MINT HEALTH ANNUAL UPDATE FORM

Name_____ Today's Date_____

Date of Birth_____ Phone #_____

Current Mailing Address_____ Race _____

Email Address _____ Social Security #_____

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

MEDICATIONS- Please list ALL medications you are taking, including Prescription, Over the Counter, Vitamins, etc

Medication	Dose	How Often?	Prescribing Doctor

Allergies- Medications, Foods, Dyes, Latex, etc

Allergy/Sensitive To	Reaction

Medical History:

Tobacco Use: ☐ Current Smoker? How many a day?_____ ☐ Former Smoker? Hong long since? _____

Last Menstrual Period:_____ In Menopause? ☐ Yes ☐ No Had a Hysterectomy? ☐ Yes ☐ No

Are you currently using any type of Birth Control? _____ If so, what kind? _____

Date of last Mammogram: _____ Any abnormal results? _____

Date of last Pap: _____ Any abnormal results? _____

Any surgeries or been hospitalized since your last visit with us? ☐ No ☐ Yes -If so, please list the date and type: _____

Your Pharmacy Name/Location:_____

(See Back Page)

Review of Systems: Please circle the medical conditions or symptoms that apply to you:

General:
- ☐ Unexplained Weight Change
- ☐ Long Lasting Fever
- ☐ Loss of Appetite

Dermatology:
- ☐ New or Changing Moles
- ☐ Skin Cancer
- ☐ Itching

Endocrinology:
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Excessive Hunger

Female Reproductive:
- ☐ Pelvic Pain
- ☐ Abnormal Vaginal Discharge
- ☐ Pain with Intercourse
- ☐ Breast Pain
- ☐ Nipple Discharge
- ☐ Marked Change in Sex Drive
- ☐ Breast Lumps
- ☐ Abnormal Periods
- ☐ Heavy Bleeding
- ☐ Cramping

Respiratory:
- ☐ Chest Pain
- ☐ Shortness of Breath When You Lie Down
- ☐ Snoring

Urology:
- ☐ Difficulty Urinating
- ☐ Frequent Urination
- ☐ Urinary Incontinence
- ☐ Frequent bladder infections

Psychiatric Review:
- ☐ Depression
- ☐ Mood Swings
- ☐ Sleep Disturbance

Gastroenterology:
- ☐ Abdominal Pain
- ☐ Shortness of Breath when you lie down
- ☐ Change in Bowel Habits
- ☐ Bloating

Hematology/Lymph:
- ☐ Recent Swollen Glands
- ☐ Easy Bleeding
- ☐ Anemia

Have you ever been diagnosed with any of the following?

- ☐ Thyroid Disease
- ☐ Kidney Disease
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Heart Disease
- ☐ Liver Disease
- ☐ Diabetes- Type I or II
- ☐ Insulin Resistance
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Hepatitis
- ☐ HPV/Condyloma
- ☐ Herpes
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ HIV
- ☐ Syphilis
- ☐ Cancer: _____
- ☐ Other:_____

SYMPTOM CHECKLIST FOR WOMEN

Name: _____ **Date:** _____

E-Mail Address: _____

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Depressive mood (feeling down/sad/lack of drive)				
Memory Loss (forgetfulness)				
Mental confusion (feeling in a mental fog)				
Decreased sex drive/libido (decreased desire for sex)				
Sleep problems (difficulty falling/staying asleep/wake up tired)				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Other symptoms that concern you:

MINT HEALTH

I, _____, understand that being seen for a "Wellness" or Annual Well Woman visit does not mean that additional problems that are addressed will be covered by my insurance at 100%. I understand if Dr. Buchert has to address an additional problem or complaint, my insurance will be billed separately and I will be responsible for any co-pay, deductible, co-insurance or bill I may receive related to that problem including, but not limited to, office visit, lab work, imaging and testing.

_____ _____

Patient/Legal Representative/Guardian/Parent Signature **Date**

_____ _____

Printed Name **Relationship**

_____

Patient DOB

MINT HEALTH

Laboratory Consent Form

Many insurance companies have a “preferred” laboratory that the patient must use for lab work to be covered by insurance. Please know that, as the patient, you are responsible for knowing the preferred lab required by your insurance company. We at Mint Health do not know the benefits of your personal health insurance policy, nor can we be familiar with all the policies of the different insurance companies for all of our patients. Dr. Buchert makes lab recommendations based on medical advice and expertise and your symptoms and health goals.

We ask that prior to your visits, you either call your insurance company or Human Resources Department to find out the preferred lab if you do not know this information. Mint Health does not take responsibility for knowing your preferred lab or knowing what lab testing may or may not be covered by your insurance policy. Also, please be aware that while a lab draw technician is located in our office, we do not process your labs and we are not responsible for your lab bills.

I understand that all lab tests ordered by Dr. Elizabeth Buchert will be sent to an outside laboratory for processing and I will be billed separately by that lab company through my insurance company. I understand that I am responsible to pay for all lab charges, whether I have insurance, and whether it is a covered benefit of my insurance. I understand that the laboratory company will bill me separately for these lab charges, and lab bills are not from Mint Health and cannot be mediated by Mint Health.

Lab tests include, but are not limited to, Pap smears, vaginal cultures, urinalysis and cultures, blood tests, and biopsies.

Signature: _____

Print Patient Name: _____

DOB: _____

Date: _____

MINT HEALTH

Nutritional Supplements

According to the Federal Food, Drug, and Cosmetics Act, as amended, §201(g)(1), the term *drug* is defined as an "article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." Technically, vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effects on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient's diet and to supply nutrition to support physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

As a service to you, we make nutritional supplements available at our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering (1) the quality of the science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. The brands of supplements we carry in our facility are those that meet our high standards and tend to produce predictable results. **You are under no obligation to purchase nutritional supplements from our clinic.**

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be absorbed and utilized by the body), and effectiveness. The chief reason we make those products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

If you have concerns about this issue, please discuss with a member of the team.

☐ I have read and understand the above information.

_____ _____

Patient Name Date

MINT HEALTH

PATIENT PORTAL

Dr. Elizabeth Buchert, Renee Beyer-Boudreaux FNP and Mint Health use a patient portal for secure viewing of clinical information and communication between the clinic and the patient. At your initial appointment, you will be web-enabled and required to provide a personal (non-work) email address. You will use the username and password provided to log into the portal and gain access to your personal health record and other helpful features from any personal computer or laptop with an internet connection.

You will use the patient portal for many reasons including:

- Request appointments
- Request prescription refills
- Update demographic information (address, telephone number, email address, etc.)
- Ask questions and send information to Dr. Buchert, Renee and the clinic staff
- Receive and review laboratory test results
- Communication from Dr. Buchert or Renee FNP, regarding treatment for abnormal lab results, changes in medications or supplements, additional testing that may be required, etc.
- Review and pay patient statements

Use of the patient portal will result in significantly improved communication between you and our office. If you need to refresh your memory on how to access the portal, the Front Desk staff will be happy to provide you with an instruction sheet.

It is extremely important that you provide our office with an accurate email address and that you check your inbox on a regular basis for messages from the portal and follow the instructions forwarded in the message regarding treatment and follow-up on lab testing.

Patient Acknowledgement and Agreement:
I acknowledge that I have read and fully understand the information contained on this form. I agree that it is my responsibility to check my email inbox for messages from the portal and to follow through with Dr. Buchert and/or Renee's recommendations.

☐ I have read this form and the above information and accept the conditions.

Email Address: _____

_____ _____

Patient Name Date

MINT HEALTH

CANCELLATION AND NO SHOW POLICY

At Mint Health, we believe that a good physician/patient relationship is based upon respect and good communication. We understand that situations arise in which you must miss or cancel your appointment. However, to be fair to all our patients and to enable us to schedule another patient who is waiting for an appointment in the slot we reserved for you, we require that you give us forty-eight (48) hours' notice that you are cancelling or rescheduling your appointment. Office appointments that are cancelled/rescheduled with less than 48 hours' notification will be subject to a $50.00 cancellation fee.

Patients who do not show up for their appointments without a call to cancel an office appointment will be considered as NO SHOW. Patients will be subject to a $50.00 fee for appointment No Show.

The Cancellation and No Show fees are the sole responsibility of the patient.

We understand that special unavoidable circumstances may cause you to cancel/reschedule/no show within 48 hours. Fees may be considered for waiver, but only with management approval.

If you have any questions about this policy, please speak with the practice manager. Thank you for helping us in providing better service and availability to you and all our patients!

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

_____	_____
Patient Name	**Date of Birth**
_____	_____
Signature	**Date**

MINT HEALTH

Behavior and Mutual Respect Policy

Our mission at Mint Health is to help you alter the trajectory of your health, and educate you on health maintenance at the level you desire to do so. As a team, we work together to provide compassionate service to our members and patients.

Our mission and values require mutual respect and appropriate behavior. Mutual respect can be defined as a feeling that something or someone is good, valuable, or important, shared between two or more people. We care for each other's thoughts and feelings and we expect respect in return. This trust is the cornerstone of a good patient/client-provider relationship.

We are grateful for the opportunity to work with you, and out of respect for all of our patients and our entire team, we have a zero-tolerance policy for behavior that is in any way abusive, disrespectful, or demanding to the providers or clinic staff. Any patient who behaves in an abusive, disrespectful, or demanding manner will be discharged from the practice.

With my signature below, I acknowledge that I have read and understand the Behavior and Mutual Respect policy at Mint Health and agree to comply with the policy. I also understand the consequences of failing to comply.

_____ _____

Patient Signature Date

_____

Patient Name

Rev. 03.25.19

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS, POWER OF ATTORNEY, ETC

I, _____, authorize Dr. Buchert to release any & all information pertaining to my care, including but not limited to, future appointments, treatment plans, prognosis, etc to the following individuals:

- If permission is given, list the names of the individual(s) who will have the authority to receive any & all information pertaining to your care and sign and date the form.

- If you do **NOT** wish any information to be released, draw an "X" over the section listed below and sign and date the form.

Name:_____

Relationship to Patient:_____

Name:_____

Relationship to Patient:_____

Name:_____

Relationship to Patient:_____

Patient Signature:_____

Printed Name of Patient:_____

Date:_____

Please visit the website below, or scan the code to complete your Hereditary Cancer Screening prior to your appointment. Thank you!

MINT HEALTH

MYRIAD myRisk® Hereditary Cancer

Your personal and family history is very important to us. Please scan the code or enter the below link on your cell phone and then take the quiz. Once completed, your provider will be notified of your result, and will discuss with you during your visit.

Consider your parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of your family

https://www.mygenehistory.com/minthealth