HOLISTIC MEDICAL SERVICES, INC.
FRANK P. MATALONE, D.O., N.M.D.
3833 Roswell Road · Suite 116 · Atlanta, Georgia 30342 · Phone: 404-941-8621 · Fax: 404-549-3005

WELCOME

Thank you for choosing Holistic Medical Services (HMS) to meet your medical needs. Our staff is committed to providing you with the best possible professional and compassionate care.

For new patients we typically spend time on your first appointment getting to know you, reviewing your history and medical records, and performing a physical exam. In order to formulate the most favorable treatment plan, it is important that all history and pertinent information be available during the visit.** This provides the tools for me to build an in-depth understanding of your specific medical concerns based on the information you share with us during your visit, tailoring a laboratory testing panel and treatment plan unique to you.

****It is imperative that you fill out all new patient paperwork before coming to your appointment; otherwise, we may need to reschedule. The history form is quite exhaustive, and it is essential that it be available for review prior to your scheduled time with the doctor. Please plan ahead to spend at minimum one hour filling out this paperwork prior to your arrival at HIM.**

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HMS PRACTICE PROTOCOL and POLICIES

Office hours are Monday through Thursday, 9:00-5:00

Scheduling

Initial appointments and testing at HMS may take several hours. We attempt to coordinate comprehensive medical assessments and testing needs in advance of your initial visit to the extent possible. If you are asked to arrive fasting for tests, drink only water during your fast to help assure you are well hydrated to help make your blood draw easier. Bring a snack to eat when your tests are completed.

Insurance

HMS is an out-of-network provider and does not work with or accept private health insurance or Medicare of any kind. You can check "Out-of-Network" benefits by calling your insurance company. HMS provides all patients with itemized walkout statements that include diagnostic and procedure codes for patients to file the received services with their private health insurer. These are given at checkout.

Legal Representation

HMS is not able to treat patients requiring medical representation in any legal cases as this process interferes with our ability to provide optimal medical care. If you will require a physician's help in legal matters, we can provide you with resources for alternate doctors to help you.

Deposits for New Patients

Because initial office visits are lengthy, and many HMS patients may live out of state or long distances from the clinic, we are often unable to re-schedule missed appointments on short notice. As such, we require a credit card number upon scheduling to hold a $150.00 deposit for your first appointment.

Appointment Cancellations

Twenty-four hours advance notice of cancellation is required to avoid the cancellation fee. HMS's business days are Monday through Thursday. HMS charges a $50.00 fee to established patients who decide to cancel the day of an appointment or do not show up to a scheduled office visit.

Emergencies

HMS physicians do not provide primary care services and do not provide services outside of regularly scheduled office hours. HMS patients are expected to maintain access to their primary care physician for after-hours care. Patients are seen by appointment only; we are unable to see walk-ins. For medical emergencies, we advise you to go to your local urgent care center or emergency room or call 911.

Return Policy

Unopened nutritional supplements with an intact factory seal can be returned within 60 days of purchase for a full refund, after that we will not refund supplements. Special order supplements cannot be returned or refunded. Unused and intact lab kits can be returned within 60 days of purchase for a full refund, minus a $25 restocking fee. Lab kits returned between 61 days and 4 months after the date of purchase will be refunded at 50 percent of cost. Lab kits returned more than 4 months from the date of purchase are not eligible for a refund.

Cell Phones

As many of our patients have extreme sensitivities, we request that cell phones be turned off during doctor appointments. Please be courteous and discreet and keep calls short if you use your cell phone in the clinic.

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Fees and Payment Options
All payment is due at the time of services rendered. Please note that all payments for services rendered, with the inclusion of ordered labs, are final. We accept cash, personal checks, all major credit cards, and CareCredit.

Returned Checks
A $30 fee will be charged per check returned due to insufficient funds.

Appointments for IV Services
Appointments are required to receive IV drips. Patients walking in without appointments will receive services after scheduled patients have their IVs started.

Fees for Unused IV Bottles
IVs at HMS are mixed individually the morning of the appointment. Once the IV is prepared, it is usable on that day only. Patients who cancel the appointment after the IV has been mixed must pay the full amount.

Weather and Travel Considerations
We ask that all patients try to arrive 10 minutes prior to their scheduled appointments. All things considered, please remember that we are located in Buckhead and that on certain days or times traffic may interfere with the amount of time it takes to arrive. As such, please take that into consideration when driving to our location.

Phone Calls and Emails
Questions in between office visits are most efficiently communicated to HMS staff by e-mail or telephone. Keeping questions brief and to the point helps us help you. Complicated, lengthy, or urgent matters are not appropriate for e-mails or phone calls. Complex health issues require an office visit. Questions will be addressed while respecting the need of scheduled patients to have office visits free of interruptions. There may be a fee at the physician's discretion for lengthy or involved calls or e-mails or for letters that require physician or staff time.

Fragrances/Smoking
Because some of our staff and patients have unpleasant or even serious reactions to the chemicals in perfumes and other fragrances, we ask that you and those who accompany you on your visit to HMS avoid using fragrances and products that contain them. HMS is a smoke-free, tobacco-free facility.

All policies are subject to change without advance notification. Please contact our office staff if you have questions regarding HMS policies.

For established clients, phone consults can occasionally be offered in lieu of office visits at the physician's discretion, usually if distance from our office is a concern. Our approach to wellness often involves intensive intervention at the start of treatment, and you may not receive all the benefits of your individual treatment plan if you cannot be available for in-office visits. At minimum, prepare to be seen at least twice a year for follow-up after this first 3-6 month period. You must make a physical visit in the office annually in order to continue medical care.

Congratulations on your commitment to better health! We look forward to serving you.

MEDICAL HISTORY FORM
(Complete PRIOR to coming to Center)

Patient's Name: _____ **Birthdate:** ___/___/___

Referred By: _____ **First Appointment:** ___/___/___

CURRENT HEALTH CONCERNS: Please list your chief health compliant(s) in order of importance:

_____

_____

What are you hoping to gain from your HIM consultation?

_____

_____

ANCESTRY OF PATIENT'S PARENTS: (example: Scotch-Irish or French-English-American Indian)
Father: _____ Mother: _____

FAMILY HEALTH HISTORY: Complete and put a check ☑ in the boxes for diseases that apply for each family member.

			Brothers				Sisters					Children			
	Father	Mother	1	2	3	4	1	2	3	4	Spouse	1	2	3	4
Age (if living)															
Age (at death)															
Cause of death															
Cancer															
Tuberculosis															
Diabetes															
Heart trouble															
High blood pressure															
Stroke															
Asthma															
Anemia or disease of blood															
Nervous breakdown															
Genetic disease															
Alcoholism/Drug addiction															
Mental Illness															
Depression/Anxiety															
Kidney disease															
Other															

List your grandparents' relevant health history and age if living (or age at time of death and cause of death):

_____

_____

_____

----------PERSONAL Health Information from This Point Forward----------

Allergies: Check those that apply

☐ **Sulfa Drugs** ☐ **Penicillin** ☐ **Aspirin** ☐ **Codeine** ☐ **Iodine** ☐ **Novocain/Local Anesthetics**
☐ **Other Antibiotics:** _____ ☐ **Other Drugs:** _____

_____ _____

Recent Healthcare

List any other physicians who have treated you in the last five years and the health problem for which you were treated.
(Do not include colds and uncomplicated influenza)

Year	Physician Name/City	Specialty	Health Problem

Major Hospitalizations / Surgeries / Accidents

Write in any hospitalizations you have had for serious medical illnesses, accidents, or surgeries below.
(Do not include uncomplicated childbirth; use additional page if necessary)

Year/Your age	Operation/Illness	Results/Benefits/Complications

Have you…or Do you…

Yes	No	
☐	☐	Have adult children living at home?
☐	☐	Care for an elderly or dependent parent/family member?
☐	☐	Have a difficult primary spouse/partner relationship? Length of relationship: _____ years
☐	☐	Work with or use a computer daily? _____ hours/day
☐	☐	Fly on passenger airlines? Flights/year _____ List foreign travel/residences: _____ _____
☐	☐	Drink milk regularly as a beverage?
☐	☐	Salt your food at the table?
☐	☐	Eat deep fried or fried foods?
☐	☐	Eat a diet that is vegetarian or vegan? (circle)
☐	☐	Eat organic foods? _____% of diet
☐	☐	Eat processed foods: artificial flavor, color, or preserved?
☐	☐	Eat compulsively or have food addictions?
☐	☐	Eat based on your emotions?
☐	☐	Repeatedly cycle through weight loss and gain?
☐	☐	Eat fast food? _____ times per week
☐	☐	Drink coffee? _____ cups/day regular or decaf (circle) use: __creamer, __sugar, __milk, __half and half
☐	☐	Drink tea: herbal / black / green (circle) w/sugar? ___ decaf or caffeinated (circle) ___ cups/day
☐	☐	Eat out? If so, _____ times/week; _____% of meals

Yes	No	
☐	☐	Eat luncheon meats, bologna, bacon, cold cuts, etc.?
☐	☐	Have a sweet tooth?
☐	☐	Have a sedentary lifestyle? Preferred exercise? _____
☐	☐	Eat desserts with meals _____ x per week
☐	☐	Drink sodas? If so, what kind? 12 oz cans/week? _____ Preferred kind? _____ _____
☐	☐	Drink high-caffeine designer drinks?
☐	☐	Depend on recreational drugs? _____
☐	☐	Depend on prescription drugs? _____
☐	☐	Smoke or use tobacco products? Cigarettes _____ packs per week Cigars _____ per week Pipe _____ bowls per week Chewing tobacco _____ tins/week
☐	☐	Quit tobacco use? If so, last used _____
☐	☐	Drink Alcohol? _____ Glasses of wine per week _____ Beers per week _____ Mixed drinks per week Preferred alcoholic beverage(s) _____
☐	☐	Quit drinking alcohol: Date of last drink _____

EARLY YEARS (ALL PATIENTS)

Birth Date: ___/___/___ Birth Weight: _____ Birth Place: _____ Vaginal Delivery: Y N
If you have siblings, where were you in birth order? (ex: 3rd of 3): _____

Were you full term? Y N If premature, give # of weeks: _____

Breast fed? Y N How long? _____ If bottle fed, were you allergic to formula or milk? Y N

Major health problems of your mother during pregnancy or delivery of you: Y N

If YES, explain: _____

_____

Occupation(s) of both parents during the years you lived at home with them:

Father: _____

Mother: _____

In your early months (0-12 months) did you have any of the following?

Jaundice	Y	N	Colic	Y	N	Severe Diaper Rash	Y	N	Thrush	Y	N

Congenital abnormalities?	Y	N	If yes, explain:	
Problems w/vaccinations?	Y	N	If yes, explain:	
Failure to thrive?	Y	N	If yes, explain:	
Developmental delays?	Y	N	If yes, explain:	
Sleep problems?	Y	N	If yes, explain:	
Frequent Infections?	Y	N	If yes, explain:	

Please give AGE you were if/when you had any of the following:

Measles _____ Mumps: _____ Chicken Pox _____ Whooping Cough: _____

FOR CHILDREN UNDER 18 ONLY: Immunizations (Vaccinations) Record:

DPT (Diphtheria, Pertussis, Tetanus)	Age(s):		Any reactions?	
Booster (usually DT)	Age(s):		Any reactions?	
Polio injection	Age(s):		Any reactions?	
Polio oral	Age(s):		Any reactions?	
MMR (Measles, Mumps, Rubella)	Age(s):		Any reactions?	
HBV (Hepatitis B Vaccine)	Age(s):		Any reactions?	
Flu Shots	Age(s):		Any reactions?	
Other:	Age(s):		Any reactions?	

Was Tylenol, ibuprofen, or another medication given before or after the immunizations? Y N
Further comments:

_____

_____

_____

YOUR HEALTH HISTORY (ALL PATIENTS):

Denote anything you currently have or once had during the listed time periods, and state your approximate AGE when you had it.

			1-5 yrs. old (If yes, age?)	6-12 yrs. old (If yes, age?)	Teen yrs. (If yes, age?)	Adult yrs. (If yes, age?)
Frequent colds or flu	Y	N				
Flu shots	Y	N				
Tonsillitis	Y	N				
Thyroid medication	Y	N				
Bronchitis, asthma, or pneumonia	Y	N				
Ear infections	Y	N				
Frequent antibiotic use	Y	N				
Sinusitis	Y	N				
Strep infections	Y	N				
Seizures/Convulsions/Tremors	Y	N				
Headache: Sinus/Tension/Migraine	Y	N				
Dental: Root canals/Fillings/Implants	Y	N				
Seasonal allergies/Hay fever	Y	N				
Fever blisters	Y	N				
Premature graying of hair	Y	N				
Hyperactivity behavior problems	Y	N				
Difficulty learning	Y	N				
Attention/Concentration problems	Y	N				
High # of absences from school/work	Y	N				
Upset stomach/Indigestion/Stomach pain	Y	N				
Increased urinary frequency/Nocturia	Y	N				
Urinary tract infections	Y	N				
Skin: Rash/Acne/Eczema/Hives	Y	N				
Yeast/Fungal infections	Y	N				
Infectious mononucleosis	Y	N				
Muscle or joint problems	Y	N				
Fibromyalgia	Y	N				
Significant weight gain/loss	Y	N				
Chronic fatigue	Y	N				
Sexually transmitted diseases	Y	N				
Tick bites: Lyme disease	Y	N				
Cancer	Y	N				
Heart disease	Y	N				
High blood pressure	Y	N				
Autoimmune disease	Y	N				
Irritable bowel	Y	N				
Diverticulitis	Y	N				
Hiatal hernia	Y	N				
Hemorrhoids	Y	N				
Ulcers of stomach or small intestine	Y	N				
Crohn's disease/Colitis	Y	N				
Gluten intolerance	Y	N				
Anorexia/Bulimia	Y	N				
Diabetes/Blood sugar disorder	Y	N				
Hepatitis/Liver disorder	Y	N				
Depression/Anxiety	Y	N				

YOUR ENVIRONMENTAL & OCCUPATIONAL HISTORY (ALL PATIENTS):

Please list dwellings (houses/apartments) where you lived for more than 6 months, including your present home. Also explain any chemical or toxic exposures you may have had at each location.

Age	Locations (city, state, country)	Pesticides or near golf course?	Natural gas	Rural/Farm	New construction materials?	Water leaks or other reasons for molds?

Do you feel that any of the above locations where you lived contributed to your health problems (or to those of any other member of your family)? If so, please explain: _____
_____
_____

Have you lived or traveled outside the United States? If so, please describe where and give your age at the time:

Age	Country	Length of Stay	Any health problems from this trip?

Please list all FULL TIME jobs you've held for more than one year from young adulthood to the present, and explain any chemical or toxic exposures you may have had at each job. (If necessary, add separate sheet):

Age	Type of business position held	Any toxic chemicals you were exposed to accidentally?	Types of protective gear worn	Water leaks or other reasons for mold?

Please circle any other stresses or exposures experienced occupationally:

Computer screen	High-intensity noise	Excessive heat or cold	Fumes/Dusts
Frequent x-rays/radiation	Metal dusts	Natural or other gas fuel	Tobacco smoke
Emotional stress/Work stress	High-voltage power		

Do you feel that any of the above jobs where you worked contributed to your health problems? If so, please explain:

_____

_____

LIFESTYLE FACTORS (ALL PATIENTS):

List foods you loved and foods you hated as a child: _____

_____

List foods you love (and crave) and foods you hate now: _____

_____

Any history of alcohol abuse? Y N If yes, what ages & for how long? _____
Do you ever drink before noon? Y N
Any history of drug abuse? Y N If yes, what ages & for how long? _____
What types of drugs were/are abused? _____
How many hours per week do you usually work? _____ Are you overly tired at end of day? Y N
Do you exercise regularly? Y N If yes, how often & how long? _____
Do any of the following prevent you from exercising?
Pain Fatigue Poor Health Lack of Time Lack of Interest
Sleep: # of hours _____ Do you snore? Y N Feel rested after sleep? Y N Daytime sleepiness? Y N

SOCIAL & ENVIRONMENTAL FACTORS:

Married: Y N How Long: _____ Age(s) when married: _____

Is your spouse or any person you live with a smoker? Y N Occupation of Spouse: _____
Do you have emotional stress that has come from your spouse (or your spouse's health problems)? Y N
If yes, please explain: _____

_____

Have you been married previously, and was (were) your spouse(s)/partner(s) smokers? Y N
Did your previous partner(s) cause you emotional stress that impacted your health history? Y N

If yes, please explain: _____

_____

Other problems from family members or health problems: _____

Are you involved in a lawsuit? _____

Are you contemplating litigation? _____

ALLERGY HISTORY (ALL PATIENTS):
Is there a seasonal pattern to your allergy symptoms? Y N What is it? _____

What are your known allergens? _____

_____

Are you on allergy desensitization? Y N For how long? _____ Prescribed by? _____

ALLERGY HISTORY (ALL PATIENTS) continued:

Are you sensitive to chemicals? (ex. Scented products, household cleaners, pesticides, etc.) Please indicate the specific products and what symptoms are provoked when you are exposed (such as brain fog, burning eyes, headache, etc.)

Chemical/Products	Symptoms

If more space is needed – please use back of this sheet.

SYSTEMIC INFLAMMATORY MEDIATOR QUESTIONNAIRE

SINUS HISTORY

Have you had a sinus infection in the past year? ☐ Yes ☐ No
If yes, how many? ☐ 0-1 ☐ 2-4 ☐ 5+
Have you taken antibiotics within the past year? ☐ Yes ☐ No
If yes, what kind(s)?_____
How many times? ☐ 0-1 ☐ 2-4 ☐ 5+
Do you get sinus headaches? (not migraines) ☐ Yes ☐ No
____ times per ☐ Week ☐ Month ☐ Year
Worse on: ☐ Right ☐ Left ☐ Both Sides ☐ Cheeks ☐ Back of Head
Have you had an aspirin allergy? ☐ Yes ☐ No
Do you experience loss of smell? ☐ Yes ☐ No
Do you have a nasal airway obstruction? ☐ Yes ☐ No
If yes, grade from 0-4+: _____ (0 = no blockage, 4+ = completely blocked on one or both sides)
Do you experience postnasal drip? ☐ Yes ☐ No
If yes, grade from 0-4+: _____ (4+ = most)
Do you have any allergies? ☐ Yes ☐ No
If so, to what?_____
Have you been tested for allergies? ☐ Yes ☐ No
Have you ever taken allergy shots? ☐ Yes ☐ No
If yes, when?_____ And for how long?_____
Have you had drainage from the nose? ☐ Yes ☐ No
Have you ever had sinus surgery? ☐ Yes ☐ No
If yes, how many?_____ And when?_____
Do you smoke? ☐ Yes ☐ No

ENVIRONMENTAL HISTORY

Has the furnace or air conditioner location in your home ever been damp? ☐ Yes ☐ No
Is the heater or air conditioner located in a dirt crawl space? ☐ Yes ☐ No
Is that area damp? ☐ Yes ☐ No
Is the heater located in the attic with blown-in insulation? ☐ Yes ☐ No
Do you have a humidifier in the central furnace? ☐ Yes ☐ No
Have you ever had a leak or flood anywhere in your home? ☐ Yes ☐ No
Do you ever notice a musty smell in the house? ☐ Yes ☐ No
Have you ever noticed any mold in the house (other than the bathroom)? ☐ Yes ☐ No
Do you or coworkers feel unwell at the office? ☐ Yes ☐ No
Do you feel better away from home or the office? ☐ Yes ☐ No
Do you feel better if you go to the beach or other clean air space? ☐ Yes ☐ No
Do you have pets in the home? ☐ Yes ☐ No
If so, which? ☐ Dog ☐ Cat ☐ Other_____
Do any of your pets sleep in the bed with you? ☐ Yes ☐ No
Do you have a front-loading washing machine? ☐ Yes ☐ No
Has your car ever leaked or been wet on the inside? ☐ Yes ☐ No
Do you drive a BMW? ☐ Yes ☐ No

SINUS AND UPPER RESPIRATORY SYMPTOMS

Asthma	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No

GENERAL SYMPTOMS

Fatigue Grade 0-10 (0 = can't get out of bed, 10 = can walk 5 miles) _____

Memory Loss/Problems Concentrating	☐ Yes	☐ No			
Abdominal Pain	☐ Yes	☐ No	Weakness	☐ Yes	☐ No
Allergic complex to foods	☐ Yes	☐ No	Irritable Bowel Syndrome (IBS)	☐ Yes	☐ No
Attention Deficit Disorder (ADD)	☐ Yes	☐ No	Blurred Vision	☐ Yes	☐ No
Constipation	☐ Yes	☐ No	Chest Tightness	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Insomnia	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No	Numbness/Tingling	☐ Yes	☐ No
Bloating and/or Gas	☐ Yes	☐ No	Laryngitis	☐ Yes	☐ No
Stomach Pain	☐ Yes	☐ No	Anxiety, Depression, or Irritability	☐ Yes	☐ No
Gut Problems (enteropathy)	☐ Yes	☐ No	Skin Rashes	☐ Yes	☐ No
Leaky Gut Syndrome	☐ Yes	☐ No	Psoriasis	☐ Yes	☐ No
Gluten Sensitivity	☐ Yes	☐ No	Eczema	☐ Yes	☐ No
Loss of Protein in Gut	☐ Yes	☐ No	Hives	☐ Yes	☐ No
Gastritis (stomach inflammation)	☐ Yes	☐ No	Urticaria (itching)	☐ Yes	☐ No
Colitis (bowel inflammation)	☐ Yes	☐ No	Tremors/Seizures	☐ Yes	☐ No
Hyperactivity	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Hypoglycemia (low blood sugar)	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Interstitial Cystitis (bladder inflammation)	☐ Yes	☐ No	Lymphoma	☐ Yes	☐ No
Migraines	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No
Obesity	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Muscle/Joint Pain (fibromyalgia)	☐ Yes	☐ No	Esophageal Acid Reflux (GERD)	☐ Yes	☐ No

FOR FEMALE PATIENTS AND/OR MOTHERS OF PEDIATRIC PATIENTS:

Age periods began: _____ Length of periods now or when menstruating: _____

How often periods occur now and/or previously? _____

Cramping? Y N Menstrual pain? Y N Heavy periods? Y N Clotting? Y N

PMS? Y N If yes, what days of your cycle do you have PMS? _____

Have you had the following? If yes, please also give age(s). (Example: "ages 13-16" or "56 to present")

Water retention/swelling	Y	N	Age:		Breast swelling	Y	N	Age:	
Fibrocystic breasts	Y	N	Age:		Loss of libido	Y	N	Age:	
Premenstrual mood swings	Y	N	Age:		Depression	Y	N	Age:	
Fat deposits in hips/thighs	Y	N	Age:		Weight gain	Y	N	Age:	
Cravings for sweets	Y	N	Age:		Endometriosis	Y	N	Age:	
Irregular menses	Y	N	Age:		Uterine fibroids	Y	N	Age:	

If menopausal, at what age did periods become irregular or cease? _____

Have you taken birth control pills? Y N What age(s)? _____

How long each time? _____

Reason for birth control pills (circle which apply):

Pregnancy Prevention *Excessive Bleeding* *Other:* _____

Have you taken Hormone Replacement Therapy (HRT)? Y N What age(s)? _____

How long on HRT? _____ Any side effects from HRT? _____

Have you had vaginal infections? Y N What age(s)? _____

What kind? *Bacterial* *Yeast* *Other:* _____

Have you had any abnormal pap smears? Y N Age: _____ Describe problems: _____

Have you had abnormal mammograms? Y N Age: _____ Describe problems: _____

Pregnancies including abortions & miscarriages	Age at time	Problems with pregnancy or delivery	Birth date (or gestational time at miscarriage)	Birth weight	How long ON birth control before trying to conceive	How long OFF birth control before conception

CURRENT MEDICATIONS & SUPPLEMENTS YOU TAKE REGULARY (add sheet if necessary):

Name of Drug (prescription or over-the-counter)	Dose & How often each day?	For what condition? & For how long?	Name of Doctor, if any, who prescribed it
Name of NUTRITIONAL SUPPLEMENT	Dose & How often each day?	For what condition? & For how long?	Name of Doctor, if any, who prescribed it

Known Drug Allergies:

Drug: _____ Typical Reaction: _____

Drug: _____ Typical Reaction: _____

Drug: _____ Typical Reaction: _____

CURRENT DIET INFORMATION:

Give examples of two days average dietary intake, including all meals, snacks, and beverages; specify if eating out or at home:

Day One	Day Two
Breakfast: _____	**Breakfast:** _____
_____	_____
Snacks: _____	**Snacks:** _____
Lunch: _____	**Lunch:** _____
_____	_____
Snacks: _____	**Snacks:** _____
Dinner: _____	**Dinner:** _____
_____	_____
Snacks: _____	**Snacks:** _____

What type of salt do you use?

None Iodized Salt Sea Salt Seaweeds (kelp, etc.) Salt Substitute

Are you trying to follow any particular diet system? Y N

If yes, which one(s)?

Atkins Paleo Vegetarian Gluten-Free Anti-Candida Other: _____

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PRIMARY CARE UNDERSTANDING

Holistic Medical Services, Inc. is not a "Primary Care Practice." Our focus is instead on nutritional and environmental influences on illness. As such, you will need to maintain your relationship with your primary care provider in order to maintain certain components of your medical care. By signing below, you agree to do this. We do not have an "on-call" physician and are not available for medical emergencies outside of office hours.

I understand that my primary care physician must handle routine medical needs and any medical emergencies.

My primary care physician is: _____

_____

City, State, and Phone

Signature: _____ Date: _____

Print Name: _____

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LEGAL REPRESENTATION

Our ultimate goal at Holistic Medical Services is to improve the health and promote the wellbeing of our patients by engaging in a comprehensive assessment of medical history, symptomatic expression, laboratory reports, and discussions during in-office consultations. This process, while well-worth the effort, requires a great deal of time for counseling, listening, and conversation, and as a result, only a small number of patients can be seen each day. In spite of this, we do try to help as many people as possible.

Experience has shown that, for us, preparing for and participating in legal processes diminishes our ability to take part in the healthcare of our patients. For this reason, we are not able to provide treatment to anyone requiring legal representation from a physician. There are a few integrative practitioners in other offices who do choose to provide medical representation in legal cases and who may be able to help you. You are welcome to contact us for referrals.

In signing this page, you acknowledge:

1. Your full awareness that we do not admit patients needing medical legal representation, and…

2. You do not require this service.

Signature: _____ Date: _____

Print Name: _____

HOLISTIC MEDICAL SERVICES, INC.
FRANK P. MATALONE, D.O., N.M.D.
3833 Roswell Road · Suite 116 · Atlanta, Georgia 30342 · Phone: 404-941-8621 · Fax: 404-549-3005

Letter of Understanding Regarding E-Mail Responses, Prescriptions, and Emergency E-Mails

E-mail is becoming a more common and accepted method of exchange of information in the medical field. While we have utilized e-mail in communicating with patients, **e-mail is typically not the medically preferred method of communication**. By signing this letter of understanding, you acknowledge that you have been informed of this policy and that if you choose to e-mail and wait for a response, you do so at your own risk and agree to hold Holistic Medical Services, its employees, and the practitioners harmless for complications that may arise indirectly or directly from an unanswered e-mail.

Staff members attempt to help patients with simple questions via e-mail, but this is not ideal for most issues. Should you choose to provide updates on your health so that information may be addressed at your next scheduled appointment, we will print your e-mail, and the document will be considered a part of your legal medical chart. Questions that require treatment changes are best addressed during scheduled phone consults or office visits. For any questions requiring a rapid response, the preferred communication is to call the office and speak with one of the staff. Due to medical/legal constraints, advice pertaining to treatments and diagnoses are generally excluded from e-mail responses. In addition, technology limitations may compromise a response via e-mail and it should not be relied upon for consistent communication. We prefer that if you desire a rapid response to your questions, you call the office and notify us that you need a reply on the same day as your call.

If you have not received an answer to your e-mail in what you would consider a timely fashion, and you feel your issue is urgent, you should contact the office immediately.

Emergencies and Prescriptions

Holistic Medical Services is not structured as an urgent care or emergency department. By signing this form you acknowledge that you have been instructed to go to an urgent care center or an emergency room for emergency issues. As such, any matters such as prescription refills or other routine items should be submitted between Monday and Thursday.

Situational Documents

There are times when patients request a letter of justification to their insurance companies for the cost of evaluation and treatments. These requests are difficult to accommodate due to the time involved in generating a complete assessment and the specialized treatment rationale for each patient. As a result, our office policy is that we do not file insurance. You will be provided with evidence of your office visit with our practitioners as well as information regarding the tests that were ordered. A letter from the doctor would incur an extra fee. Your insurance

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company may or may not reimburse you, depending on your plan's deductible and its policy for out-of-network providers. We regret this policy, but due to the complex nature of most patient illnesses and the detail to which we evaluate these problems, it cannot be avoided. Disability letters are also difficult and time-intensive to craft for similar reasons and fall under the same policy: time spent = amount billed. The typical rate is $250 per 60 minutes of your doctor's time needed in researching and composing the document. Our office does not participate in workman's compensation claims, nor does it provide depositions for lawsuits filed for any reason. By signing below, you acknowledge you have been informed of these policies and will abide by them when utilizing our facilities and functions.

Patient Signature: _____

Witness Signature: _____

Date: _____

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PLEASE DO NOT WEAR ANY PERFUME OR COLOGNE WHEN VISITING THIS OFFICE

Perfumes today are made from toxic chemicals instead of flowers. More than 4,000 chemicals are used in fragrances. Of these, 95% come from petroleum.

In addition, we ask that you **do not smoke** before entering the office. Cigarette smoke contains many toxins and, like perfume, can trigger reactions in asthmatics as well as chemically sensitive patients.

Since we serve a chemically sensitive population of patients, for their safety, you may be asked to leave and return to the office in chemical-free clothing.

Thank you in advance for your consideration toward the wellbeing of others!

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Patient Information Consent Form

Note: HIPAA laws allow HMS to use your Protected Health Information (PHI) without your written permission for reasons that include the following: contacting you, communicating with other specialists or services to which we have referred you, conducting internal operations related to your medical care, and discussing your health with individuals for whom you have given us written consent.

I understand that HMS may use or disclose my PHI for the purposes of carrying out treatment or referrals, prescribing drugs, obtaining payment, evaluating quality of services, and completing any administrative operations related to my treatment or payment. I understand that I have the right, upon written notification, to restrict how my PHI is used and disclosed for diagnosis, treatment, payment, and administrative operations. I understand that HMS will consider requests for exemptions on a case-by-case basis, but does not have to comply with such requests.

HMS may need to initiate contact with me regarding my healthcare. I am aware that there is no assurance that messages from HMS will remain secure or private. I consent to receiving messages from HMS regarding my PHI (e.g., appointment reminders, test results, medical advice, etc.) by:
(*Check all that apply)*

☐ Voicemail ☐ Answering machine ☐ E-mail ☐ Fax ☐ Posted letter _____ *(initial)*

HMS staff may contact me at my workplace regarding my health care ☐ yes ☐ no _____ *(initial*)

My signature below authorizes the designated persons named below to access or discuss PHI with HIM practitioners and their staff regarding my medical condition, diagnosis, treatment, test results, and financial status of my account.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

No one but myself _____ (initial)

I hereby freely and willingly consent to the use and disclosure of my information for purposes noted in the most current revisions given by HMS. I understand I retain the right to revoke this consent by notifying HMS in writing at any time.

Please wait to sign this page until someone in the office can witness your signature.

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness Signature Date

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INSURANCE INFORMATION

The practice of medicine at the Holistic Medical Services combines both traditional and alternative concepts in medical diagnosis and therapeutics. It is important that there be a clear understanding concerning fees for tests and therapies. You will always be informed of what these tests and/or treatments are, their intended purpose, and the fee schedule.

Insurance companies may reimburse for a portion of the diagnostic procedures and office visits, if the individual has out-of-network benefits. Traditional medical treatment modalities should be paid as any other medical facility; however, it is possible that your insurance company deems treatment as an alternative approach and will not pay for services.

We are not Medicare/Medicaid providers. The doctors have filed the Opt-Out documents required in order to be able to treat those with Medicare; however, you will be asked to sign a document of understanding that **NO** Medicare claims will be filed, whether it be a primary or secondary coverage. Medicare also will not allow you to file claims yourself.

Each individual is financially responsible for the sum of their services due at the time of service. We do not file insurance claims. You will be provided with accurate and appropriate documentation for office visits with the providers, lab tests, and services rendered. By signing this form you acknowledge that you are responsible for payment of services rendered at Holistic Medical Services, Inc. and by Frank P. Matalone, D.O., and there is no guarantee that your insurance company will reimburse you for these procedures and treatments.

Patient Signature: _____

Witness Signature: _____

Date: _____

We are a cash practice, meaning that you pay in full at the time of your visit. We provide walkout statements for you to submit to your insurance company for reimbursement. Your contact is with your insurance company and not with Holistic Medical Services, Inc. once you file your claim. We do provide more information as necessary regarding diagnosis, treatment, etc. upon request of the insurance company.

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PERSONAL INFORMATION

TODAY'S DATE ___/___/____

NAME: LAST _____ FIRST _____ MIDDLE INITIAL _____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

PHONE #s: HOME (_____) _____ - _____ CELL (_____) _____ - _____

WORK (_____) _____ - _____ EXT. _____ E-MAIL _____

By giving us your e-mail address, you are authorizing us to send information to you; your e-mail will not be shared.

DATE OF BIRTH ___/___/____ **SEX** ☐ F ☐ M **SOCIAL SECURITY #** _____ - ____ - _____

PRIMARY CARE DOCTOR _____ **REFERRING PHYSICIAN** _____

MARITAL STATUS: ☐ SINGLE ☐ DIVORCED ☐ LEGALLY SEPARATED ☐ PARTNER

☐ MARRIED (SPOUSE NAME _____) ☐ WIDOWED ☐ UNKNOWN

RESPONSIBLE PARTY: ☐ SELF ☐ GUARANTOR

RELATIONSHIP _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH ___/___/____

EMERGENCY CONTACT:

RELATIONSHIP _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH ___/___/____

HOME PHONE (_____) _____ - _____ CELL PHONE (_____) _____ - _____

WORK PHONE (_____) _____ - _____ EXT. _____

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WHAT HAPPENS NEXT?

Please read over this section carefully as it will probably answer more than 90% of your questions.

Upon your arrival at HMS, you will check in at the front desk and turn in your "Medical History" and signature forms. It is **VERY IMPORTANT** that all paperwork be filled out before arriving for your appointment time as it takes 30 minutes to one hour to fill out. You may be asked to reschedule your appointment if your paperwork is incomplete. If for some reason you have difficulty downloading and printing the forms, we will mail them or have them available in our office for you to arrive early and fill them out prior to your appointment.

After collecting your paperwork, we will take your vitals and then escort you to an exam room**.**

Your doctor will be in to assess your history and add or make changes to your completed patient questionnaire. This takes approximately 75-90 minutes. Based on this history, your office visit, and a brief physical exam, she will discuss an initial treatment plan. If your testing involves urine, saliva, or stool collections, we will send kits home with you to collect the specimen and then mail it off in prepaid FedEx, UPS, or Priority Mail envelopes. The results take 2-3 weeks from the time the lab receives the specimen.

After the consultation ends, a medical assistant will enter shortly afterward to go over the doctor's recommendations and the costs of each one.

Next you will be taken to the lab for blood to be drawn if necessary. We will also provide any take-home test kits at this time if your doctor recommends them.

If provocation/neutralization allergy testing is recommended, we may be able to start this at your initial visit. Allergy testing can take as short a time as one hour or as long as one or several days. We test only one food or inhalant at a time, finding the proper neutralizing dose before moving on to the next allergen. This is time-consuming but extremely accurate and individualized for you.

Additionally, our office has an alternate and increasingly popular treatment known as Low Dose Antigen Immunotherapy (LDA). This treatment requires special dietary preparation and has to be scheduled for a subsequent visit. More information about both types of allergy treatment will be provided to you if appropriate at the time of your visit.

You will need two follow-up appointments. The first takes place about two weeks after the initial consultation, which allows enough time for the lab results to arrive at our office for analysis. You will receive a call from us when we have this information to give a brief overview of the results in preparation for the visit, during which we will provide a copy of the report,

discuss the findings in detail, and use the data to complete your treatment plan. The third appointment generally occurs after one or two months, depending on the course of your therapy. This visit will be used to assess your body's response to your treatment and make any changes or adjustments if necessary. If IV therapy is part of the treatment plan, more intensive follow-up may be required during this period between the second and third appointments. The wait time for any appointments beyond the third will be determined at the end of each visit. Maintenance of certain treatments over time may require updated lab work and office visits every six months or one year.