

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 at least 24-hours notice.

Directions to Metta Health Care, Ann Huycke, MD (4501 N. Alamosa Street, Boise, ID, 83702, 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 Alamosa St. After you turn left onto Alamosa we are the first driveway on the left.
- **From Eagle:** Take State Street East toward downtown Boise. After Collister, Alamosa Street will be the second street on your right. Turn right (South) onto Alamosa Street. After you turn right onto 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 Alamosa Street. We are the first driveway on the left.

Patient Information

Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

E-mail Address: _____

Social Security Number: _____ 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.

- | | | | |
|--|---|---|--|
| <p>GENERAL</p> <input type="checkbox"/> Chills
<input type="checkbox"/> Depression
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Fainting
<input type="checkbox"/> Fever
<input type="checkbox"/> Forgetfulness
<input type="checkbox"/> Headache
<input type="checkbox"/> Loss of sleep
<input type="checkbox"/> Loss of weight
<input type="checkbox"/> Nervousness
<input type="checkbox"/> Numbness
<input type="checkbox"/> Sweats <p>MUSCLE/JOINT/BONE
 Pain, weakness, numbness in:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips
<input type="checkbox"/> Back <input type="checkbox"/> Legs
<input type="checkbox"/> Feet <input type="checkbox"/> Neck
<input type="checkbox"/> Hands <input type="checkbox"/> Shoulders <p>GENITO-URINARY</p> <input type="checkbox"/> Blood in urine
<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Lack of bladder control
<input type="checkbox"/> Painful urination | <p>GASTROINTESTINAL</p> <input type="checkbox"/> Appetite poor
<input type="checkbox"/> Bloating
<input type="checkbox"/> Bowel changes
<input type="checkbox"/> Constipation
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Excessive hunger
<input type="checkbox"/> Excessive thirst
<input type="checkbox"/> Gas
<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Indigestion
<input type="checkbox"/> Nausea
<input type="checkbox"/> Rectal bleeding
<input type="checkbox"/> Stomach pain
<input type="checkbox"/> Vomiting
<input type="checkbox"/> Vomiting blood <p>CARDIOVASCULAR</p> <input type="checkbox"/> Chest pain
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Irregular heart beat
<input type="checkbox"/> Low blood pressure
<input type="checkbox"/> Poor circulation
<input type="checkbox"/> Rapid heart beat
<input type="checkbox"/> Swelling of ankles
<input type="checkbox"/> Varicose veins | <p>EYE, EAR, NOSE, THROAT</p> <input type="checkbox"/> Bleeding gums
<input type="checkbox"/> Blurred vision
<input type="checkbox"/> Crossed eyes
<input type="checkbox"/> Difficult swallowing
<input type="checkbox"/> Double vision
<input type="checkbox"/> Earache
<input type="checkbox"/> Ear discharge
<input type="checkbox"/> Hay fever
<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Loss of hearing
<input type="checkbox"/> Nose bleeds
<input type="checkbox"/> Persistent cough
<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Vision - Flashes
<input type="checkbox"/> Vision - Halos <p>SKIN</p> <input type="checkbox"/> Bruise easily
<input type="checkbox"/> Hives
<input type="checkbox"/> Itching
<input type="checkbox"/> Change in moles
<input type="checkbox"/> Rash
<input type="checkbox"/> Scars
<input type="checkbox"/> Sore that won't heal | <p>MEN only</p> <input type="checkbox"/> Breast lump
<input type="checkbox"/> Erection difficulties
<input type="checkbox"/> Lump in testicles
<input type="checkbox"/> Penis discharge
<input type="checkbox"/> Sore on penis
<input type="checkbox"/> Other <p>WOMEN only</p> <input type="checkbox"/> Abnormal pap smear
<input type="checkbox"/> Bleeding between periods
<input type="checkbox"/> Breast lump
<input type="checkbox"/> Extreme menstrual pain
<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Nipple discharge
<input type="checkbox"/> Painful intercourse
<input type="checkbox"/> Vaginal discharge
<input type="checkbox"/> Other <p>Date of last menstrual period _____
 Date of last Pap Smear _____
 Have you had a mammogram? _____
 Are you pregnant? _____
 Number of children _____</p> |
|--|---|---|--|

~ Conditions ~

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

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

~ Medications ~ List medications you are currently taking.

~ Allergies ~

Pharmacy Name: _____ Phone: _____

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 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!

Metta Health Care
Ann Huycke, MD

4501 N. Alamosa St.
Boise, ID 83703
Telephone (208)658-5570
Fax (208)658-6811

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**). *Submission 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 unless payment arrangements have been approved in advance by our office manager. The new adult patient will usually be charged \$185.00-\$230.00. New patient visits for children are normally \$130.00 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 spend with Dr. Huycke).

Follow up visits range from \$60 - \$165. We require that you pay for all follow up visits at the time of service, unless payment plan arrangements have been established prior to your visit.

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.

-----**Date**-----

Ann Huycke, MD
4501 N. Alamosa St.
Boise, ID 83703
(208) 658-5570
Fax (208) 658-6811

Medicaid Exclusion Agreement

MHC/Ann Huycke, MD ceased to be a Medicaid provider September 30, 2003. By law, we are able to provide medical services to Medicaid 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, 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 fee schedule.
- You are free, at any time, to seek services of a Medicaid provider.

I, _____, a Medicaid 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 MHC/Ann Huycke, MD.

Beneficiary/patient

Witness

Date

Ann Huycke, MD
4501 N. Alamosa St.
Boise, ID 83703
(208) 658-5570
Fax (208) 658-6811

Medicare Exclusion Agreement

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

- Medicare will not reimburse you for any of our services.
- Medicare 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 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 Medicare's fee schedule.
- You are free, at any time, to seek services of a Medicare provider.

I, _____, a 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 MHC/Ann Huycke, MD.

Beneficiary/patient

Witness

Date