Wayne Bonlie, MD
Holistic Medicine

30 E Padonia Rd, #305, Timonium, MD 21093 Phone: (410) 560-7404 Fax: (443) 588-1725
Email: info@waynebonliemd.com

Please use as much space as needed to answer questions. If you are filling in this form by hand and not on the computer, please use the back of the page or use additional pages if needed. You may fax or email this information to me prior to your appointment (preferred) or you may bring it with you to your appointment.

Name:	
Address:	
DOB:	
Telephone:	
Email:	
Referral Source?	

Medical History
Current Problem: (when it started, major symptoms, previous treatment)

Other Medical Problems	
1. Currently being treated	
2. Past Hospitalizations	
3. Surgeries	
4. Injuries	

Allergies	
1. Medication Allergies	
2. Environmental Allergies	
3. Food Allergies	

Family History	Significant illnesses or medical conditions. If deceased, cause and age of death if known.
1. Mother	
2. Father	
3. Maternal GM	
4. Maternal GF	
5. Paternal GM	
6. Paternal GF	
7. Siblings	

Habits	
Current Smoker?	
Amount:	
Years:	
Past Smoker?	
Do you drink alcohol?	
Amount:	
Caffeinated beverages?	
Amount:	
Soda?	
Amount:	

How often have you had antibiotics in the past?

Have you had problems with yeast, fungal or candida infections in the past or currently?

Describe your diet.

What is your employment?
Do you enjoy your work?

What is your current relationship status?
Who lives in your current household?

Any spiritual beliefs or practices that play a role in your life?

What are your hobbies or leisure activities?

Medications and Supplements you are currently taking.

Adrenal Checklist

	Hypoglycemia
	Shakiness relieved with eating
	Recurrent sore throats that take a long time to go away
	Is life very stressful now, or have you been under a lot of stress in the past?
	Low blood pressure
	Dizziness on first standing
	Have you been on prednisone or cortisone for more than one week?
	If yes, did you feel better when you were on it?
	Do you feel like you've been "hit by a truck" the day after exercise?
	Increased thirst?
	Salt craving?

Thyroid Checklist

	Weight Gain
	How many pounds?
	Over how many years?
	Low body temperature (under 98 degrees)
	Aching, tight muscles
	High cholesterol
	Cold intolerance
	Dry Skin
	Thin hair or excessive hair loss
	Heavy periods
	Constipation
	Fatigue
	Depression
	Fluid retention

Estrogen - WOMEN ONLY

	Do you have premenstrual symptoms?
	Are your symptoms worse the week before your period?
	Decreased vaginal lubrication?
	Are you menopausal?
	Day or night sweats or hot flashes?
	History of fibroid tumors and endometriosis?
	Have you had a hysterectomy, ovaries removed, or a tubal ligation?
	Decreased libido?

Testosterone - MEN ONLY

	Decreased libido?
	Decreased erections?
	Decreased mood?

Sleep

	What is the average number of hours you sleep at night?
	Are you often tired when you wake up, even when you have slept well?
	Trouble falling and/or staying asleep
	Do you often wake at night to urinate?
	If yes, how many times per night?
	Do your legs jump a lot at night?
	Do you snore? If yes:
	Are you more than 20 lbs overweight?
	Do you have periods where you stop breathing?
	Do you have high blood pressure?

Essential Fatty Acid deficiency

	Dry eyes?
	Dry mouth?

GI

	Do you sometimes have diarrhea?
	If so, is it severe?
	Do you get constipation?
	Do you have well water?
	Do you ever get blood in your stool?
	Do you ever see mucous in your stool?
	Does food feel like it sits in your stomach for a long time?
	Do you get bloating?
	Do you have heartburn or reflux?
	Do you get frequent indigestion?
	Do you get stomach pain that is relieved by antacids, eating or dairy?

Yeast Questionnaire

	50	Have you been treated for acne with antibiotics for one month or longer?
	50	Have you taken antibiotics for any type of infection for more than two consecutive months or more than three shorter courses within twelve months.
	6	Have you ever taken antibiotics
	25	Have you ever had prostatitis or vaginitis?
	5	Have you ever been pregnant?
	15	Have you taken birth control pills?
	15	Have you taken corticosteroids such as Prednisone, Cortef or Medrol
	15	When you are exposed to perfumes, insecticides or other odors or chemicals do you develop wheezing, burning eyes, or any other distress?
	20	Are your symptoms worse on damp or humid days or in moldy places?
	20	Have you ever had a fungal infection such as jock itch, athlete's foot, or a nail or skin infection that was difficult to treat?
	20	Do you crave sugar or breads?
	10	Does tobacco smoke cause you discomfort such as wheezing or burning eyes?

	Total Score

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POLICIES AND PROCEDURES

General Office Hours:
Monday, Wednesday & Thursday: 9:30 am - 5:00 pm
Friday: 9:30 am - 3:30 pm

APPOINTMENT TYPES AND CANCELLATION POLICY

Please arrive on time for appointments: Arriving late may result in the appointment time being shortened at full fee value of scheduled time.

Appointment Types: Standard follow up appointments are 30 minutes minimum. We do not offer 15 minute appointments except for MMCC renewals. ***All appointment fees are subject to a minimum $60 additional charge for each 7+ minute overage.***

Frequency of Appointments: Patients are required to have one appointment annually to continue to receive treatment. ***Dr. Bonlie reserves the right to withhold any medical treatment or service if patients do not follow the recommended planned follow up schedule.***

Cancellation Policy: Please provide 24 hour notice should you need to cancel or reschedule your appointment. Cancellations without notice are subject to a 50% charge of scheduled appointment fee.

PRACTICE CHARACTERISTICS

Dr. Bonlie will not act as your Primary Care Physician: Most patients do maintain a separate PCP in their insurance network. Dr. Bonlie does not have privileges at any hospital, nor does he do hospital work. ***He is not on call 24 hours a day for emergencies.***

Dr. Bonlie is not a "Concierge" doctor, meaning: He does not respond in detail to emails or conduct appointments via email. Lab/test result interpretation requires a standard appointment.

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SUBMITTING TO INSURANCE

Submitting to Insurance: Our office does not participate with or coordinate any document submissions to insurance programs. Submitting to insurance is the sole responsibility of the patient. Patients receive itemized invoices with procedure and diagnosis codes for possible reimbursement. Keep these receipts in your files for income tax purposes. ***There is a fee for replacing these forms at the end of the year.***

Dr. Bonlie is not a Medicare provider: If Medicare is your primary insurance, you will be responsible for the complete payment of your appointment. ***Submission to Medicare or Tricare for reimbursement is not allowed.*** Medicare patients are required to sign a Medicare Opt Out form prior to their initial appointment.

PHONE AND EMAIL ETIQUETTE & QUESTIONS FOR DR. BONLIE OUTSIDE OF APPOINTMENTS

Phone: If you get our voicemail, please leave a a brief message including your name and phone number. ***In case of an emergency and nobody is able to take your call, please call or go to the nearest Urgent Care or ER.***

Email: Emails are fielded through the office staff first as Dr. Bonlie is with patients the majority of the day. Emails should be kept brief and questions should be limited. The office staff reserves the right to recommend an appointment based on the length of your email, the amount of questions asked, and the topics you wish to discuss with Dr. Bonlie in further detail.

Emailing Documents: Medical records, lab results, test results, patient forms, etc. should all be emailed in a PDF or Word document. **Please do not email images of your documents and do your best to send your documents in order.**

*****Please refrain from sending multiple voicemails and emails in the same day. Allow 24 hour business hours for a response. We will do our best to get back to you at our earliest availability.***

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MEDICATION, LAB REQUISITION, DOCUMENT/FORM/LETTER, AND MEDICAL RECORDS REQUESTS

New Medication: If Dr. Bonlie has not previously prescribed you a medication, this is considered a "new medication request" and requires an appointment first.

Medication Refills: Medication refill requests outside of annual appointments or planned follow up schedule are subject to a $15 service fee. Check your prescription refills prior to your appointments so refill requests between appointments can be minimized. ***All medication requests made after 3:00pm on Friday may not be reviewed and authorized until the next business day.***

Lab Requisitions: For lab requisitions requested outside of appointments, there is a $15 service fee. A finalized lab requisition cannot be edited. Requesting additional tests requires a new requisition. LabCorp requisitions expire in 6 months and Quest requisitions expire in 12 months. To replace expired or lost lab requisitions, there is a $15 service fee.

Documents/Forms/Letters: Requests for documents, forms and/or medical letters to be completed by Dr. Bonlie require Dr. Bonlie's time and will be billed according to the office fee schedule.

Medical Records: Patients are responsible for providing their records to our office. We cannot access your personal health portals from other offices and hospitals to access your records for you. Patients who request a copy of their medical records will be billed according to the Maryland Medical Society copying fee schedule.

SUPPLEMENT ORDERS

Ordering Supplements: Please call or email the office to place a supplement order. If we do not have the desired supplement in stock, we may be able to special order it for you. All supplement orders require payment beforehand. If you prefer we ship the supplement to you, there is a shipping fee.

I have read, understand, and agree to abide by the above office policies. This consent form is valid until all or part is revoked in writing.

_____	_____	_____
Patient Name (please print)	**Patient Signature**	**Date**

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PAYMENT POLICY

Payment: All fees are due at the time of service, unless otherwise specified by Dr. Bonlie or Wanda. We require all patients to have the correct credit card information on file they wish to have billed for their appointment. If you wish to use a different form of payment after we have completed our billing transaction, a service fee will be charged. The credit card information we have on file is stored securely and will only be billed at the time of service, unless you make other arrangements with the office ahead of the appointment time.

I have read, understand, and agree to abide by the above office payment policy. This consent form is valid until all or part is revoked in writing.

_____	_____	_____
Patient Name (please print)	**Patient Signature**	**Date**

CONSENT FOR TREATMENT

I request treatment by Wayne Bonlie, MD or designee. I understand that I have the right, as a patient, to be informed about my condition and the recommended treatment to be used so that I can make an informed decision whether or not to undergo the treatment after I have been told both the potential benefits, risks, and hazards involved.

Some treatments used at Wayne Bonlie, MD, PA are considered "off label" use by the Food and Drug Administration. In the United States, the regulations of the FDA permit physicians to prescribe or use approved medications for other than their intended indications. The practice is known as "off-label use" or "unlabeled uses." Such uses are not indicative of inappropriate usage but are legal and common. To access more information on off-label uses, please visit the FDA's website: **www.fda.gov/eder**

I have read and understand this consent form and agree to its terms. I understand that payments for procedures at Wayne Bonlie, MD, PA are non-refundable and that it is possible that these procedure treatments may be of little or no help at all. I have had the opportunity to ask any questions about the treatment including: outcomes, risks, complications and alternative therapies. I further understand that Wayne Bonlie, MD, PA cannot guarantee the results and will not hold its employees responsible for the individual results of the treatment that I have requested. I also understand that follow up treatments required will be at my own expense. **This consent form is valid until all or part is revoked in writing.**

_____	_____	_____
Patient Name (please print)	**Patient Signature**	**Date**

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HIPAA ACKNOWLEDGEMENT

Wayne Bonlie, MD, PA will follow HIPAA guidelines regarding patient privacy. We will not release your health information without your consent unless subpoenaed by a court of law.

I hereby acknowledge that I have been made aware that the physicians have a privacy policy in place in accordance with the Health Insurance Portability Act of 1996 (HIPAA). As a patient, I acknowledge that the physician or designee has a privacy policy in effect and has made this policy available to me. I am entitled to an additional copy of the privacy policy if I desire.

Circle Y or N - I authorize the physician or designee to discus my medical care and treatment with the following people (spouse, children, parent, etc.)

1. _____ 2. _____

I have read, understand, and agree to abide by the above HIPAA policy. This consent form is valid until all or part is revoked in writing.

_____	_____	_____
Patient Name (please print)	**Patient Signature**	**Date**

PHOTOS/EMAILS/TEXTS

Any photos taken will be kept in the patients medical chart as part of medical record, and such will be kept private as per HIPAA regulation.

Circle Y or N - I consent to communication of my information specific to my medical history, diagnosis, treatments and/or recommendations via email and/or text.

I have read, understand, and agree to abide by the above office policy. This consent form is valid until all or part is revoked in writing.

_____	_____	_____
Patient Name (please print)	**Patient Signature (Parent or Guardian if under 18)**	**Date**

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EMERGENCY CONTACT(S)

1. Name: _____ Relationship: _____ Phone: _____

2. Name: _____ Relationship: _____ Phone: _____

3. Name: _____ Relationship: _____ Phone: _____

I consent to communication on my behalf of my information specific to my medical history, diagnosis, treatments and/or recommendations with my Emergency Contact in the event I am unable to speak for myself. This consent form is valid until all or part is revoked in writing.

_____	_____	_____
Patient Name (please print)	**Patient Signature**	**Date**