMPTOMS:

Symptoms Worsen With: **Symptoms Improve With:**

Bowel Dysfunction: + / – Bladder Dysfunction: + / – Erectile Dysfunction + / -

Date of Symptom Onset:

CURRENT ILLNESS HISTORY:

PAST TREATMENTS TRIED: Chiropractor: + / – Physical Therapy: + / – NSAIDS: + / –
Local Nerve Blocks: + / – Epidural Injections: + / – Braces: + / – IV antibiotics: +/–
Oral antibiotics: +/– Acupuncture: +/– Herbal remedies: +/–

OTHER MEDICAL CONDITIONS:

PRIOR SURGERIES:

RECENT MEDICAL IMAGING:

FAMILY MEDICAL HISTORY: Mother: Father: Siblings: Children:

SOCIAL HISTORY: Tobacco: + / – ETOH Use: + / – Recreational Drug use: + / –

Height: **Weight:** **BMI:** **RH/LH** **Age:** **Marital Status:** S M D W P **Employment:**

CURRENT MEDICATIONS/SUPPLEMENTS:

DOCTOR USE ONLY

BP: **P:** **T:** **Pain Level: /10**

NOTES/RX:

Name:_____ DOB: _____ DOS: _____

Review of Systems

General:

Fever	YES	NO
Weight Loss	YES	NO
Excessive Fatigue	YES	NO
Night Sweats	YES	NO

Head:

Dizziness	YES	NO
Headache	YES	NO
Difficulties with speech	YES	NO

Eyes:

Wears Glasses/Contacts	YES	NO
Date of last Eye Exam:_____		
Cataracts	YES	NO
Glaucoma	YES	NO
Blindness	YES	NO
Blurred/Double Vision	YES	NO

Ears:

Hearing Aids	YES	NO
Hearing Loss	YES	NO
Ear Infections	YES	NO
Ringing in Ears	YES	NO
Drainage from Ears	YES	NO

Nose and Sinus:

Nasal Discharge	YES	NO
Nose Bleeds	YES	NO
Sinus Problems	YES	NO
Inability to Smell	YES	NO

Mouth and Throat:

Hoarseness	YES	NO
Salty Taste back of throat	YES	NO
Mouth Sores	YES	NO
Dentures	YES	NO
Difficulty Swallowing	YES	NO

Neck:

Pain	YES	NO
Limited Motion	YES	NO
Goiter	YES	NO
Lump	YES	NO

Breast:

Breast Pain/Swelling	YES	NO
Nipple Discharge	YES	NO
Breast/Lump removed	YES	NO
Date of last Mammo____ Normal Y/N		

Genitourinary:

Urinary Tract Infections	YES	NO
Painful Urination	YES	NO
Blood in Urine	YES	NO
Incontinence	YES	NO
Retention	YES	NO
Frequent Urination	YES	NO

Musculoskeletal:

Joint Pain	YES	NO
Arthritis	YES	NO
Limited Range of Motion	YES	NO

Circle: Upper Extremity/Lower Extremity

Respiratory:

Asthma	YES	NO
Chronic Cough	YES	NO
Shortness of Breath	YES	NO
Bloody Sputum	YES	NO
Date of last Chest X-Ray_____Normal? Y/N		

Cardiovascular:

Chest Pain or Angina	YES	NO
Irregular Pulse	YES	NO
Heart Murmur	YES	NO
Mitral Valve Prolapse	YES	NO
Date of last EKG_____Normal? Y/N		

Peripheral Vascular:

Varicose Veins	YES	NO
Blood (vein) Clots	YES	NO
Poor Healing	YES	NO

Gastrointestinal:

Indigestion/Reflux	YES	NO
Abdominal Pain	YES	NO
Nausea/Vomiting	YES	NO
Constipation	YES	NO
Diarrhea	YES	NO
Bloody Stools	YES	NO
Hemorrhoids	YES	NO

Neurological:

Blackouts/Fainting Spells	YES	NO
Seizures	YES	NO
Tremors	YES	NO
Paralysis	YES	NO

Hematologic:

Anemia	YES	NO
Bleeding Tendency	YES	NO
Hemophilia	YES	NO
Blood Transfusion		
if yes, when? _____		

Endocrine:

Diabetes	YES	NO
Thyroid Disease	YES	NO
Excessive Thirst	YES	NO
Excessive Urination	YES	NO
Hormone Problems	YES	NO

Psychiatric:

Anxiety	YES	NO
Depression	YES	NO
Other Psychiatric Disorder	YES	NO

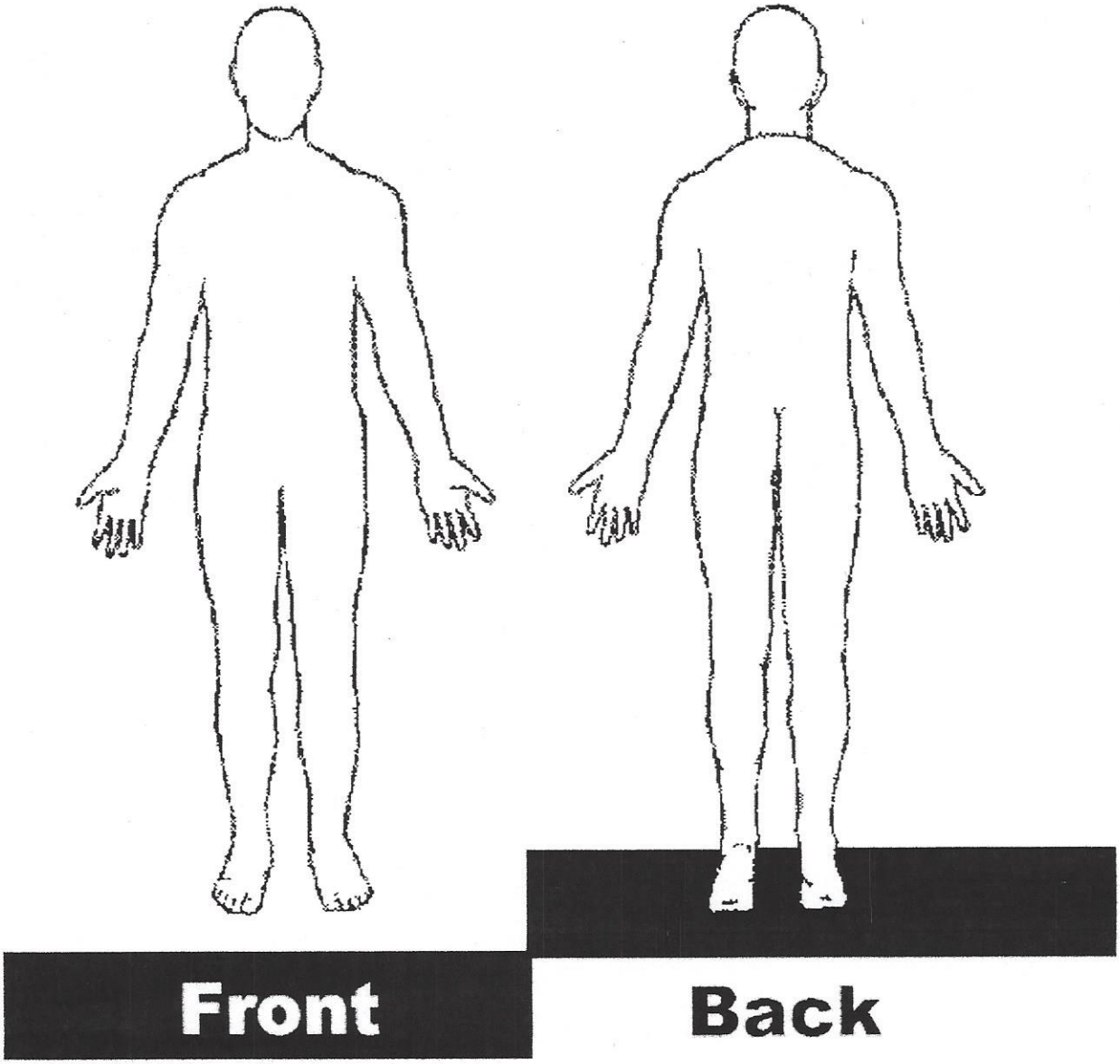
Dental:

Silver Fillings	YES	NO
TMJ	YES	NO
Root Canal	YES	NO

Skin:

Rash	YES	NO	WHERE:_____
Tick/Spider bite	YES	NO	WHEN:_____
Eczema/Dry Skin	YES	NO	WHERE:_____

Name: _____ DOB: _____ DOS: _____



Mark the pain chart with xxx for sharp pain, + + + for numbness and tingling, and /// wherever you feel dull pain.

Sharp Pain: x x x x x x

Numbness and Tingling: + + + + + +

Dull Pain: / / / / /

RASH: .....

Welcome to the Practice of

PAMELA J. COSTELLO, M.D., P.C.

Patient Insurance Information & Release Authorization

(PLEASE PRINT CLEARLY)

Date _____

Patient Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone ( ) _____ Work Phone ( ) _____

Cell Phone ( ) _____

E-mail Address: _____ Pharmacy Phone ( ) _____

Gender: M F Social Security Number: _____

Family Physician: _____ Referring Physician: _____

Address _____ Address _____

Phone Number _____ Phone Number _____

Emergency Contact _____ Phone ( ) _____

Patient Employer _____ Phone ( ) _____

PRIMARY HEALTH INSURANCE

Name _____

ID # _____

Group # _____

Subscriber's Name _____

Subscriber's DOB _____

Relationship _____

SECONDARY HEALTH INSURANCE

Name _____

ID # _____

Group # _____

Subscribers Name _____

Subscriber's DOB _____

Relationship _____

Accident Related Claims WORK AUTO OTHER _____

Date of Accident _____ Where did accident happen? _____

I, the undersigned, hereby grant permission to release my medical information and authorize payment of health insurance benefits to Pamela Costello, MD. I also understand that I am fully responsible for payment of DEDUCTIBLES AND CO-PAYMENT and any other charges that are incurred and not covered by my insurance. MEDICARE PATIENTS: "I request that payment of authorized medical benefits be made either to me or on my behalf to Pamela J. Costello, MD for any services furnished to me by physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits and payment for related services."

SHOULD THIS ACCOUNT GO TO COLLECTIONS FOR NON-PAYMENT, THE PATIENT/GUARANTOR ACCEPTS RESPONSIBILITY FOR ALL COLLECTION FEES.

Signature _____ Date _____

Dr. Pamela Costello MD, PC, Holistic Neurological Medicine
3915 Bristol Hwy. STE 103
Johnson City, TN 37601

I consent to medical evaluation and treatments by Dr. Pamela Costello, MD, PhD and the staff of Dr. Costello. I understand that Dr. Costello may recommend various methods to help me regain my health and she will discuss those methods with me. I understand fully that Dr, Costello may recommend treatments including medications, injections, herbs, homeopathic remedies or intravenous vitamin therapy which may not be fully supported by the FDA, or for which clinical indications have not yet been proved.

I choose to take this treatment with full consent

_____ _____

Signature Date

_____ _____

Witness Date

GENERAL MEDICAL RELEASE

This is a general release for the purpose of treatment, payment and health care operations only. The general release does not allow release of any information other than that identified in this notice. We request that you sign this general release prior to treatment being rendered. If you fail to sign the release, Dr. Pamela J. Costello reserves the right to limit or discontinue treatment. You have the right to limit or rescind the release of all medical information. Dr. Pamela J. Costello is not required to agree to the requested restriction and Dr. Pamela J. Costello retains the right to review your care for further treatment. In all cases, Dr. Pamela J. Costello will retain the right to release your information for payment, treatment and operations rendered prior to the receipt of such restriction.

I _____ give my permission for Dr. Pamela J. Costello to release my health care information as outlined in the privacy notice for the purpose of treatment, payment and health care operation.

Signature _____ Date _____
Patient Signature

Witness_____Date _____

Legal Guardian_____Date_____

Relationship_____

STATEMENT OF FINANCIAL RESPONSIBILITY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Please ask if you have any questions about this or our fees or your responsibility. FULL PAYMENT IS DUE AT TIME OF SERVICE- WE ACCEPT CASH, CHECK AND CREDIT CARDS. Please be sure we have your current insurance information on file- not doing so may result in a denial payment from your insurance. Returned checks will automatically be billed to you along with applicable bank fees. Please note if this occurs, all future visits will have to be paid in cash.

NO SHOW POLICY

I understand if I do not keep two consecutive appointments without calling to cancel or reschedule within 24 hours of my appointment, I will be responsible for a $50.00 fee.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I _____acknowledge that I have received and reviewed the privacy notice of Dr. Pamela J. Costello.

Signature_____ Date_____

Witness_____ Date_____

Legal Guardian_____Date_____

Relationship_____

PAMELA J. COSTELLO, MD
Holistic Neurological Medicine
3915 Bristol Hwy. STE 103, Johnson City, TN 37601
Phone 423-461-0073
Fax 423-461-0076

HIPPA PRIVACY ACT INFORMATION FORM

Please circle below for release of medical information:

Release information only to me: Yes or No
Release information to spouse: Yes or No
Spouse Name: _____

Release records to other: Yes or No
Name: _____ Phone: _____

Would you like for us to leave medical information on your answering machine?

Yes or No

Signature: _____ Date: _____

Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information about you. Please review it carefully.

Dr. Pamela Costello, MD, PhD and staff are committed to protecting the confidentiality of our patient's medical records. Dr. Pamela J. Costello is required by law to provide each patient with notice of our responsibilities and our privacy practices. We are bound by law to abide by the terms of this notice to protect your records.

We may use and disclose your personal health information (PHI) for treatment, payment, and for operational purposes. For example, in the course of treatment, it may be necessary to release a copy of your records to another physician whom you may choose to review your records or treat with. We may disclose your PHI (your name, address, date of birth, social security number, insurance information, the treatment rendered and the reason for that treatment) to your insurance carriers to bill and collect payment for your treatment. It may be necessary to use and disclose your PHI internally as part of the operation of Dr. Costello's practice. An example of this is when we evaluate the quality of your care or to conduct business planning activities for Dr. Costello's practice.

Dr. Pamela J. Costello is permitted by law to release medical information without specific patient consent or authorization in the following circumstances:

>Emergencies
>Identification of deceased, or cause of death
>Public Health Issues (including abuse, neglect or domestic violence)
>Healthcare system oversight
>Judicial and Administrative proceedings
>Requirements under law enforcement
>Requirements for specialized government functions (e.g. Military, National Defense, Security)

Other than the above listed exceptions, Dr. Costello may not release your PHI unless an authorization is provided with your signature. The authorization that you sign will have specifications of necessary PHI to be released, the purpose of the information, and a specific period when the relevant treatment was provided.

If you are treated by Dr. Pamela J. Costello, you have the right to review and to request copies of your PHI, including confidential communications of PHI. To request copies or to review your records, Dr. Pamela J. Costello requires a dated request be submitted in writing. We will respond to your request within 30 days. You will have the opportunity to review your records in the presence of a staff member. Copies will be made available if you wish.

If, in your opinion, there is an error in your records you have the right to request a correction. Please submit your dated request in writing with details of your concern. We will review the request, and a written request will follow within 30 days. We may deny or grant your request for an amendment of your PHI. If your request results in a correction, we will forward copies to all parties who may have received the record in error. You also have the right to request a reporting of non-routine use and disclosure of your PHI. This request may be dated in writing and we will reply in writing within 30 days.

Additionally, you have the right to a copy of this notice and to review our full **Privacy of Medical Records Policy.** If you so request, please contact office at (570)558-2870. Any complaints regarding the use or disclosure of your PHI may be directed to the Secretary of the Department of Health and Humen Services. If you have additional questions regarding this privacy notice please contact our office.

Dr. Pamela J. Costello reserves the right to amend this privacy notice. Amendments will be

promptly provided to our patients as posted in the office. Dr. Pamela J. Costello is required to retain your medical records and your signed privacy notice for a minimum of 6 years.

Attached to this document is a general release for the purpose of treatment, payment and health care operations only. **The general release does not allow release of any information other than that identified in this notice.** We request that you sign this general release prior to treatment being rendered.

If you fail to sign the release, Dr. Pamela J. Costello reserves the right to limit or discontinue treatment. You have the right to limit or rescind the release of all medical information. If you do so, Dr. Pamela J. Costello is not required to agree to the requested restriction and Dr. Pamela J. Costello retains the right to review your care for further treatment. In all cases, Dr. Pamela J. Costello will retain the right to release your information for payment, treatment and operations for services rendered prior to the receipt of such restriction.

Pamela J. Costello MD

Phone consultations

Phone consultations with Dr. Costello for out of state patients may be done over the phone but please note that the patient needs to be seen in the office within 3-6 months of the initial phone consultation. Also, all phone sessions are to be cash pay, paid in advance, as health insurance cannot be billed for these services.

I consent to the above phone consult terms including traveling to Albuquerque, NM within the designated time frame for an in person office visit.

Signature_____ Date_____

Witness_____ Date_____

Legal Guardian_____Date_____

Relationship_____

EMT - FOOD CHART

Circle what you eat *at least* once a month.
Bring back next visit.

**Eat organic as much as possible.*
**Avoid microwaved foods.*

Name _____
Date _____

✓ OK to eat
✗ Avoid

Alkaline Foods ≡ Neutral Foods ::: Acid Foods ■

Animal Protein
beef
chicken
clam
cod
crab
egg white
egg yolk
flounder
haddock
halibut
ham
lamb
liver
lobster
pork
salmon
sardine
shrimp
sole
tuna
turkey

Dairy, Dairy Substitutes
cow's cheese
rice milk
rice milk cheese
cow's milk
cow's yogurt
almond milk
coconut milk
soy milk
soy cheese
soy yogurt

Beans
adzuki
anasaki
black
chickpea
kidney
soy/tofu
lentil
mung
navy
northern
pinto
white

Nuts, Seeds
almond
brazil
cashew
macadamia
peanut
pecan
pine
pistachio
pumpkin
sesame
sunflower
walnut

Fats
avocado
butter
coconut oil
cream
ghee
margarine
olive oil
vegetable oil

Low-Starch Vegetables
arugula
asparagus
broccoli
brussel sprouts
cabbage
cauliflower
celery
chinese cabbage
collard
cucumber
eggplant
endive
escarole
garlic
green beans
kale
kohlrabi
leek
lettuce
lotus root
mushroom
mustard green
okra
parsley
pepper
radish
scallion
sorrel
spinach
sprouts
summer squash
swiss chard
turnip
turnip green
watercress
zucchini

High-Starch Vegetables
artichoke
beet
carrot
chestnut
corn
lima bean
parsnip
pea
potato
pumpkin
winter squash
yam

Grain Products (Starch)
amaranth
barley
buckwheat
millet
quinoa
kamut
kasha
oats
rice *Gluten-free only*
rye
triticale
wheat
spelt

Sugars
barley malt
brown sugar
honey
maple syrup
rice syrup
sucanat
stevia
turbinado
white sugar
white bread

Acid Fruits
grapefruit
kumquat
kiwi
lemon
lime
orange
pineapple
strawberry
tomato

Sub-Acid Fruits
apple
apricot
blackberry
blueberry
cherry
grape
mango
nectarine
papaya
peach
pear
plum
raspberry
tangerine

Sweet Fruits
banana
date
currant
fig
raisin

Melons
cantaloupe
casaba
christmas
honeydew
watermelon

Misc.
fruit preserve
sugar-free jam
vinegar
coffee
tea
alcohol

≡ *Alkaline foods - eat 4 for each 1 acid food*

■ *Acid foods - eat 1 for every 4 alkaline foods*

::: *Neutral foods - remain neutral only when pH is stable*

≡ *Acid foods that convert to alkaline only when pH is stable*