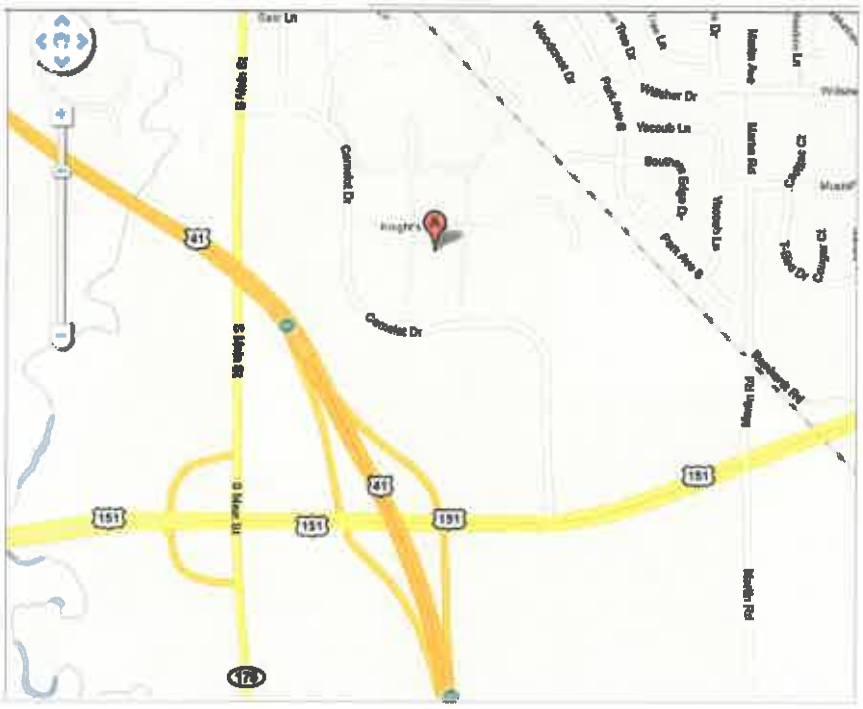
Fox Valley Wellness Center

"An integrated medical approach to complement your lifestyle"

Fox Valley Wellness Center/Midwest Hyperbarics is located at

180 Knights Way
Fond du Lac, WI 54935



For people coming from the north: Take Hwy 41 south to the south side of Fond du Lac. Exit 151 North (also known as the bypass or exit 95). Turn left at the end of the off ramp. Follow 151 North for about ¼ mile and turn left on Camelot Drive. Follow Camelot to Knights Way and turn right. We are located at 180 Knights Way.

For people coming from the east and northeast: Take the 151 bypass around the east and south portions of Fond du Lac to Camelot Drive. Turn right on Camelot Drive. Follow Camelot to Knights Way and turn right. We are located at 180 Knights Way.

For people coming from the south (up Hwy 41): Exit at US 151 North (bypass/ exit 95). Turn right off the exit ramp. Go about ¼ mile and turn on Camelot Drive. Follow Camelot to Knights Way and turn right. We are located at 180 Knights Way.

For people coming from the west: Take Hwy 151 North (going east) connecting with Hwy 41 (southbound). Follow 151 North for about ¼ mile past Hwy 41 and turn left on Camelot Drive. Follow Camelot to Knights Way and turn right. We are located at 180 Knights Way.

WHAT TO EXPECT ON YOUR FIRST VISIT

Your first visit includes several different tests and services. Below is a list of the tests and services that will be provided to you on your first visit. Some services are an additional charge which is listed for your review.

- **Total Body Composition** – Measures total fat, body mass index (BMI), water percentage, lean mass weight and ideal body weight. A height is also measured along with a waist measurement to look at the height/waist ratio.

- **Positional Vital Signs** – Taking blood pressure and pulse while supine and standing can give important information about mineral and water status.

- **Iodine Spot Test** – To evaluate for the bioavailability of iodine which is important for thyroid function.

- **Computer Entry** – All prescription and nutritional supplements will be entered to be filed in your permanent record.

- **Physician Evaluation** – This may take between 60 – 120 minutes as the history, medical records, physical exam and laboratory testing will be evaluated. A treatment plan may be initiated at this step.

- **RN Education and Consultation** – This will include handouts, computer printout of the days visit, possible injections or IV therapy and instructions.

- **Blood Draw** – Any blood drawn at FVWC will have a $42.00 draw fee for all blood drawn each visit.

- **Nutritional Counseling** – A one hour nutritional consultation will be done on every new patient. This is a one-time $75.00 fee that can be done as an individual, family or group. The importance of nutrition in our program is critically important. A follow-up microscopy evaluation to individualize the nutritional status of the patient can be scheduled in follow-up.

PLEASE NOTE: There are additional charges for any other provider services, EKG, IV administration, lab charges, etc.

11/15/18 cw

WELCOME TO FOX VALLEY WELLNESS CENTER / MIDWEST HYPERBARICS

It is our desire to accommodate both you and your medical needs with professional medical services. Your initial appointment with Dr. Meress will begin a medical process to develop an ITP (Individual Treatment Plan) specifically for you. We welcome and encourage our patients to become an integral part of their healthcare at Fox Valley Wellness.

2 WEEKS BEFORE YOUR FIRST APPOINTMENT
We require the following be E-mailed, mailed, or faxed to Fox Valley Wellness Center two weeks prior to your first appointment: **1. Your past 2 years of medical records. These records provide valuable information critical to evaluating you and developing your ITP. Your records may include: doctor's progress notes, laboratory test results, radiological testing results, medical imaging, etc. The records you provide will become part of your ITP medical documentation at Fox Valley Wellness.** **2. Pre-appointment paperwork. This allows us an opportunity to prepare and ready your chart for your initial appointment with Dr. Meress.**

BLOOD TESTS AND RESULTS

During your appointment, Dr. Meress may order blood tests. You may have your blood drawn at our clinic or take the lab orders to a clinic/laboratory of your choice. It is your responsibility to have doctor ordered blood testing done. If you choose to have your blood tests done at a lab other than Fox Valley Wellness, please have the blood drawn at least **8-10** days prior to your scheduled appointment. This allows for test processing time and fax/mail delivery to our office. If you choose to use the services at Fox Valley Wellness be assured we utilize the services of several reputable laboratories that we feel meet the specific needs of your health conditions.

We ask that you not call the office to check the status of your test results. If your results are within normal ranges they will be discussed with you at your next scheduled appointment. If abnormal results are reported, our office will contact you and our nursing staff will discuss Dr. Meress' recommendations.

FOLLOW UP VISITS

Your medical condition and/or tests may require follow-up appointments. We ask that you schedule your appointment before you leave the office. By doing this, you are assured a return visit in the time frame requested by Dr. Meress.

The nurses assist our doctors with scheduled patient appointments. We ask you respect Dr. Meress and our nursing staff's time with scheduled appointments.
Thus, it would be greatly appreciated if you reserve your questions for your scheduled follow-up appointment and not utilize a "walk-in basis" to have your questions answered.

TIMELY ARRIVALS

Your scheduled appointment time as well as other patients scheduled times will be honored by your timely arrival for your appointment. Early arrival allows our staff adequate time to perform in-office procedures. This request provides for a full utilization of your scheduled time with Dr. Meress. Late arrivals may cause your appointment to be cancelled.

TELEPHONE CALLS

The following issues relate to telephone calls frequently received by our office. We ask you follow these recommendations:

- If you have a condition that is life threatening, please dial 911 or go to the nearest emergency room.
- If you have an issue that relates to care provided by your primary care physician, please contact that physician.

PAYMENT POLICY

Fox Valley Wellness Center/Midwest Hyperbarics is a cash-based facility. Payment must be paid in FULL at time of service. Upon request, we will complete and mail a claim form to you which you can use to submit to your insurance company for reimbursement directly to you. FVWC does not offer payment plans. FVWC accepts cash, personal check, Visa, MasterCard & Discover.

LABORATORY AND INTRAVENOUS SCHEDULE

Lab blood draws must be completed **before** 3:00 P.M. to allow adequate processing time and same day shipment to the appropriate lab.

Intravenous therapy appointments are available **after** 9:00 A.M. unless prior arrangements have been made.

Thank you,
Steven G. Meress, M.D.
Staff of Fox Valley Wellness Center/Midwest Hyperbarics

PATIENT RESPONSIBILITY & COMPLIANCE AT FOX VALLEY WELLNESS CENTER/ MIDWEST HYPERBARICS™

STEVEN G. MERESS MD, FACP, ABHIM
DONNA J. ABFALL, ND
BRIAN BORDEN, ND

- Dr. Meress, Dr. Abfall, Dr. Borden and the entire staff at Fox ValleyWellness Center strive to provide you the educational tools to understand your healthcare issues. Help us by being an integral part of your care. Be proactive, read the information we provide and seek out additional resources to foster your ability to understand your illness. Compliance with the following recommendations will maximize your healing response:

- Elimination of all caffeine and stimulants.

- Cessation of all nicotine products.

- Low intensity exercise and activities are encouraged. However, we prefer you refrain from activities that enduce sweating.

- Compliance relative to supplement and dietary recommendations are strongly encouraged.

- You, the patient, are responsible for obtaining your laboratory blood draws at the time your doctor has ordered them. A consequence of non compliance to ordered blood draw times is the absence of blood test results on the day of your appointment. This may influence the intended care plan your doctor would have discussed with you.

- When late blood draw test results are received, a second followup appointment will be scheduled. The doctor will discuss your test results at the appointment. A followup appointment charge may be assessed.

- If urine and saliva samples are needed prior to a doctor visit, you, the patient, are responsible for obtaining your first morning urine at home and fasting per directions until able to provide saliva samples at time of visit. Directions will be mailed.

- Questions relating to prescription medication should be directed to your pharmacy. Refill requests are usually generated from your pharmacy. FVWC will refill prescriptions upon pharmacy fax/telephone requests. Exceptions to this will be antibiotic/pain medications.

- More than five (5) calls between appointments will result in a $50.00 charge.

- In an effort to meet your immediate concerns, we will schedule a telephone consult with your provider if you have multiple/complex questions between scheduled appointments but you will be responsible for our phone consult fee.

- Maximization of proper sleep and nutrition will positively impact your body's ability to heal.

Patient Signature: _____ Date: _____

FOX VALLEY WELLNESS CENTER/MIDWEST HYPERBARICS POLICIES

INITIALS	ITEM #	POLICY
	1	**Emergencies:** FVWC will make every attempt to address your health care needs. In the event of an emergency, please dial 911 or seek medical attention at the nearest Emergency Room.
	2	**Prescription refills:** It is our policy that you should be responsible to know when your medications must be refilled at least one week before you run out. Medications are refilled only at the patient visit or when requested in advance through your pharmacy. We cannot take weekend, after hours or phone call refill requests. Refills cannot be made if the provider has not seen you for an extended period of time.
	3	**Telephone encounters and sick patients:** We do not treat new patients or new illnesses over the telephone. Dr. Meress may elect to treat an existing patient seeking continuing care for an existing straight-forward illness over the phone. Telephone consults are provided for a fee starting at $183. Payment by credit card is due at the time of service.
	4	**Information:** You agree to provide your correct name, current address, cell, work and home telephone numbers, e-mail address, Social Security number (when necessary), up-to-date insurance information and a picture at the time of registration. You are responsible to update FVWC with any changes.
	5	**Financial responsibility:** By your initials and your signature below, you accept financial responsibility for all charges for services rendered to you. If you are a minor, your parent or guardian assumes financial liability.
	6	**Payment methods:** We accept cash, check and most major credit cards.
	7	**Appointments:** Our office will schedule appointments as a common courtesy for patients and in consideration of your time. We require a minimum of 48 business hours (or the Wednesday before a Monday appointment) notice of cancellation for established patients. A fee will be charged for non-cancelled and missed appointments. A pattern of non-cancelled appointments may result in discharge from the practice.
	8	**Form fees:** Our practice charges for additional paperwork outside of the completion of the medical record. The following fees apply: (a) single page forms $25.00; (b) multi-page forms $50.00; (c) FMLA, disability and driver's license forms $104.00. Additional fees may apply at the discretion of the practice.
	9	**Medical records:** The medical chart is the property of FVWC. However, copies of your pertinent medical information are available upon request. FVWC does charge a fee for copies of the records & needs a HIPPA formed signed before records can be sent. ***Records cannot be released without review by the physician with the patient.*** If however, you would like records faxed directly to your physician, there is no charge for this service.

	10	**Accident & Worker's Compensation:** Although our office is happy to treat your medical conditions, if the cause is related to an auto or work accident your will be required to pay full fees at the time of your visit.
	11	**Statement policy:** Our office sends patient statements each month. Payment is due upon receipt. Delay in insurance processing or payment does not release your responsibility for payment.
	12	**Collection and bank fees:** Banks charge us for a check that does not clear or cannot be cashed. You agree to be liable for all charges levied against FVWC by our financial institution. Additionally, FVWC will charge you a fee of $25.00.
	13	**Patient discharge:** FVWC reserves the right to discharge a patient for any reason. Please note that discharges may occur for failure to meet your obligations under this document. In addition, because of quality care conditions, the practice may discharge you for failure to comply with treatment plan(s) as outlined by Dr. Meress Discharge may also result if profanities, inappropriate language or threats are made against FVWC or any members of its staff.
	14	**Payment:** FVWC is a cash-based facility meaning that payment must be made in full at time of service. NO EXCEPTIONS! Upon request, we will complete and mail a claim form to you which you can use to submit to your insurance company for reimbursement. Any payment made by your insurance company would be mailed directly to you. FVWC has chosen to "Opt Out" of Medicare, therefore we do not issue claim forms to patients who have Medicare or governmental insurance.
	15	**Laboratory order charges:** FVWC assumes no responsibility for charges incurred for for ordered laboratory testing. In choosing to have tests run, the patient accepts all financial responsibilities.

I have read and understand all the terms of this policy. My initials and signature below indicate I fully understand each item and agree to all of the above stated terms.

Signature: _____

Printed Name: _____ **Date:** _____

Fox Valley Wellness Center | 180 Knights Way Fond du Lac, WI 54935 | ph: 877-676-LIFE (5433) or 920-922-LIFE (5433)

Patient Demographics 2019

Patient Name: _____ **DOB:** ____/____/_____

Address: _____
Street City State Zip Code

Marital Status: S / M / D **Sex: Male / Female** **Last 4 digits of SS #**_____ **Cell #** _____

Daytime Phone # _____ **Email Address:** _____

Responsible Party for Medical Expenses

____**Parent** ____**Spouse** ____**Self** ***(if self, go to insurance section)*** **Phone #** _____

Parent or Spouse's Name: _____ **DOB:** ___/___/____ **Last 4 digits of SS#**_____

Address: _____ **Employer:** _____

Medical Insurance Company

Primary Insurance: _____ **Group#** _____ **ID#** _____

Subscriber Name: _____ **DOB:** ___/___/____ **Effective Date:** ___/___/____

Secondary Insurance: _____ **Group#** _____ **ID#** _____

Subscriber Name:_____ **DOB:** ___/___/____ **Effective Date:** ___/___/____

Emergency Contact

Name: _____ **Relationship:** _____ **Ph #** _____

Address: _____
Street City State Zip Code

Authorization for Release of Information

Authorization is hereby granted to release to the above named Insurance Company. Such information may be necessary for the completion of my clinic claims. I understand I am financially responsible for charges not covered by insurance and assign any insurance benefits to above said clinic.

Signature: _____ **Date:** _____

Who do we thank for referring you to us today? _____

PRESCRIPTION MEDICATION & SUPPLEMENT DATA SHEET

(Examples are used)

Patient Name: _____ **Date:** _____

Pharmacy Information:

Name: _____

Phone: _____

Location: _____

Allergies (Please list food, drug, environment, etc.): _____

_____

_____

Current Prescription Medications

Name	Strength	Dosing Instructions
Example: Lasix	20mg	Once a day or divided and given twice a day

Current Supplements (*For fish oil supplements, please include EPA/DHA mg)

Name	Strength	Dosing Instructions
Example: Calcium	500mg	One tablet in the morning

Laboratory Information: If you choose to have blood tests drawn outside of Fox Valley Wellness Center please provide the name and telephone number of the lab you use.

Lab Name: _____

Phone: _____

Fox Valley Wellness Center

"An integrated medical approach to compliment your lifestyle"

Name:

Date (Black):

Date (Red):

Date (Green):

Check-list of Current Symptoms: This is not meant to be used as a diagnotstic scheme, but is provided to streamline the office interview. Note the format - complaints referable to the specific organ systems and specific co-infections are clustered to clarify diagnoses and to better display multi-system involvement.

Have you had any of the following in relation to this illness? (CIRCLE " Y " or " N ")					
Tick bite	Y	N	Where in the world (location) were you bitten		
Spotted rash over large area:	Y	N	"EM" rash (discrete circle)	Y	N
Linear red streaks	Y	N	History of steroid use	Y	N
Do you have a family member with Lyme	Y	N	Exposed to domestic/wild animals/fleas/lice/lizards	Y	N
Do you have pets	Y	N	Have your pets had Lyme	Y	N
Musty basement	Y	N	Water damage at your: house, work, environment	Y	N
Have you ever been diagnosed with: Celiac Disease / IBS / Diverticulosis / Diverticulitis / Leaky Gut Syndrome (please circle if any apply)					

	CURRENT SEVERITY					CURRENT FREQUENCY			
SIGN OR SYMPTOM	None	Mild	Moderate	Severe	NA	Never	Occasional	Often	Constant
Persistent swollen glands									
Sore throat									
Fevers									
Sore soles, especially in the A.M.									
Joint pain:									
Fingers, toes									
Ankles, wrist									
Knees, elbows									
Hips, shoulders									
Joint swelling:									
Fingers, toes									
Ankles, wrists									
Knees, elbows									
Hips, shoulders									
Unexplained back pain									
Stiffness of joints or back									
Muscle pain or cramps									
Obvious muscle weakness									
Twitching of face/muscles									
Confusions, difficulty thinking									
Difficulty w/concentration, reading, problem absorbing information									
Word search, name block									
Forgetfulness, poor short-term memory, poor attention									
Disorientation: getting lost, going to wrong places									
Use wrong words, misspeak									
Mood swings, irritability, depression									
Anxiety, panic attacks									
Psychosis: hallucinations, delusions, paranoia, bipolar									
Tremors									
Seizures									

	CURRENT SEVERITY					CURRENT FREQUENCY			
SIGN OR SYMPTOM	None	Mild	Moderate	Severe	NA	Never	Occasional	Often	Constant
Headaches									
Neck pain, stiffness, creaks or cracks									
Tingling, numbness, burning, stabbing or shooting pains, skin hypersensitivity									
Rash, new stretch marks									
Light sensitivity									
Vision: double, blurry, floaters									
Sound sensitivity									
Hearing: buzzing, ringing, decreased hearing									
Motion sickness, vertigo, spinning									
Off balance, "tippy" feeling									
Lightheadedness, wooziness									
Unavoidable need to sit or lie down									
Facial paralysis-Bell's palsy									
Dental pain									
Chronic cough									
Fatigue, tired, poor stamina									
Insomnia, fractioned sleep, early awakening									
Excessive night time sleep									
Napping during the day									
Unexplained weight gain									
Unexplained weight loss									
Unexplained hair loss									
Pain in genital area									
Menstrual irregularity									
Loss of libido									
Unexplained milk production									
Breast pain									
Irritable or dysfunctional bladder									
Erectile dysfunction									
Queasy stomach or nausea									
Heartburn, stomach pain									
Constipation and/or diarrhea									
Ear Pain									
Abdominal pain, cramps									
Abdominal bloating after eating or taking Probiotics									
Heart murmur or valve prolapse									
Heart palpitations or skips									
Heart block on EKG									
Chest wall pain or ribs sore									
Head congestion									
Night sweats									
Exaggerated/worse hangover from alcohol									
Symptoms flare every 4wks									
Degree of disability									

YEAST QUESTIONNAIRE

ADULT

NAME: _____

In Section A, circle the score for each YES answer. For Sections B and C score as indicated. Record total scores at the end of the questions. Add the totals to get your **GRAND TOTAL.**

SECTION A – HISTORY

1. Have you taken tetracyclines (Sumycin, Panmycin, Vebramycin Minocin, etc.) or other antibiotics for acne for one month or longer? 35
2. Have you ever taken other "broad spectrum" antibiotics for urinary, respiratory or other infections for two months or longer or in shorter courses four or more times in a one year period? 35
3. Have you ever taken a "broad spectrum" antibiotic drug? 6
4. Have you ever been bothered by persistent prostatitis, vaginitis or other productive organ problems? 25
5. Have you been pregnant: two or more times? 5
   one time? 3
6. Have you taken birth control pills for more than two years? 15
   For six months to two years? 8
7. Have you taken prednisone, Decadron or other cortisone-type drugs for more than two weeks? 15
   for two weeks or less? 6
8. Does exposure to perfumes, insecticides, fabric shop odors and other chemicals provoke:
   Moderate to severe symptoms 20
   Mild symptoms 5
9. Are symptoms worse on damp, muggy day or in moldy places ? 20
10. Have you had athlete's foot, ring worm, "jock itch" or other chronic fungus infections of the skin or nails?
    Severe or persistent 20
    Mild to moderate 10
11. Do you crave sugar? 10
12. Do you crave breads? 10
13. Do you crave alcoholic beverages? 10
14. Does tobacco smoke really bother you? 10

SECTION B – MAJOR SYMPTOMS

Enter the appropriate score each symptom below

If a symptom is occasional or mild	Score 3 points
If a symptom is frequent or moderately severe	Score 6 points
If a symptom is severe or disabling	Score 9 points

1. Fatigue or lethargy ..... _____
2. Feeling of being "drained" ..... _____
3. Poor memory ..... _____
4. Feeling "spacey" or "unreal" ..... _____
5. Depression ..... _____
6. Numbness, burning or tingling ..... _____
7. Muscle aches ..... _____
8. Muscle weakness or paralysis ..... _____
9. Joint pain ..... _____
10. Abdominal pain ..... _____
11. Constipation ..... _____
12. Diarrhea ..... _____
13. Bloating ..... _____
14. Troublesome vaginal discharge ..... _____
15. Persistent vaginal burning or itching ..... _____
16. Prostatitis ..... _____
17. Impotence ..... _____
18. Loss of sexual desire ..... _____
19. Endometriosis ..... _____
20. Cramps and/or other menstrual irregularities ..... _____
21. Premenstrual tension ..... _____
23. Erratic vision .....

SECTION C – OTHER SYMPTOMS

Enter the appropriate score for each symptom below

If a symptom is occasional or mild	Score 1 point
If a symptom is frequent or moderately severe	Score 2 points
If a symptom is severe or disabling	Score 3 points

1. Drowsiness ..... _____
2. Irritability or jitteriness ..... _____
3. Incoordination ..... _____
4. Inability to concentrate ..... _____
5. Frequent mood swing ..... _____
6. Headache ..... _____
7. Dizziness/loss of balance ..... _____
8. Pressure above ears, feeling of head tingling ..... _____
9. Itching ..... _____
10. Other rashes ..... _____
11. Heartburn ..... _____
12. Indigestion ..... _____
13. Belching and intestinal gas ..... _____
14. Mucus in stools ..... _____
15. Hemorroids ..... _____
16. Dry Mouth ..... _____
17. Rash or blisters in mouth ..... _____
18. Bad breath ..... _____
19. Joint swelling or arthritis ..... _____
20. Nasal congestion or discharge ..... _____
21. Postnasal drip ..... _____
22. Nasal itching ..... _____
23. Sore or dry throat ..... _____
24. Cough ..... _____
25. Pain or tightness in chest ..... _____
26. Wheezing or shortness of breath ..... _____
27. Urgency or urinary frequency ..... _____
28. Burning on urination ..... _____
29. Failing vision ..... _____
30. Burning or tearing of eyes ..... _____
31. Recurrent infections or fluid in ears ..... _____
32. Ear pain or deafness ..... _____

Scores: Section A_____ Section B_____ Section C_____

The **GRAND TOTAL SCORE** will help determine if your health problems are yeast connected. Scores in women will run higher because more questions apply to women than to men.

Yeast connected health problems are almost **CERTAINLY PRESENT** in women with scores over 180 and men with scores over 140.

Yeast connect with health problems are almost **PROBABLY PRESENT** in women with scores over120 and in men with scores over 90.

Yeast connected health problems are almost **POSSIBLY PRESENT** in women

SYMPTOM QUESTIONNAIRE

Name: _____ Date: _____

If you have amalgam fillings please check how often you have encountered the symptoms below that could possibly signify mercury toxicity. Rate them accordingly to the following scale:

0 = Never **1 = Rarely** **2 = Often** **3 = Always**

Central Nervous System

____ Irritability
____ Anxiety/nervousness
____ Restlessness
____ Exaggerated response to stimulation
____ Fearfulness
____ Emotional instability
____ Lack of self-control
____ Mood swings
____ Fits of anger
____ Violent behavior
____ Loss of self-confidence
____ Indecision
____ Shyness/timidity
____ Easily embarrassed
____ Memory loss
____ Insomnia
____ Depression/despondency
____ Manic depression
____ Withdrawal
____ Suicidial thoughts/tendencies
____ Numbness/tingling of: hands/feet/fingers/toes
____ Muscle weakness
____ Tremors/trembling in hands
____ Headaches
____ Confusion
____ Poor physical coordination
____ Slurred speech

Digestive Tract

____ Nausea or vomiting
____ Colitis
____ Bloating
____ Heartburn
____ Constipation
____ Blood in stool
____ Crohn's Disease
____ Diarrhea
____ Abdominal pain
____ Belching, passing gas
____ Poor appetite
____ Food sensitivities
____ Food cravings
____ Binge eating/drinking
____ Compulsive eating
____ Excessive weight gain
____ Weight loss

Head, Neck, Oral Cavity

____ Bleeding gums
____ Loosening of teeth
____ Excessive salivation
____ Foul breath
____ Metallic taste
____ Burning sensation lip/tongue
____ Canker sores
____ Gagging
____ Frequent clearing of throat

LIFESTYLE HISTORY

NAME _____ **DATE** _____

DIET (List specific foods)

1. Breakfast _____ Time _____
2. A.M. Snack _____ Time _____
3. Lunch _____ Time _____
4. P.M. Snack _____ Time _____
5. Dinner _____ Time _____
6. Late Snack _____ Time _____
7. Other _____ Time _____

Do you or have you eaten diet foods or drank diet soda on a regular basis? Y N

What is your largest meal? _____

How many B.M.'s per day? _____

Have you ever had a Colonoscopy? Y N If yes, when? _____

SLEEP

1. What time do you go to bed? _____
2. How long to fall asleep? _____
3. Do you wake up during the night? Y N If yes, how many times? _____
4. Do you dream? Y N
5. What time do you wake up? _____ Do you feel refreshed? Y N

FEMALES ONLY

1. Menarche age (age of your first period) _____
2. Menopause age _____
3. Days between periods _____ Days of flow _____
4. Symptoms associated (cramping, PMS, etc.) _____
   Severity (0-10) _____
5. How many pregnancies? _____ Live births? _____
6. Have you ever taken birth control pills? Y N If yes, when & how long? _____
7. When was you last pap smear? _____ Last mammogram? _____

EXERCISE

1. What type of exercise do you do? _____
2. How many times per week on average? _____
3. What length of time per episode? _____
4. Have you ever had a bone density (DEXA) test? Y N If yes when? _____

VACCINATIONS (Please list all vaccinations you have had in your lifetime and when):

_____

_____

_____

MEDICAL HISTORY FORM

NAME _____ **AGE** _____ **DATE** _____

A. List past or present illnesses, injuries, surgeries, hospitalizations:

Condition	Date	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

B. List any physical limitations:

_____

C. List allergies (i.e. hay fever, bee sting, foods, medications, molds, dust, animals, latex, etc.):

_____

D. Family History (i.e. premature sudden death, heart attack, stroke, diabetes, cancer, asthma, etc.):

Relation to You	Condition
_____	_____

E. Have you had any metal devices placed in your body (i.e. dental amalgams or restorations, prosthetic joints, IUD's, vascular stents) or have you ever reacted to any metal? Y N (If yes, please explain):

_____

F. Do you or have you used any of the following: (If yes, please include amount and how many years).

Cigarettes	Y	N	_____
Alcohol	Y	N	_____
Caffeine	Y	N	_____

G. Marital Status _____ Children _____ Occupation _____ Frequent travel Y N

H. Do you have, or have you ever sought medical care for any of the following:

Mental Health	No	Yes	Explain
Depression	___	___	_____
Insomnia	___	___	_____
Fatigability	___	___	_____
Eating disorders	___	___	_____
Other	___	___	_____
Head & Neck	**No**	**Yes**	**Explain**
Frequent headaches	___	___	_____
Chronic sinus	___	___	_____
Glasses/Contacts	___	___	_____
Hearing difficulty	___	___	_____
Sores of the mouth	___	___	_____
Root canal	___	___	_____
Other _____	___	___	_____

Lungs/Breathing	No	Yes	Explain
Wheezing	___	___	_____
Shortness of breath	___	___	_____
Chronic cough	___	___	_____
Asthma	___	___	_____
Heart & Circulation			
Chest pains	___	___	_____
Irregular heart beats	___	___	_____
Leg/feet swelling	___	___	_____
High blood pressure	___	___	_____
Exertional	___	___	_____
Heart murmur	___	___	_____
Digestive			
Recent weight changes	___	___	_____
Diarrhea/Constipation	___	___	_____
Nausea/Vomiting	___	___	_____
Jaundice (yellow skin or eyes)	___	___	_____
Kidney/Bladder Reproductive			
Abnormally colored urine	___	___	_____
Kidney disease	___	___	_____
Frequent urine infections	___	___	_____
Severe menstrual cramps	___	___	_____
Cancer			
Precancerous condition	___	___	_____
Cancer	___	___	_____
Hematological			
Blood Transfusions	___	___	_____
HIV, Hepatitis	___	___	_____
Bone/Joint/Muscle			
Hernia	___	___	_____
Carpal Tunnel Syndrome	___	___	_____
Joint pain/arthritis	___	___	_____
Strain/sprain	___	___	_____
Skin			
Rashes	___	___	_____
Other skin problems	___	___	_____
Neurologic			
Seizures	___	___	_____
Tremors	___	___	_____
Loss of consciousness	___	___	_____
Endocrine			
Diabetes	___	___	_____
Thyroid problems	___	___	_____
Unexplained weight changes	___	___	_____
Other glandular problems	___	___	_____

Patient Signature _____ Date _____

FOX VALLEY WELLNESS CENTER / MIDWEST HYPERBARICS
180 KNIGHTS WAY
FOND DU LAC, WI 54935

REQUIRED DISCLOSURE AND CONSENT FOR DIAGNOSIS AND TREATMENT OF PERSISTENT LYME DISEASE

There is considerable uncertainty regarding the diagnosis and treatment of Lyme disease. No single diagnostic and treatment program for Lyme disease is universally successful or accepted. Current testing for Lyme disease can be problematic and may lead to false results. If you are tested for Lyme disease and the results are positive, this does not necessarily mean that you have contracted Lyme disease. In the alternative, if the results are negative, this does not necessarily mean that you have not contracted Lyme disease. If you continue to experience symptoms or have other health concerns, you should contact your health care provider and inquire about the appropriate of additional testing or treatment.

Medical opinion is divided, and two schools of thought regarding diagnosis and treatment exist. Each of the two schools of thought is described in peer-reviewed, evidence-based treatment guidelines. Until we know more, patients must weigh the risks and benefits of treatment in consultation with their doctor.

My Diagnosis. The diagnosis of Lyme disease is primarily a clinical determination made by my doctor based on my exposure to ticks, my report of symptoms, and my doctor's observation of signs of the disease, with diagnostic tests playing a supportive role.

Doctors differ in how they diagnose Lyme disease.

- Some physicians rely on the surveillance case criteria of the CDC for clinical diagnosis. These physicians may fail to diagnose some patients who actually have Lyme disease. For these patients, treatment will either not occur or will be delayed.

- Other physicians use broader clinical criteria for diagnosing Lyme disease. These physicians believe it is better to err on the side of treatment because of the serious consequences of failing to treat active Lyme disease. These physicians sometimes use the antibiotic responsiveness of a patient to assist in their diagnosis. Since no treatment is risk-free, use of broader clinical criteria to diagnose disease could in some cases expose patients to increased treatment complications. This approach may result in a tendency to over diagnose and over treat Lyme disease.

My Treatment Choices. The medical community is divided regarding the best approach for treating persistent Lyme disease. (1) Many physicians follow the treatment guidelines of the Infectious Diseases Society of America (IDSA) that recommend short-term treatment only and view the long-term effects of Lyme disease as an autoimmune process or permanent damage that is unaffected by antibiotics. (2) Other physicians believe that the infection persists, is often associated with other tick-borne co-infections, is difficult to eradicate, and therefore requires long-term treatment with intravenous, intramuscular, or oral antibiotics, frequently in high and/or combination or pulsed dosing. These physicians follow the guidelines promulgated by the International Lyme and Associated Diseases Society (ILADS), which recognize that commercial diagnostic tests may be insensitive and that diagnosis and treatment must be based on the physician's clinical judgment and that the risk/benefit of any treatment must be individualized.

Potential Benefits of Treatment. Some clinical studies support longer term treatment approaches, while others do not. The experience in this office is that although most patients improve with continued treatment, some do not.

Risks of Treatment. There are potential risks involved in using any treatment, just as there are in foregoing treatment entirely. Some of the problems with antibiotics may include (a) allergic reactions, which may manifest as rashes, swelling, and difficulty with breathing, (b) stomach or bowel upset, or (c) yeast infections. Long term antibiotic treatment can have serious, irrevocable consequences. Severe allergic reactions may require emergency treatments, while other problems may require suspension of treatment, or adjustment of medication. Other problems such as adverse effects on liver, kidneys, gallbladder, or other organs may occur.

Factors to Consider in my Decision. No one knows the optimal treatment of symptoms that persist after a patient is diagnosed with Lyme disease and treated with a simple short course of antibiotic therapy. The appropriate treatment may be supportive therapy without the administration of any additional antibiotics. Or, the appropriate treatment might be additional antibiotic therapy. If additional antibiotic therapy is warranted, no one knows for certain exactly how long to give the additional therapy. By taking antibiotics for longer periods of time, I place myself at greater risk of developing side effects. By stopping antibiotic treatment, I place myself at greater risk that a potentially serious infection will progress. Antibiotics are the only form of treatment shown to be effective for Lyme disease, but not all patients respond to antibiotic therapy and antibiotic therapy has the risks discussed above. There is no currently available diagnostic test that can demonstrate the eradication of the Lyme bacteria from my body. Other forms of treatment designed to strengthen my immune system also may be important. Some forms of treatment are only intended to make me more comfortable by relieving my symptoms and do not address any underlying infection.

My decision about continued treatment may depend on a number of factors and the importance of these factors to me. Some of these factors include (a) the severity of my illness and degree to which it impairs my quality of life, (b) whether I have co-infections, which can complicate treatment, (c) my ability to tolerate antibiotic treatment and the risk of major and minor side effects associated with the treatment, (d) whether I have been responsive to antibiotics in the past, (e) whether I relapse or my illness progresses when I stop taking antibiotics, and (f) my willingness to accept the risk that, left untreated, a bacterial infection potentially may get worse.

For example, if my illness is severe, significantly affects the quality of my life, and I have been responsive to antibiotic treatment in the past, I may wish to continue my treatment. However, if I am not responsive to antibiotics, I may wish to terminate treatment. I will ask my doctor if I need any more information to make this decision and am aware that I have the right to obtain a second opinion at any time if I think this would be helpful.

My doctor has made no written or verbal agreement with me and has made no promise or warranties outside of those outlined in this consent document and has not pressured me as regards my decision. I make this decision as regards my treatment for Lyme disease of my own free will. All of my questions have been answered and I fully understand the decision I must make and the significance of my decision to my health care. _____ Initial

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I am over the age _____ (age of consent in my state) and I realize that the choice of treatment approach to use in treating my condition is mine to make in consultation with my physician. After weighing the risks and benefits of the two treatment approaches, I have decided: (CHECK ONE)

☐ To treat my Lyme disease through a treatment approach that relies heavily on clinical judgment and may use antibiotics until my clinical symptoms resolve. I recognize that this treatment approach does not conform to IDSA guidelines and that insurance companies may not cover the cost of some or all of my treatment.

☐ Only to treat my Lyme disease with antibiotics for thirty days, even if I still have symptoms.

☐ Not to pursue antibiotic therapy.

I understand the benefits and risks of the proposed course of treatment, and of the alternatives to it, including the risks and benefits of foregoing treatment altogether. My questions have all been answered in terms I understand. All blanks on this document have been filled in as of the time of my signature.

Signature: _____ **Date:** _____

Print Name: _____ **Witness:** _____

Revised January 2016

FOX VALLEY WELLNESS CENTER/MIDWEST HYPERBARICS
180 KNIGHTS WAY, FOND DU LAC, WI 54935

FAX: 920-273-0480
PHONE: 920-922-5433

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name _____ DOB _____

Address _____ Phone (____)_____

Organization Authorized To *Disclose* Patient's Health Information

Fox Valley Wellness Center
Name of Health Care Provider/Other

180 Knights Way
Street Address

Fond du Lac, WI 54935
City / State / Zip Code

Organization or Individual Authorized To *Receive* Patient's Health Information

_____
Name of Person / Organization / Facility

_____
Street Address

_____
City / State / Zip Code

Fax Number _____

HEALTH INFORMATION TO BE DISCLOSED _____

_____

PURPOSE FOR NEED OF DISCLOSURE (Check applicable information)

__ Further medical care __ Legal Investigations __ At the risk of the individual
__ Insurance eligibility/benefits __ Other _____

Your rights with respect to this authorization are set forth on the back of this authorization form.

EXPIRATION DATE: This authorization is good until the following date/event _____
If there is no date or event specified, this authorization will expire one (1) year from the date signed.

PROHIBITION OF RE-DISCLOSURE: This information is protected by Federal and Wisconsin Confidentiality laws. Such laws prohibit making any further disclosure of this information unless further Disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise Permitted by such laws. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules (42C.F.R. Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I have had an opportunity to review and understand the content of this Authorization. By signing this Authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF PATIENT/LEGAL REP._____ **DATE** _____

Relationship or authority to act for the patient_____
(If you are signing as a parent of a minor patient listed above, you are declaring that you have not been denied physical placement of the child because such a placement would endanger the child's physical, mental, or emotional health.

WITNESS (when applicable) _____ Date _____

For office use only: Records picked up by_____ Date_____ Time_____ Initials____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION INSTRUCTION SHEET

This authorization is not valid if one or more required elements are omitted.
Failure to complete this Authorization in its entirety will result in the denial of your request for us to disclose your/the patient's health information.

PATIENT INFORMATION: Fill in the complete name, address, date of birth and telephone number of the individual whose health information you are requesting to be disclosed.

PERSONS/ORGANIZATIONS AUTHORIZED TO DISCLOSE PATIENT'S HEALTH INFORMATION:
Fill in the name of the person or organization and their address.

PERSONS/ORGANIZATIONS AUTHORIZED TO RECEIVE PATIENT'S HEALTH INFORMATION:
Fill in the name of the person or organization and their address.

HEALTH INFORMATION TO BE DISCLOSED: You are not obligated to authorize a disclosure of your/the patient's health information. You may authorize disclosure of as much or as little of your/the patient's health information as you wish.

PURPOSE FOR NEED OF DISCLOSURE: Check applicable category or provide other reason if not listed.

EXPIRATION DATE: This Authorization will be good for one (1) year unless otherwise specified. A valid authorization must be signed and dated after the date of service or event has taken place.

SIGNATURE AND DATE: It is your responsibility to review and understand this Authorization. If you have any further questions about this Authorization, please contact Medical Records Department.

WITNESS (when applicable): When patient is physically unable to sign his/her entire signature.

You are required to sign and date this Authorization.

If you request health information that has been created after the date of this Authorization, you will be required to complete another Authorization.

If you are a parent and have been denied physical placement of your child because it would endanger the child's physical, mental or emotional health, the law denies you access to obtain the child's health information.

A legal representative is a person authorized to obtain the patient's health information. This may include the parent, guardian or legal custodian of a minor patient, the guardian of a patient adjudged incompetent, the personal representative or spouse of a deceased patient or any person who would be authorized in writing by the patient. Proof of such authority is required.

If no spouse survives a deceased patient, an adult member of the deceased patient's immediate family may qualify.

A court appointed temporary guardian to consent to the release of health information may also qualify. Proof of such guardianship is required.

Power of Attorney for Health Care takes effect upon finding that the patient is incapacitated. Two (2) physicians or one (1) physician and one (1) psychologist, who personally examine that patient and sign a statement that the patient is incapacitated, make this determination. Proof of such Power of Attorney for Health Care is required.