Richard H. Armond, III, D.O.
530 Highland Station Drive, Suite 3008 ◆ Suwanee, GA 30024
(770) 614-4455 ◆ www.osteopathtowellness.com

PATIENT INFORMATION

Name (First, M.I. & Last) _____

Birth Date _____

Street Address _____

City, State, Zip _____

Phone: Home _____ Cell _____

E-Mail Address _____

Please list Parent(s) or Guardian **(if the patient is a minor child)**

Mother _____ Father _____

Social Security # **(last 4 digits only)** _____

Marital Status **(Check One):** ☐ Single ☐ Married ☐ Widowed ☐ Divorced

EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone _____ Cell or Work # _____

INSURANCE INFORMATION

Person responsible for account (Patient or Guardian) _____

Street Address _____ City, State, Zip _____

Phone: Home _____ Cell _____

Please indicate if you have health insurance or if you are enrolled in any of the following insurance plans by checking the appropriate box below.

☐ Medicare ☐ Medicap ☐ Other Insurance (name of company) _____

Dr. Armond does not accept or file health insurance. However we will provide you with the necessary paper work to file your eligible insurance at your request. **I agree not to bill or ask Dr. Armond to bill Medicare or Medigap Insurance for his services.** Other supplemental plans may elect not to make payments for services not paid for by Medicare.

I will notify Dr. Armond's office if I obtain or become eligible for Medicare, Medicaid, or disability insurance.

Please Note: Everyone will be required by law to present a pictured ID. Please have your ID ready when presenting this form to staff.

Signature _____ Date _____

 Please feel free to request a copy of our Notice of Privacy Practices at any time.

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OFFICE POLICY

Dr. Armond is board certified in Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine. He draws on his vast repertoire of medical interventions to stimulate your body's ability to heal. In order to achieve optimal results, your participation is required and your willingness to adhere to treatment recommendations will enhance results.

Optimal treatment results depend in part on good communication between patient and doctor. If at any time during the treatment it becomes apparent to you that these modalities are not meeting your expectations, please discuss your concerns with Dr. Armond. Neither you nor Dr. Armond are under any obligation to continue the doctor-patient relationship if it is not mutually beneficial.

Neuromusculoskeletal and Osteopathic Manipulative Medicine techniques are effective treatments for many conditions. However, chronic conditions may take longer to respond to any type of intervention. No promise or guarantee of cure for any disease or condition is implied in any oral or written communication set forth by this practice.

Dr. Armond does **not** practice as a primary care physician. All patients are expected to have a Primary Care Physician for conventional medical treatments such as, but not limited to, prescriptions, screenings, X-rays, laboratory tests, ultrasound and/or surgery.

A new patient visit is $295.00 and can last up to one hour. Subsequent visits can cost from $145.00 to $230.00 (depending on the number of areas treated) and last approximately 30 to 60 minutes. Both new and established patients are solely responsible for paying for the cost of treatment upon arrival to office. Although we are happy to accept payment via phone, however, **payment must be received prior to appointment time.**

We would appreciate you being on time for appointments. If you are late, **we may need to abbreviate your appointment and if you are more than 15 minutes late we may need to reschedule**. Dr. Armond respects your time and makes every effort to stay on schedule. However, because he cannot anticipate what a person will need, he will take whatever time is necessary to treat each and every patient. If you are kept waiting, please know that you will receive the same commitment to excellence.

Please give **forty-eight hour notice** to change or cancel an appointment. Most of the time we have a waiting list of patients who would like to have an appointment. If an appointment has been reserved for you and is not kept, there is a **missed appointment fee of $75.00 for a half hour and $150.00 for an hour appointment** that will be charged. If an individual fails to keep an initial appointment, the full charge of $295.00 may be assessed before another appointment can be scheduled. We reserve the right to charge up to the full amount of a visit if a patient repeatedly misses or cancels without proper notice.

Please Note: This office does not deal with managed care or legal issues. If Dr. Armond or his staff are required to communicate either orally or in writing with an attorney, insurance company, etc., you will be billed a prorated fee for the time at his forensic rate of $250.00 per hour. This is NOT reimbursable by insurance.

Please be considerate of patients and staff who have allergies to perfume, cologne, essential oils, etc., and refrain from wearing them to your appointment.

We are honored and privileged to be part of your healthcare team.

I have read and understand the above paragraphs and have been given a copy to keep. I give consent to be treated. I accept the parameters of the treatments referenced and I am not expecting any treatment other than those described. Furthermore, I understand and agree that I am solely responsible for paying for my treatment(s) in full.

[redacted] [redacted]

Signature Date

Name_____ DOB_____ Date_____

Please describe your problem:_____

In what way is your problem limiting you? _____

What movements or activities make it worse? _____

What movements or activities make it better? _____

What medications and/or therapies have you tried? _____

Please list any imaging and/or procedures you have had for this problem: _____

Please describe any traumatic injuries you have sustained in your life, including motor vehicle accidents, falls, concussions and broken bones: _____

Confidential

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Conditions

Check (✓) conditions you currently have or have had in the past year.

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

Medications

List medications you are currently taking.

_____

_____

_____

_____

Pharmacy Name _____ Phone _____

Allergies

_____

_____

_____

_____

_____

Health History

Family History

Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which you use and how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

Occupational

Check (✓) if your work exposes you to:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed By — Date

Richard H. Armond, III, D.O.

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

A copy of the Privacy Practices of **Richard H. Armond III, D.O.** has been made available to me.

_____ _____

Patient/Parent/Guardian Signature Date

Copy has been accepted_____
Patient/Parent/Guardian initials