The HFM Zone
HEALTH • FITNESS • MOTIVATION
HARRISONVILLE FAMILY MEDICINE

Thank you for scheduling with The HFM Zone! We would like to give you an overview of what you can expect at your initial visit with us.

The HFM Zone is a one-year wellness program focused on health, fitness, and motivation. This is where you come to assess your health and work to prevent serious chronic illnesses that are more common as we age, such as: heart disease, diabetes, or cancer. Individual goals will be set and together we will work toward reaching those goals. What sets The HFM Zone apart from other medical practices is our concentration on wellness.

Unlike traditional doctor visits, which are generally very short, the initial The HFM Zone appointment will be extensive and lengthy. Your visit will last approximately two and a half to three hours. It will include a consultation with Dr. Holden, during which you will discuss your previous medical history, any current health concerns, and he will listen to goals you would like to reach within this year long program.

After seeing Dr. Holden, you will have the following tests performed:

Bioscan – A full body scan that shows body fat and muscle mass percentages to get an understanding of your body's composition. We will use this as the starting point and do this test again over the next 1 year to verify your body's composition is changing.

Antioxidant Screen – This test measures antioxidants, the first line of defense against disease. It will show your personalized Skin Carotenoid Score, which is a general indication of your overall antioxidant status. We will do this test again over the next 1 year to verify your anti-oxidant score is improving.

Bio-Energy Testing – – Bio-Energy Testing involves the use of a device connected to a computer that is able to measure how much oxygen the body uses and how much carbon dioxide the body is producing at a given time. A series of measurements are taken at rest and during a progressively more difficult exercise program. This test will tell us your resting and maximal mitochondrial efficiency and your resting and maximal fat metabolism.

EKG – This is a noninvasive test that is used to reflect underlying heart conditions by measuring the electrical activity of the heart. Information about many heart conditions can be learned by looking for characteristic patterns on the EKG.

****You will also have comprehensive labs drawn. These lab tests will require you to be fasting for 10-12 hours. *It is ok to drink water and take meds the morning of testing. * Please drink lots of water the day before so you will be well hydrated.**

Please wear comfy clothes to your appointment. Also, please avoid wearing any metal on clothing, and no jewelry. (This will save a little bit of time in the process.)**

It will be necessary for you to read, complete, and return all paperwork we have included in this packet.

We will schedule your follow-up appointments at each visit. Dr. Holden will see you back in two weeks to discuss all your test results. You will receive his recommendations and treatment plan at this time. At this point, you can then decide to continue with us or take his recommendation with no further commitment. How often you are seen after this will depend on what treatment is recommended. *For instance, patients focusing on weight loss will be seen more often than patients being seen for hormone replacement therapy.* You will alternate seeing Dr. Holden and Amy Gibbens-Nurse Practitioner every other visit.

When you approach the end of your first year, you will be offered the opportunity to extend your commitment for another year. **We will collect the Yearly Scan Fee at that time.** Should you decide to continue, a complete re-evaluation will be done. We will see how close you are to meeting your goals. We will perform another full body scan and antioxidant screening, along with a complete physical. These results will be side by side with those from your first visit. With a re-evaluation, we can determine how to proceed as we continue your journey to great health.

We look forward to seeing you soon!

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Appointment Checklist

To ensure proper check-in, we have designed this checklist to help you remember what time to check-in and what to bring with you to your first HFM Zone appointment.

****Arrive 30 Minutes Early for Check-In ** Check-In Time: _____ am**

- ☐ ****All Zone Paperwork MUST be Completed and Brought to Appointment**

  This paperwork is vital to this first visit and must be completed ahead of time**
- ☐ Come Fasting 10-12 Hours (nothing to eat or drink besides water)
- ☐ Please take all prescription meds as normal but hold vitamins and supplements the day of only.
- ☐ Bring Your Photo ID and Insurance Card/Cards
- ☐ Have Your Zone Payment of _____ Ready at the Time of Service
- ☐ Sign up for Our Patient Portal and join our Facebook Group

(For quicker/easier access, please sign up for our HFM Patient Portal. You can request appointments and leave messages all through the easy-to-use patient portal.)
Just go to harrisonvillefamilymedicine.com and the link to sign up is in the top right corner.
To join our HFM Zone Facebook Group, please go to https://www.facebook.com/groups/1445499530311 55.

****Please give us a call if you have not received your paperwork packet before your visit. If the paperwork is not completed by check-in time, your appointment MUST be rescheduled.****

We can't wait to see you at your appointment!

Please give us a call at (816) 380-3582 if you have any last minute questions!

The HFM Zone
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HFM Zone Financial Agreement

Thank you for choosing The HFM Zone for your health care needs. We are committed to providing the best possible care. Please understand that management of your billing is important in ensuring that we can continue to take care of your health care needs. Please read the following information carefully and sign where noted below.

By executing this agreement, you are agreeing to pay for all services that are received.

Many of the labs and tests done as part of the Zone program are for screening purposes. These tests are NOT considered medically necessary and therefore may not be covered by your insurance.

The $750 yearly program fee must be paid in full by the date of service, or you can set up a monthly payment plan. Payments may be arranged but must be paid in full within 3 months of starting the program. If a balance occurs and is not paid at the time of visit, future visits will not be scheduled until the balance is paid in full.

By signing this agreement, I understand that I am completely and fully responsible to pay any balance that my insurance company may leave to my responsibility and future visits will not be scheduled until the balance is paid in full.

If there are any charges not covered by Medicare or Medicare replacement policies, I understand that I am completely and fully responsible to pay any amount that may be left to my responsibility.

Patient Signature:_____ Date:_____

Revised 3/25/21

Harrisonville Family Medicine, Inc.

Financial Policy

Effective Date: 7/1/2019

Thank you for choosing Harrisonville Family Medicine as your healthcare provider. Please read the following information carefully. This is an agreement between Harrisonville Family Medicine, Inc., as creditor, and the patient / debtor / responsible party. By executing this agreement, you are agreeing to pay for all services that are received.

Contracted Insurance: You are expected to pay deductibles and co-payments at the time of service. You must also pay outstanding balances prior to being seen in the office. **If you are not able to resolve an outstanding balance or pay the copay due before your next appointment, please be aware that your appointment will need to be rescheduled until your balance is paid in full or reasonable payment arrangements are made. If your appointment is rescheduled due to non-payment at time of check in there will be a $40 no show fee applied.** The deductible will be collected until your yearly deductible has been reached. It is your responsibility to know what is and what is not covered under your plan. It is the insurance company that makes the final determination of your eligibility and coverage. **You will be responsible for any and all charges not covered by your insurance company.**

Self-Pay Patients: Payment is expected at the time of service. If you cannot pay at the time of service, your appointment will be rescheduled.

Monthly Statements: If you have a balance of $10.00 or more on your account, we will send a monthly statement. **Please remember when you receive our statement you have already received quality care from your physician, your insurance has been filed and any payment or adjustment from your insurance company has been applied. The balance on your account is due and payable when the statement is issued.**

Past Due Accounts: Balances that remain on your account past 45 days are considered overdue and full payment will be expected at future appointments unless a payment plan has been arranged and approved by our billing department. Accounts over 90 days in arrears will be sent to our collection agency. At that point, for any new charges to be added to your account our office will require a credit card on file. Once an account has been placed in collections, the physician/patient relationship could be terminated, and your records will be transferred to a physician of your choice. If your balance is paid after termination has taken effect, reinstatement will involve a fee of $25. **If a balance occurs on the account again, this will result in FINAL TERMINATION and reinstatement will not be an option.**

Forms & Fees: Your portion of any form must be filled out completely before submitting it to us. A fee will be charged and collected when your form is returned to you or submitted on your behalf.

No Show Policy: A $40 fee will be charged for any missed appointment without 24-hour notice. This is not covered by insurance and must be paid prior to your next appointment. Multiple no shows in any 12-month period could result in termination from our practice.

Print Name:_____ **Signature:**_____ **Date:**_____

Revised 10/14/2021

As a courtesy, to our HFM Zone patients, the following policy will become effective September 2, 2013

THE HFM ZONE

Late Appointment /Cancellation / No Show Policy

1. *Late Appointments*

We understand delays can happen, however, we must try to keep other patients and the doctor on time. If you arrive 10 minutes past your scheduled time, we will ask that you reschedule your appointment.

2. *Appointment Cancellations*

When you do not call to reschedule/cancel an appointment, you are preventing another patient from receiving treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" schedule. We ask that you give at least 24 hours in advance notice to reschedule an appointment or for appointment cancellations.

3. *No Show Appointments*

If your appointment is not cancelled AND you have previously "no showed" more than one appointment, you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company and must be paid prior to your next appointment.

My signature below indicates that I understand the above cancellation/no show policy for my appointments with Dr. Holden through The HFM Zone program. If I am unable to keep my scheduled appointment, I will reschedule or cancel within 24 hours. If I am a "no-show" appointment more than once, I understand a charge of $50.00, will be applied to my account.

_____ _____

Patient Signature Date

Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Last Name:
First Name:
Middle Name:
Address:
City: State:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Sex:
Date of Birth:
Social Security No.:
Patient email:
Required by government mandate [although you may refuse]:
Language:
Race:
Ethnicity:
Marital Status:

Other

Patient Referred by:

Primary Care Provider:

Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email

Guarantor Information (to whom statements are sent)

Name:
Address:

Relationship to patient: _____
Date of Birth:
Social Security No.:
Phone: ( ) _____ - _____

Emergency Contact Information

Name:
Relationship:
Phone:
Mobile Phone:( ) _____ - _____

Employer Information

Employer:
Address:
Phone:

Pharmacy Information:

Name:

Crossroads:

Phone:

Primary Insurance Information

Insurance Plan Name:
Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): M or F
Employer Name:
Patient's relationship to policy holder:

Secondary Insurance Information

Insurance Plan Name:
Last Name:
First Name.:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): M or F
Employer Name:
Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed_____ Date:_____

Please sign and date each item below

ACKNOWLEDGEMENT AND AUTHORIZATION:

- I have read and understand the HIPAA/Privacy Policy for HARRISONVILLE FAMILY MEDICINE INC

Signed_____ Date:_____

- I hereby assign my insurance benefits to be paid directly to the healthcare provider

Signed_____ Date:_____

- I authorize HARRISONVILLE FAMILY MEDICINE INC to release medical information required to process my claim

Signed_____ Date:_____

- I have read and understand the Financial Policy for HARRISONVILLE FAMILY MEDICINE INC

Signed_____ Date:_____

- I authorize HARRISONVILLE FAMILY MEDICINE INC to obtain/have access to my medication history

Signed_____ Date:_____

- I authorize my provider's office to contact me by mobile phone

Signed_____ Date:_____

Harrisonville Family Medicine, Inc,

Privacy Consent Form

(Check all that apply)

_____ Myself

_____ Spouse: _____

Family Member:

_____ ALL Adult Family Members

_____ ONLY: _____

_____ Parent or Family Member (For Minor Child)

Mother: _____

Father: _____

_____ May leave a detailed message on answering machine / voicemail

_____ NO Details on answering machine / voicemail – Only to call office

_____ Email: _____

_____ Consent to text (i.e. appt reminders, office closure due to weather or holidays, etc.)

_____ Other: _____

Note: It is your responsibility to notify HFM of any changes that need to be made to this form.

I acknowledge that by signing below, that I authorize Harrisonville Family Medicine, Inc. to disclose any information related to my / my child's care, with the choices I have indicated above. I also acknowledge that I have received and read a copy of HFM Notice of Privacy Practices.

_____ _____

Patient / Personal Representative Date

_____ _____

Relationship to Patient Witness

REVISED 11/10/2016

Past Medical History Form

Gastrointestinal
Ulcer
Colon Polyps
Colon Infections
Diverticulosis
Diverticulitis
Acid Reflux
Hepatitis
Liver Disease
Irritable Bowel
Crohn's

Endocrine
Elevated Thyroid Levels
Low Thyroid Levels
Diabetes Type I
Diabetes Type II

Pulmonary
Environmental Allergies
Chronic Lung Disease
Chronic Bronchitis
Chronic Sinusitis
Asthma
Sleep Apnea

Musculoskeletal
Low Back Pain
Gout
Rheumatoid Arthritis
Osteoporosis
Osteoarthritis
Fibromyalgia

Cardiovascular
Coronary Artery Disease
Atrial Fibrillation
Previous Heart Attack
Elevated Blood Pressure
Hyperlipidemia
Blood Clot
Congestive Heart Failure

Genitourinary
Kidney Stones
Chronic Kidney Disease
Urinary Tract Infections

NeuroPsych
Seizure Disorder
Stroke
Attention Deficit Disorder
Depression
Anxiety
Dementia
Alzheimer's
Bipolar Disorder
Migraine Headache

Miscellaneous
Anemia
HIV Infection
Glaucoma

Social History
Smoking Status:
Current
How Often?
Former
Quit Date?
Never
Alcohol Use

Male
Elevated PSA
Erectile Disorder
Prostate Enlargement

Female
LMP
Last Pap Smear
History of Abnl Paps
# of Pregnancies
Contraception
Sexually Active

Personal History of Cancer
Brain Cancer
Thyroid Cancer
Breast Cancer
Colon Cancer
Lung Cancer
Prostate Cancer
Leukemia
Lymphoma
Ovarian Cancer
Cervical Cancer
Uterine Cancer
Kidney Cancer

Family Medical History

	Relationship
Heart Attack	
High Blood Pressure	
Heart Disease	
Heart Failure	
Blood Clots	
Asthma	
Chronic Lung Disease	
Cancer	
Type:	
Diabetes	
Depression	
Anxiety	
Mental Illness	
Alcoholism	
Alzheimer's	
Seizure Disorder	
Migraine Headaches	
Stroke	
Kidney Disease	

Past Surgical History
Cardiovascular
Aneurysm Repair
Heart Bypass Surgery
Carotid Artery Surgery
Heart Valve Replacement
Pacemaker
Defibrillator
Stent Placement

Musculoskeletal
Hip Replacement
Knee Surgery
Knee Replacement
Shoulder Surgery
Rotator Cuff Repair
Carpel Tunnel
Lower Back Surgery
Neck Surgery

Genitourinary
Kidney Removal
Kidney Stone Surgery
Vasectomy
Prostate Surgery

Gastrointestinal
Appendectomy
Gallbladder Removal
Colectomy
Colostomy
Ileostomy
Weight Loss Surgery
Hemorrhoid Surgery
Pancreas Surgery
Spleen Removal

Hernia Repair
Incisional
Inguinal
Umbilical
Abdominal

Other
Lung Surgery
Thyroid Surgery
Cateract Surgery
Ear Tubes
Tonsillectomy
Adenoidectomy

OB/Gyn
Total Abd. Hysterectomy
With Ovary Removal
Vaginal Hysterectomy
Tubal Ligation
Cesarean Section
Mastectomy
Lumpectomy
Breast Augmentation
Breast Reduction

Revised 5-14-20

THE HFM ZONE

Name: _____ Appointment: _____

Health History Circle all that apply

High blood pressure	Breast cancer	Surgeries:
Heart attack	Ovarian cancer	Gallbladder
Heart stent	Prostate cancer	Appendix
Heart bypass surgery	Colon cancer	Cataracts
Atrial fibrillation	Endometrial cancer	Sinus
Aneurysm	Other cancers:	Thyroid
Peripheral arterial disease		Shoulder surgery
Carotid artery disease	Irritable bowel	Knee surgery
Stroke/TIA	Interstitial cystitis	Low back surgery
High cholesterol	Fibromyalgia	Neck surgery
Diabetes	Migraine headaches	Hip surgery
Sleep apnea		Hysterectomy
Depression	Reflux	Do you still have ovaries? Y/N
Anxiety	COPD	Mastectomy
Chronic kidney disease	Asthma	Carpal tunnel
Auto-immune disease	Other:	Bariatric surgery
Blood clots		
Liver disease		

Social Smoking: current past never Alcohol: none / occasional / daily

Testing: Please provide date or approximate if unknown

Colonoscopy_____ Mammogram_____ Bone density_____ Pap Smear _____

Echocardiogram_____ Stress Test_____ PSA _____ Carotid Doppler_____

Family History: circle all that apply

Colon cancer	Heart disease	Diabetes	Alzheimers/dementia
Parkinson's disease	Prostate cancer	Breast cancer	Mental illness

Other:

THE HEM ZONE

Intake Form

Symptoms

Fatigue	Y / N	Do you get up at night to urinate?	Y / N
Excessive daytime sleepiness	Y / N	Pain on urination	Y / N
Cold hands/feet	Y / N	urinary incontinence	Y / N
Cold intolerance	Y / N	Recurrent urinary infections	Y / N
Decreased body temperature	Y / N	Trouble with starting or stopping stream	Y / N
Chest pain	Y / N	Joint pains	Y / N
Shortness of breath	Y / N	Muscle aches	Y / N
Heart palpitations	Y / N	Muscle cramp	Y / N
Leg pain with activity	Y / N	Muscle weakness	Y / N
Swelling in legs	Y / N	Muscles decreasing in size	Y / N
Fluid retention	Y / N	Low back pain	Y / N
Puffy face in morning	Y / N	Hip pain	Y / N
		Leg aches	Y / N
		Knee pain	Y / N
Heartburn	Y / N	Shoulder pain	Y / N
Bloating	Y / N		
Nausea	Y / N	Acne	Y / N
Constipation	Y / N	Dry skin	Y / N
Diarrhea	Y / N	Thin/brittle fingernails	Y / N
		Thickened skin, especially heels	Y / N
Trouble sleeping	Y / N	Dry or thinning hair	Y / N
Do you snore?	Y / N	Loss of or thinning eyebrows	Y / N
Do you stop breathing at night?	Y / N	Hair Loss	Y / N

THE HFM ZONE

Symptoms (continued)

Decreased concentration	Y / N	Hot Flashes	Y / N
Memory concern or loss	Y / N	Night sweats	Y / N
Dizziness	Y / N	Decreased libido/sex drive	Y / N
Headaches	Y / N	Breast tenderness	Y / N
Numbness in arms/legs/feet/hands	Y / N	Excessive facial or body hair	Y / N
Tingling in arms/legs/feet/hands	Y / N	Vaginal dryness	Y / N
		Regular menses	Y / N
Depressed mood	Y / N	Irregular menses	Y / N
Anxiety	Y / N	Mid-cycle bleeding	Y / N
Agitation	Y / N	Heavy menstrual bleeding	Y / N
Feeling nervous	Y / N	Post-menopausal	Y / N
Racing thoughts	Y / N	Fibrocystic breasts	Y / N
Anger	Y / N	Irritable before menses	Y / N
Low self-esteem	Y / N	Emotional before menses	Y / N
Mood swings	Y / N	Weight gain/inability to lose	Y / N
Hypersensitive/Overly emotional	Y / N		

Through The HFM Zone program, Dr. Holden's attention will focus on wellness only. Issues addressed within the Zone program will include cardiac risk reduction, diabetes, weight loss, fatigue, motivation, nutrition and exercise, along with bio-identical hormone replacement therapy.

It is important for you to have a primary healthcare provider who will oversee your primary care and any acute health issues. Typical acute or primary health issues may include: sinusitis, bronchitis, asthma, low back pain, knee pain, flu symptoms, stomach virus. You should contact or schedule with your primary care provider for any "traditional" healthcare needs.

Tell us, who is your primary healthcare provider?_____

Current Medication or Supplements List

Date: _____

Patient Name: _____ Date of Birth: _____

Medication or Supplement Name	Strength	Dose	Frequency
Example: Vita D3	5,000iu	2 tablets	1 Morning, 1 Evening

Allergy to Medications List

Date: _____

Patient Name: _____ Date of Birth: _____

Name of Medication: Ex: Amoxicillin	**Reaction to Medication:** Ex. Rash

HARRISONVILLE FAMILY MEDICINE

2820 E. Rock Haven Road, Ste 100
Harrisonville, MO 64701
Phone (816) 380-3582 Fax (816) 380-6964

Patient Name | Social Security Number | Date of Birth

Releasing records *FROM:* _____
(physician or organization name)

_____
(mailing address, phone and fax number)

Releasing records *TO:* _____
(physician or organization name)

_____
(mailing address, phone and fax number)

Please select only ONE of the following: I give my permission to release the following records to the above stated entity: (include dates where appropriate)

_____ Confined to records for the time period of: _____

_____ Confined to records regarding the specific information: _____

_____ All records without regard to limitations placed on dates, history of illness, or diagnostic and therapeutic information, including AIDS testing or diagnosis, information or treatment for alcohol, drug abuse, and testing and diagnosis of psychiatric illness.

For the purpose of: _____

This authorization is voluntary. This authorization will expire _____ (e.g. 60 days) from the date of my signature below. I understand that I may revoke this authorization at any time by notifying the office in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. I agree to waive all claims against the office for the release of the requested information. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the office if the recipient of the information is not a health plan, health care provider, health clearinghouse, or a business associate that has a contract with the office. I understand that I must provide the office with at least twenty-four (24) hours notice before coming to the facility to review records. I understand that after I have reviewed the records, I must provide the office with two (2) working days advance notice of any copies of the records that I would like to pick up at the office. I understand that if I request that records be copied and sent to me that the office will send those records to me within thirty (30) days. I understand that if I wish to have copies of records made, then the office will assess a fee for copying the records. The facility will notify me of the total amount due for copying and shipping of the requested records. I agree that the office will only send me the requested information once payment has been received in full for those costs. I understand that once the requested records leave HFM, they are the responsibility of the patient/ recipient. I understand that I have the option to have these records copied to a data disc, or an electronic copy can be made. The patient/ recipient will be responsible for providing a flash drive for the electronic copy.

_____
Signature of Patient or Legal Representative | Date

_____
If Signed by Legal Representative, Relationship to Patient | Signature of Witness

Patient Name: _____ Patient DOB: ___/___/_____ Date:

Wellness Update

Do you experience any of these symptoms?	*Yes*	*No*
Runny Nose		
Itchy Nose		
Stuffy Nose		
Itchy Eyes		
Watery Eyes		
Frequent Sneezing		
Itchy Mouth/Lips/Throat		
Post Nasal Drip (drainage down the back of the throat, clearing throat)		

How often do you experience these symptoms?

- ☐ Occasionally (2-3 times per year)
- ☐ Over 3 times a year
- ☐ A few long periods of time per year (Spring, Summer, Fall, Winter)
- ☐ Most of the year

Do you take prescription or over-the-counter (OTC) medications for the management of your allergy symptoms? ☐ Yes ☐ No

If yes, name of medication and last date taken: _____

Please indicate below symptoms/conditions you've experienced during the last 1 – 2 years

- ☐ Sinus related issues (sinus pressure/pain, headaches, sinusitis)
- ☐ Re-occurring Seasonal Colds
- ☐ Chronic colds (lasting longer than 2 months)
- ☐ Migraine Headaches
- ☐ Restless sleep, challenges sleeping through the night, snoring
- ☐ Consistent or Re-occurring coughing
- ☐ Feeling of fatigue, irritability, & restlessness
- ☐ Asthma
- ☐ Skin conditions (dry and/or itchy skin, etc...)

Patient/Guardian Signature: _____ **Date:** ___/___/_____

Patient Phone: _____

FOR PROVIDER USE ONLY:

Order Allergy Test: ☐ Yes ☐ No

Date of last ENT exam: ___/___/_____

Provider Signature: _____ **Date:** ___/___/_____