Dr. Rebecca Ford ND, IFMCP, MS, RN
8000 IH 10 West
San Antonio, Tx. 78230
Ph: 210-524-7745
http://www.imctex.com
https://www.facebook.com/IntegrativeMedicineCareOfTexas

Name:_____ **Today's Date:**_____

Age:____ **Date of Birth:**_____**Height**_____**Weight**_____

Mailing Address:_____

_____ **Email**

Address:_____ **Phone**

(home):_____ **(cell):**_____

Occupation: _____

Name of spouse (or parent for minor child):_____

Whom may we contact in case of emergencies? Name_____

Phone #_____ **Cell #**_____

Relationship to patient:_____

Where did you hear about Dr. Ford?
__Friend/Family __FaceBook/IG __Google __IFM __Referring Doctor __Website

Integrative Medicine Care of Texas Office Policies

(Please Initial Each Statement):

____ Initial Consultations are $700 (not to exceed 120 minutes); Follow ups are $350 (not to exceed 60 minutes unless a longer visit is needed to review results or discuss the client's protocol). The full visit fee amount is due at the time of service.

____ Shorter appointments at a discounted rate are not offered. Reviewing labs, updating recommendations, and researching what each client needs according to what is discussed during a visit is not done during the client's visit time. *These tasks are completed outside of the visit itself and are included in the appointment fee.*

____ Dr. Ford does require that an active credit card be kept on file at all times. If your card info changes or updates please contact the office to provide the necessary information.

_____Due to Dr. Ford's schedule, replying to email inquiries are done on a first come/first serve basis and usually occur within five business days by IMCTex staff. It's understood that conversing via email may not be protected and is subject to fees noted on page three.

____ Appointment Deposits of 20% are required for all New Clients, regardless of appointment type (In Person, Online, Telephone, etc) and *will be applied to the visit charge once the appointment is complete.* All deposits are non-refundable for "No Call/No Show" missed appointments.

____ "No Shows" or Missed Appointments *will be billed* at the appointment rate *if 48 hours advance notice is not provided.* Appointment confirmations are sent via email, at least, 24 hours prior to scheduled visit. Gifting or applying the No Show fee to another client's visit is not allowed and can only apply to the client who's visit was missed.

____ If your appointment needs to be rescheduled, we ask that you let us know *at least 48 hrs in advance.* You can telephone the office at 210-524-7745 and speak with us directly, leave a voicemail, text us at 210-394-0404, or email us at Imctex.info@gmail.com. If 48 hrs notice is not provided, a $75.00 fee will be charged to the card on file for any type of rescheduled appointment (in person, virtual, or phone).

____ The cost of supplement recommendations, being highly individualized, will vary for each client. The client will order recommended supplements from their own account set up through Dr. Ford, and will be able to order them at their discretion.

_____ Recommended lab tests vary for each client. Dr. Ford will discuss the cost of recommended labs with the client and order them from her office.

_____Refunds for supplements will be handled through the company from which they were purchased.

_____Refunds will not be provided for used Test Kits. Unused kits are subject to a 25% restocking fee.

_____Emergency care is not provided and IMCT staff replies to all messages (voice, email, text, etc) within 48 business hours, on a first-come-first-serve basis. Multiple messages will not elevate your request.

Communications and Analysis

Emails, Phone Calls, or Mailed questions that require pulling of your chart, investigation, research, and/or review of new documents/results outside of a scheduled appointment are billed in 15 min increments at Dr. Ford's regular rate (15 minute increments at $87.50) and billed to the credit card on file.

_____ Client Signature

Although Dr. Ford explains, thoroughly, the regimen she is planning for her clients during the visit there are, occasionally, going to be questions that come up after the visit.

If Dr. Ford can quickly look at an emailed question and provide a quick "yes or no" response, she is happy to do so at no charge. If the question(s) is/are more complex and/or has multiple parts to it, Dr. Ford requires a scheduled, brief, phone call to clarify and get all questions answered at that time.

Your card on file will be billed in 15 min increments at Dr. Ford's regular rate (15 minute increments at $87.50). Dr. Ford encourages her clients to make a list of their questions, as they come to mind so that they can be answered during their scheduled visit or brief phone call.

_____ Client Signature

Recent outside lab results (results from another provider) are welcomed and can be reviewed by Dr. Ford at the client's request anytime. Review, analysis, and implementation of results from an outside source/provider will be charged at Dr. Ford's regular rate (15 minute increments at $87.50) and billed to the credit card on file.

_____ Client Signature

All records requests are processed within 72 business hours. A client signed HIPAA form must be received (via email, fax, or by hand) by the requesting office and a fee of $2.50 per page will be billed to the credit card on file.

_____ Client Signature

Please do NOT print these forms DOUBLE SIDED Please bring a CURRENT and TYPED supplement/vitamin/medication list with you that includes the following information: Brand, Name of Product (exact name please), dose or amount per serving, and how many times a day you take it. PLEASE no handwritten pages...thank you!

*******Notice to Parents of Young Children***** Please arrange for someone to watch your child during your visit with Dr. Ford as this office is not equipped to entertain little ones (10 and under). As precious as they are, children can be a significant distraction, and it is paramount that Dr. Ford can devote her entire attention to YOU, your history, and your health concerns. Due to potential health topics discussed, conversation may not be suitable or appropriate for children to hear.**

Integrative Medicine Care of Texas, LLC
8000 IH 10 West Ste. 600
San Antonio, Tx. 78230
Ph: 210-524-7745
Dr. Rebecca Ford ND, IFMCP, MS, RN

Naturopathic Medicine Legal Disclosure

As a valued client of IMCT, it is important that you are fully aware of the legal issues surrounding Naturopathic Medicine. The state of Texas does not regulate Naturopathic Doctors or the use of the title "N.D." Therefore, it is especially important to verify a Naturopath's training and licensure because there are many practitioners in Texas using the title "ND" who received a certificate from an online correspondence course. For more, updated, information regarding Texas and Nautropathic Medicine please visit: https://txand.org/FAQs
I acknowledge the above (initial) _____

Dr. Rebecca Ford attended a fully accredited four-year post-graduate medical program at Southwest College of Naturopathic Medicine in Tempe, AZ. She passed medical board exams for the state of Arizona, *and carries* a current and valid Arizona medical license. In Arizona, naturopathic doctors are licensed as primary care physicians and can diagnose, treat, prescribe pharmaceutical medications, order labs, X-Rays, CTs, MRIs, have hospital privileges, and perform minor surgery. Naturopathic doctors are not licensed in Texas to practice medicine at this time, largely due to strong opposition from unlicensed alternative health care providers such as the correspondence course "Traditional Naturopaths" who feel that full licensure for Naturopath Doctors would negatively impact their business. Due to lack of state licensure, Dr. Ford is not able to diagnose or treat disease, prescribe pharmaceutical drugs, perform minor surgeries, or administer injections in the state of Texas. Because Naturopathic Physicians are not licensed in the state of Texas, Dr. Ford's services are those of a health care consultant and she advises you to maintain care with a Texas licensed medical professional such as a Primary Care Physician or Specialist.
I acknowledge the above (initial) _____

Due to the non-licensed status of NDs within the state of Texas, *Dr. Ford can NOT be listed as a "previous doctor" or as your Primary Care Provider* on ANY insurance or medical forms. In the state of Texas, insurance companies do not recognize NDs as licensed providers, therefore Dr. Ford will NOT be able to answer questions posed by your insurance company regarding any health concerns addressed during your time as her client.
I acknowledge the above (initial) _____

Dr. Ford is able to assess, evaluate, make recommendations, and care for her clients using natural methods such as health counseling and education, nutritional, botanical, and homeopathic supplement recommendations, which typically lead to an increase in overall health and wellness and elimination of symptoms. It is important that you realize that Dr. Ford cannot be "your primary care doctor" and strongly recommends that you continue services with your primary care physician. If you are interested in learning more about Naturopathic Medicine and current licensing efforts, please go to www.naturopathic.org and/or www.txand.org.

Signature_____ Date_____

Signature of Parent/Guardian for minors _____

HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Lab testing and obtaining results (including direct or indirect consultation by other healthcare providers involved in my care)
- The day to day healthcare operations of your practice
- Communications between Dr. Ford, office employees, and myself regarding any sensitive client information (such as lab results, diet recommendations, supplement recommendations), or any information pertaining to the private and individual needs of myself as a client via e-mail, which may not be secure.

You have the right to request restrictions on how your protected health information is used and disclosed to carry out treatment, payment, and health care operations. You may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date you revoke this consent is not affected.

Signature_____ Date_____

Signature of Parent/Guardian for minors _____

Record(s) Requests

I understand that should another provider request copies of my results, recommendations sheet(s), and/or Intake Forms, the requesting office must email my signed release to imctex.info@gmail.com. Upon receipt of my signed release, IMCT will process the request within 3 business days and charge my card, on file, $25.00 per page being requested.

I understand that the digital or paper copies I receive, during my appointments/visits, are the same as those possessed by Dr. Ford. I am free to share those copies with any person or institution of my choosing.

Signature_____ Date_____

Signature of Parent/Guardian for minors _____

Dr. Rebecca Ford ND, IFMCP, MS, RN

CONFIDENTIAL PATIENT INFORMATION

Please fill in all portions of this form. If you need help, please ask.

Patient Name _____ Today's Date _____

Reason(s) for Visit _____

CURRENT Symptoms: Please check all that apply

GENERAL
- ☐ Chills
- ☐ Fever
- ☐ Sleep Disturbance
- ☐ Sweats

EMOTIONAL
- ☐ Anxiety
- ☐ Depression
- ☐ Eating Disorder
- ☐ Fear/Panic
- ☐ High Strung
- ☐ Irritability
- ☐ Psychiatric Disorder
- ☐ Suicidal

NEUROLOGICAL
- ☐ Carpal Tunnel
- ☐ Dizziness
- ☐ Fainting
- ☐ Forgetfulness
- ☐ Numbness/Tingling
- ☐ Paralysis
- ☐ Sciatica
- ☐ Seizures

SKIN
- ☐ Bruise Easily
- ☐ Change in Moles
- ☐ Dry Skin
- ☐ Itching
- ☐ Rash
- ☐ Sores that Won't Heal
- ☐ Warts

HEENT
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Difficult Swallowing
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Earache
- ☐ Ear Discharge
- ☐ Hair Loss
- ☐ Headache
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Glaucoma
- ☐ Gum Disease
- ☐ Migraine
- ☐ Mouth Sores
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Persistent Cough
- ☐ Post Nasal Drip
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Swollen Lymph Nodes
- ☐ Visual Disturbance

MUSCULOSKELETAL
- ☐ Joint Pain
- ☐ Lack of Coordination
- ☐ Stiffness
- ☐ Tremors
- ☐ Weakness

GI
- ☐ Bad Breath
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Change in Appetite
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting

HEART/LUNGS
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Pulse
- ☐ Low Blood Pressure
- ☐ Murmur
- ☐ Pain Breathing
- ☐ Palpitations
- ☐ Poor Circulation
- ☐ Rapid Heart Beat
- ☐ Short of Breath
- ☐ Suffocating Feeling
- ☐ Swelling Ankles
- ☐ Varicose Veins
- ☐ Wheezing

MALE ONLY
- ☐ Breast Lump
- ☐ Discharge from Penis
- ☐ Erection Difficulties
- ☐ Lump in Testicle
- ☐ Sore on Penis
- ☐ Testicular Pain
- ☐ Testicular Swelling
- ☐ Other: _____

FEMALE ONLY
- ☐ Abnormal Pap Smear
- ☐ Breast Lump
- ☐ Heavy Bleeding
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse DPMS
- ☐ Vaginal Discharge
- ☐ Vaginal Dryness
- ☐ Other
- ☐ Last Menstrual Period: _____
- ☐ Last Pap: _____
- ☐ Have you had a Mammogram? _____

URINARY
- ☐ Blood in Urine
- ☐ Difficult Urination
- ☐ Frequent Infections
- ☐ Frequent Urination
- ☐ Lack of Bladder Control
- ☐ Painful Urination

Medications
Please list all medications and dosages
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Allergies
Please List:
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Health Habits
Please check which substances you use and list how much:
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

PAST Conditions

Please check any conditions you have had.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gall Bladder Disease
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Leg Cramps
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Psoriasis/Eczema
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

FAMILY HISTORY

Relation	Father	Mother	Sibling 1	Sibling 2	Child 1	Child 2
Age if living:						
Age at death:						
Cause of death:						
Please check if any of the following conditions applied to the above relatives:						
Auto-Immune Disease:	☐	☐	☐	☐	☐	☐
Cancer:	☐	☐	☐	☐	☐	☐
Diabetes:	☐	☐	☐	☐	☐	☐
Heart Attack/Stroke:	☐	☐	☐	☐	☐	☐
Heart Disease:	☐	☐	☐	☐	☐	☐
High Blood Pressure:	☐	☐	☐	☐	☐	☐
Mental Illness:	☐	☐	☐	☐	☐	☐
Osteoporosis:	☐	☐	☐	☐	☐	☐
TB:	☐	☐	☐	☐	☐	☐

HOSPITILIZATIONS, SURGERIES AAND MAJOR ILLNESSES

Year	Condition or Procedure	Outcome
☐		
☐		
☐		
☐		

PREGNANCY HISTORY

Number of Pregnancies:_____

Number of Live Births:_____

Please check if you have any of the following:

☐Abortion ☐Miscarriage ☐Preemie

SLEEP HISTORY

How many hours Per night?_____

Please check if you have any of the following:

☐Frequent Waking ☐Nightmares ☐Snoring

☐Nap during day ☐Sleepwalk ☐Grind Teeth

OCCUPATION

Check if you are exposed to:

☐Heavy Lifting ☐Hazardous Substances

EXERCISE

How often do you exercise? _____

What Type? _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____