

# Welcome to Metta Health Care!

**We look forward to seeing you. Please review the following items before you start your paperwork! See you soon!**

- Please use a pen to fill out your paperwork. You may bring the paperwork with you to your appointment (please DO NOT mail it back).
- If you have specific questions/concerns you want Dr. Huycke to address, it would be very helpful for you to write them down and bring them with you to your appointment.
- Please bring a complete list of all Pharmaceutical medications and natural supplements you are currently taking.
- If you intend to cancel your appointment, please call us as soon as possible giving us a least 24-hours notice.

**Directions to Metta Health Care, Ann Huycke, MD (4501 N. Alamosa Street, Boise, ID, 83703, Phone 208.658.5570):**

- **From I-184 the connector:** Take the Curtis Road Exit and turn North. Curtis Road turns into Veteran's Parkway. Turn left at State St. then go through the next stop light (Willow Street) then turn left (South) onto W. Alamosa Street. After you turn left onto W. Alamosa Street we are the first driveway on the left.
- **From Eagle:** Take State Street East toward downtown Boise. After Collister, W. Alamosa Street will be the second street on your right. Turn right (South) onto W. Alamosa Street. After you turn right onto W. Alamosa Street we are the first driveway on the left.
- **From Downtown Boise:** Take State St. West toward Eagle. Pass through the stop light at Veterans Parkway and State Street. One block past Willow Street then turn left (South) onto W. Alamosa Street. We are the first driveway on the left.

**Metta Health Care | Ann Huycke M.D.**

4501 N. Alamosa Street • Boise, ID 83703 • Phone (208) 658-5570 • Fax (208) 658-6811 • [www.DrAnnHuycke.com](http://www.DrAnnHuycke.com)

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**PATIENT INFORMATION**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Message Phone: \_\_\_\_\_

Preferred number where messages can be left

E-mail Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Spouse Name and Phone Number:  
\_\_\_\_\_

Emergency Contact and Phone Number:  
\_\_\_\_\_

Whom may we thank for your referral?  
\_\_\_\_\_

Reason for visit?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Date of last physical examination: \_\_\_\_\_  
 What is your reason for visit? \_\_\_\_\_

**~ Symptoms ~**

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

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| <p><b>GENERAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chills</li> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Fainting</li> <li><input type="checkbox"/> Fever</li> <li><input type="checkbox"/> Forgetfulness</li> <li><input type="checkbox"/> Headache</li> <li><input type="checkbox"/> Loss of sleep</li> <li><input type="checkbox"/> Loss of weight</li> <li><input type="checkbox"/> Nervousness</li> <li><input type="checkbox"/> Numbness</li> <li><input type="checkbox"/> Sweats</li> </ul> <p><b>MUSCLE/JOINT/BONE</b><br/>Pain, weakness, numbness in:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Arms      <input type="checkbox"/> Hips</li> <li><input type="checkbox"/> Back      <input type="checkbox"/> Legs</li> <li><input type="checkbox"/> Feet      <input type="checkbox"/> Neck</li> <li><input type="checkbox"/> Hands      <input type="checkbox"/> Shoulders</li> </ul> <p><b>GENITO-URINARY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blood in urine</li> <li><input type="checkbox"/> Frequent urination</li> <li><input type="checkbox"/> Lack of bladder control</li> <li><input type="checkbox"/> Painful urination</li> </ul> | <p><b>GASTROINTESTINAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Appetite poor</li> <li><input type="checkbox"/> Bloating</li> <li><input type="checkbox"/> Bowel changes</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Excessive hunger</li> <li><input type="checkbox"/> Excessive thirst</li> <li><input type="checkbox"/> Gas</li> <li><input type="checkbox"/> Hemorrhoids</li> <li><input type="checkbox"/> Indigestion</li> <li><input type="checkbox"/> Nausea</li> <li><input type="checkbox"/> Rectal bleeding</li> <li><input type="checkbox"/> Stomach pain</li> <li><input type="checkbox"/> Vomiting</li> <li><input type="checkbox"/> Vomiting blood</li> </ul> <p><b>CARDIOVASCULAR</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chest pain</li> <li><input type="checkbox"/> High blood pressure</li> <li><input type="checkbox"/> Irregular heart beat</li> <li><input type="checkbox"/> Low blood pressure</li> <li><input type="checkbox"/> Poor circulation</li> <li><input type="checkbox"/> Rapid heart beat</li> <li><input type="checkbox"/> Swelling of ankles</li> <li><input type="checkbox"/> Varicose veins</li> </ul> | <p><b>EYE, EAR, NOSE, THROAT</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bleeding gums</li> <li><input type="checkbox"/> Blurred vision</li> <li><input type="checkbox"/> Crossed eyes</li> <li><input type="checkbox"/> Difficult swallowing</li> <li><input type="checkbox"/> Double vision</li> <li><input type="checkbox"/> Earache</li> <li><input type="checkbox"/> Ear discharge</li> <li><input type="checkbox"/> Hay fever</li> <li><input type="checkbox"/> Hoarseness</li> <li><input type="checkbox"/> Loss of hearing</li> <li><input type="checkbox"/> Nose bleeds</li> <li><input type="checkbox"/> Persistent cough</li> <li><input type="checkbox"/> Ringing in ears</li> <li><input type="checkbox"/> Sinus problems</li> <li><input type="checkbox"/> Vision - Flashes</li> <li><input type="checkbox"/> Vision - Halos</li> </ul> <p><b>SKIN</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bruise easily</li> <li><input type="checkbox"/> Hives</li> <li><input type="checkbox"/> Itching</li> <li><input type="checkbox"/> Change in moles</li> <li><input type="checkbox"/> Rash</li> <li><input type="checkbox"/> Scars</li> <li><input type="checkbox"/> Sore that won't heal</li> </ul> | <p><b>MEN only</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Breast lump</li> <li><input type="checkbox"/> Erection difficulties</li> <li><input type="checkbox"/> Lump in testicles</li> <li><input type="checkbox"/> Penis discharge</li> <li><input type="checkbox"/> Sore on penis</li> <li><input type="checkbox"/> Other</li> </ul> <p><b>WOMEN only</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Abnormal pap smear</li> <li><input type="checkbox"/> Bleeding between periods</li> <li><input type="checkbox"/> Breast lump</li> <li><input type="checkbox"/> Extreme menstrual pain</li> <li><input type="checkbox"/> Hot flashes</li> <li><input type="checkbox"/> Nipple discharge</li> <li><input type="checkbox"/> Painful intercourse</li> <li><input type="checkbox"/> Vaginal discharge</li> <li><input type="checkbox"/> Other</li> </ul> <p>Date of last menstrual period _____<br/>       Date of last Pap Smear _____<br/>       Have you had a mammogram? _____<br/>       Are you pregnant? _____<br/>       Number of children _____</p> |
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**~ Conditions ~**

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

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| <ul style="list-style-type: none"> <li><input type="checkbox"/> AIDS</li> <li><input type="checkbox"/> Alcoholism</li> <li><input type="checkbox"/> anemia</li> <li><input type="checkbox"/> Anorexia</li> <li><input type="checkbox"/> Appendicitis</li> <li><input type="checkbox"/> Arthritis</li> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Bleeding Disorders</li> <li><input type="checkbox"/> Breast Lump</li> <li><input type="checkbox"/> Bronchitis</li> <li><input type="checkbox"/> Bulimia</li> <li><input type="checkbox"/> Cancer</li> <li><input type="checkbox"/> Cataracts</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Chemical Dependency</li> <li><input type="checkbox"/> Chicken Pox</li> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Emphysema</li> <li><input type="checkbox"/> Epilepsy</li> <li><input type="checkbox"/> Glaucoma</li> <li><input type="checkbox"/> Goiter</li> <li><input type="checkbox"/> Gonorrhea</li> <li><input type="checkbox"/> Gout</li> <li><input type="checkbox"/> Heart Disease</li> <li><input type="checkbox"/> Hepatitis</li> <li><input type="checkbox"/> Hernia</li> <li><input type="checkbox"/> Herpes</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> High Cholesterol</li> <li><input type="checkbox"/> HIV Positive</li> <li><input type="checkbox"/> Kidney Disease</li> <li><input type="checkbox"/> Liver Disease</li> <li><input type="checkbox"/> Measles</li> <li><input type="checkbox"/> Migraine Headaches</li> <li><input type="checkbox"/> Miscarriage</li> <li><input type="checkbox"/> Mononucleosis</li> <li><input type="checkbox"/> Multiple Sclerosis</li> <li><input type="checkbox"/> Mumps</li> <li><input type="checkbox"/> Pacemaker</li> <li><input type="checkbox"/> Pneumonia</li> <li><input type="checkbox"/> Polio</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Prostate Problem</li> <li><input type="checkbox"/> Psychiatric Care</li> <li><input type="checkbox"/> Rheumatic Fever</li> <li><input type="checkbox"/> Scarlet Fever</li> <li><input type="checkbox"/> Stroke</li> <li><input type="checkbox"/> Suicide Attempt</li> <li><input type="checkbox"/> Thyroid Problems</li> <li><input type="checkbox"/> Tonsillitis</li> <li><input type="checkbox"/> Tuberculosis</li> <li><input type="checkbox"/> Typhoid Fever</li> <li><input type="checkbox"/> Ulcers</li> <li><input type="checkbox"/> Vaginal Infections</li> <li><input type="checkbox"/> Venereal Disease</li> </ul> |
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**~ Medications ~** List medications you are currently taking.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**~ Allergies ~**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



# Metta Health Care - Additional Questions

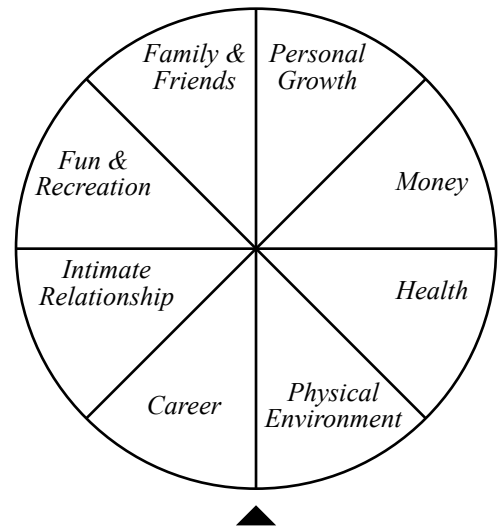
NAME: \_\_\_\_\_

- Do you eat MSG? Yes / No
- Do you eat texturized vegetable protein? (Meat substitute for vegetarians) Yes / No
- Do you drink tap water? Yes / No
- Do you eat beef? Yes / No
- Do you eat fish? Yes / No
- Do you have allergies or reactions associated with Latex or rubber products? Yes / No
- Do you have a history of autoimmune or congenital urological disorders? Yes / No
- Do you have multiple allergic reactions requiring injections? Yes / No
- Do you have food allergies related to bananas, kiwi or avocado? Yes / No
- Do you sleep under an electric blanket? Yes / No
- Do you sleep with an electric alarm clock/radio near your head? Yes / No
- Do you use a microwave to heat your food? Yes / No

Do you use any of the following products?

- Soda Yes / No
- Coffee Yes / No
- Tea Yes / No
- Nutra-sweet Yes / No
- Saccharine Yes / No
- Deodorant/Antiperspirant(circle one) Yes / No
- Soy Yes / No

- Do you use a cell phone? Yes / No
- Do you use portable phones? Yes / No
- Do you use WiFi? Yes / No \_\_\_\_\_ at Home \_\_\_\_\_ at Work
- Do you exercise? Yes / No \_\_\_\_\_ Daily \_\_\_\_\_ Weekly
- Exercise makes me feel better/worse.
- Cravings: \_\_\_\_\_
- Last cholesterol test: \_\_\_\_\_
- Last triglyceride test: \_\_\_\_\_
- Do you have exposure to or concern about AIDS?
- Do you have concerns about abuse?



How do you feel about these areas in your life?  
 On a scale from 1-10, please rate these items.  
 1 = I don't like this much  
 10 = I feel great about this

What is your religion? \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

How many hours a day do you:

Watch TV \_\_\_\_\_ Listen to your stereo \_\_\_\_\_ Play video or computer games \_\_\_\_\_

WOMEN: How many hours a day do you wear a bra? \_\_\_\_\_  
 Last pap test: \_\_\_\_\_  
 Last Mammogram: \_\_\_\_\_

PLEASE MAKE A SEPARATE LIST OF MEDICATIONS, SUPPLEMENTS and VITAMINS THAT YOU ARE CURRENTLY TAKING. THANK YOU!

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# FINANCIAL POLICY

We are committed to providing you with the best health care possible. Your clear understanding of our Financial Policy is important to our professional relationship. Therefore, we wish to clarify the following points:

Beginning on and continuing after October 1, 2003, the office of Ann Huycke, MD is serving you on a "Cash-Only" basis **(Checks, Master Card/Visa Credit and Debit Cards, Money Orders and Cash are acceptable)**. *Submittal of claims and collection of payment from your insurance company will be the responsibility of the patient.*

**Payment for your office visits are due at the time of service** by our office manager. The new adult patient will usually be charged \$200.00. Usual fees for new cancer patients will be \$250.00, which includes an extended new patient consultation. New patient visits for children are normally \$185.00 or less. (These charges are typical with the exception of extremely brief or extremely comprehensive appointments. Generally all charges in the office are billed according to time spent with Dr. Huycke).

Follow up visits range from \$110.00 - \$150.00. We require that you pay for all follow up visits at the time of service.

Lab tests are generally billed to you on the date of service. Lab tests that are not billed to you at the time of service will be billed to you within 45 days. When they are billed, payment is due upon receipt.

If Dr. Huycke provides you with natural medicine (in-house stock or ordered), you are required to pay for it before you leave the office.

We ask that you please be prepared to make your agreed payment at each office visit. All overdue and unpaid balances may be referred to Bonneville Collections without notification to you.

Thank you for your understanding and cooperation.

**I understand and agree to the above information.**

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**Signature**

**Date**

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**Print Name**

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# MEDICAID/MEDICARE EXCLUSION AGREEMENT

Metta Health Care/Ann Huycke, MD ceased to be a Medicaid or Medicare or provider September 30, 2003. By law, we are able to provide medical services to Medicaid or Medicare beneficiaries only if they enter into a contractual agreement acknowledging that they fully understand:

- Medicaid will not reimburse you for any of our services.
- Medicaid cannot be billed for any of our services, by Dr Huycke or you. This means that you will get a special invoice for each visit to Dr Huycke. The invoice will not be paid by Medicaid, Medicare, Medigap or a supplemental carrier.
- You are financially liable for all of our charges for services rendered to you by Dr Huycke.
- We are not binded to Medicaid’s or Medicare’s fee schedule.
- You are free, at any time, to seek services of a Medicaid or Medicare provider.

I, \_\_\_\_\_, a Medicaid or Medicare beneficiary, have read and understood all the above terms and conditions and agree to accept them in full, as a requirement for medical treatment by Metta Health Care/Ann Huycke, MD.

*I am not a Medicare or Medicaid recipient but I understand that Dr. Huycke is not a Medicaid or Medicare provider.*

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**Beneficiary/patient**

**Date**

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# INFORMED CONSENT

**Integrative Health:** I acknowledge and understand that Dr. Huycke and staff members provide nutritional and other health related information to help me attain and maintain my best health. Doctor Huycke uses alternative therapies to compliment traditional treatments for cancer, auto immune disease, etc. It is assumed that you maintain your medical relationship with your Oncologist, rheumatologist or other specialist. Dr. Huycke can help enhance your health using natural substances even if you are on western medications, chemotherapy or radiation.

**Office Fees:** The office visit fee for Dr. Huycke is \$200.00 the first hour, prorated for actual time spent with the patient. If you are late it is included in the hour. Follow-up appointments are usually recommended at 1 to 8 week intervals and average 30 minutes or less per session, depending on each patient's needs and concerns. We accept credit cards and local checks. Note: if paying by check, an additional \$30 fee will be assessed for each returned check, or "stop payment."

**Time Allotment:** It is your responsibility to observe the length of time your consultation is taking. If you do not wish to go beyond a certain time limit, please inform Dr. Huycke before your consultation begins.

**Interruptions:** Occasionally there may be interruptions during your Doctor consultation by staff. If this happens, the number of minutes of the interruption will be deducted from your total time, unless the time is made up by the Doctor. We apologize for any inconvenience.

**Telephone Consultations:** If you have many questions and/or would like to speak personally with Dr. Huycke, please call to schedule a phone consultation. Dr. Huycke will then answer your questions during the scheduled consultation time. Consultation fees range from \$55-98, depending on length of time, starting at ten minute increments.

**Bio-Identical Hormone Replacement Therapy:** It is understood that when a patient is being treated with hormones laboratory tests will be required. Generally laboratory tests will be required every six weeks until your ultimate hormone levels are met, at which time annual laboratory tests will be required prior to renewal of your prescriptions. It is the patient's responsibility to call the office for lab orders at least 1 week prior to their prescriptions being depleted. Some lab tests can take 4-5 days to process.

**Emergencies:** If you have an emergency or would like to speak immediately with Dr. Huycke, please call to schedule an emergency consultation. Dr. Huycke will call you back immediately or at her earliest convenience that same day.

I have read this informed consent and understand it. I am not a minor (under the age of 18). Additionally, I am here on this day and any subsequent visit, solely on my own behalf and not as an agent for federal, state, or local agencies on a mission of entrapment or investigation.

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Signature

Date

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Print Name