Wayne Bonlie, MD
Holistic Medicine

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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

Policies and Procedures

In the interests of ensuring a smooth process for patient care, please review the following information.
To maximize the time with the provider, ARRIVE 15 minutes prior to your appointment to take vitals and complete paperwork. Out of respect for all of our patients' time, if a patient is late the visit may be shortened to accommodate subsequent scheduled patients. Longer appointment times are available with the provider (please contact our office for details).

General Office Hours

Monday	9:00 am - 4:00 pm
Tuesday	9:00 am - 4:00 pm
Wednesday	9:00 am - 4:00 pm
Thursday	9:00 am - 4:00 pm
Friday	9:00 am - 4:00 pm

CANCELLATION POLICY: If a patient cancels within 24 hours of the appointment or fails to keep the appointment, there will be a $50 fee.

PATIENT COMPLIANCE: All patients agree to schedule office visits at intervals recommended by the provider who reserves the right to withhold refilling of medications if patients do not follow the recommended office visit/ appointment schedule.

SUBMITTING TO INSURANCE

Although New Paradigm Wellness providers do not participate with any insurance programs patients receive itemized invoices with insurance claim codes for possible reimbursement. Since the providers have opted out of all **Medicare/Tricare** programs, **patients are NOT permitted to submit claims to any Medicare** or Tricare programs for reimbursement.

QUESTIONS FOR THE PROVIDERS: To ensure timely response, questions should be emailed to info@waynebonliemd.com or call the office during regular office hours at 410-560-7404. Please allow 24 hours for a response.

PRESCRIPTION REFILLS: Patients should first contact their pharmacist who will submit a request to our office. Allow 48 hours for all refill requests. **Requests made after 1:00 p.m. on Friday through Sunday may not be reviewed and authorized until Monday.**

SUPPLEMENT ORERS: Our preferred method of receiving supplement orders is via email at info@waynebonliemd.com or at the next visit. Phone orders can be placed during regular office hours Monday through Friday.

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

_____	_____	_____
Patient Name (Printed)	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 New Paradigm Wellness 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 agree to comply with any pre-treatment, treatment and post treatment instructions as indicated by the medical provider. I agree to immediately report any adverse reaction or problem to New Paradigm Wellness.

Dr Bonlie will act as primary care only on specific agreement to do so. Many insurance companies do not allow a provider who is not in network to be your primary care provider. Most patients do maintain a separate primary care physician who is in their insurance network. Dr. Bonlie does not have privileges at any hospital and does not do any hospital work.

I understand that New Paradigm Wellness does not accept insurance company payments for possible treatment nor does New Paradigm Wellness coordinate document submission for potential insurance company reimbursement. Any attempt to be reimbursed by an insurance company is solely the patient's responsibility.

Although New Paradigm Wellness is not subject to the Health Insurance Portability and Accountability Act (HIPAA), we follow HIPAA guidelines regarding patient privacy. We will not release your health information without your consent unless subpoenaed by a court of law.

I have read and understand this consent form and agree to its terms. I understand that payments for procedures at New Paradigm Wellness 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 New Paradigm Wellness 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 any 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 (Printed)

_____ _____

Patient Signature Date Provider Signature Date

Payment, Photo, Email and Text Consent Form

Patient Name: _____ Date of Birth:_____

PAYMENT POLICY
I understand that all fees are due at the time of service, unless otherwise specified by the provider.

I understand that there is a 24 hour cancellation policy that I will be charged $50 for either not showing for an appointment or for canceling an appointment within 24 hours of said appointment.

PHOTOS
By checking one of the boxes below I give the provider permission to use my photographs in the following manner:

☐ I only want my photos used in the medical chart

☐ I do not want any photos taken

☐ Unrestricted use of photographs
This may include lectures, before and after pictures, website, etc.

COMMUNICATION VIA EMAIL AND/OR TEXT
By checking the boxes below I consent to communication/notification of the following:

☐ Medical information specified to my medical history, diagnosis, treatments and/or recommendations

☐ Appointment reminders

For Email Notifications enter Email Address:_____

For Text Notifications enter **CELL PHONE #** _____-_____-_____

This consent form is valid until all or part is revoked in writing.

_____ _____ _____
Patient's Name **Signature** (Parent or Guardian if under 18) **Date**

PATIENT INFORMATION & CONSENT

_____ _____ _____
Last Name First Name Date of Birth

_____ _____
Address Apt #

_____ _____ _____
City State Zip Code

_____ _____ _____
Home # Work # Cell #

Name of emergency contact _____Relationship _____ Phone _____

INSURANCE (Please circle one of the following)

Do you have:
Medicare Tricare Neither

The providers have opted out of all Medicare/Tricare programs, patients are NOT permitted to submit claims to any Medicare/Tricare program for reimbursement.

If you checked Medicare or Tricare do you have a secondary insurance? ____ Yes _____ No

HIPAA Acknowledgement

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.

❑ I authorize the physician or designee to discuss my medical care and treatment with the following people (spouse, children, parent, etc.)

1. _____ 2._____

3. _____ 4. _____

I understand this form is valid until all or part is revoked in writing.

X_____ _____
Patient signature or guarding for the minor patient Date

Costs and Fees:

Fibromyalgia and CFS and Other Patients:

1st Visit ($200/hr):	$200 - $300
Follow Up Visit ($200/hr):	typically $150 but may vary depending on time
I.V.:	$145
Trigger Point Injections:	$95 per session
Lab Testing (Blood):	Varies/Usually covered by insurance
Lab Testing (Saliva):	
- Hormones	$150 per kit
- Adrenal	$150 per kit
Medications:	Varies

Bioidentical Hormone Patients

1st Visit:	$250
Follow Up Visit	$150
Lab Testing (Blood):	Varies/Usually covered by insurance
Lab Testing (Saliva):	$150 per kit. Usually done at first or second follow up visit and annually.
Medications:	Varies. The basic estimate for a standard bio-identical hormone cream is approximately $40 per month but may be more.