MAYBERRY NATUROPATHY & INTEGRATIVE MEDICINE

PRIMARY CARE • TELEVISIT INTAKE & CONSENT FORM

113 Fairplay St, Rutledge, GA 30663 | 470-791-8230 | info@mayberryclinic.com

Please complete as accurately as possible before your appointment. If a question does not apply, enter “N/A.” Please have your current medication and supplement list available during your tele-visit.

1. PATIENT INFORMATION

Full legal name

Preferred name

Date of birth

Age

Sex at birth

Pronouns (optional)

Street address

City / State / ZIP

Phone

Email

Emergency contact

Relationship / phone

Primary care physician / clinic

Pharmacy name & location

Visit type: ☐ New patient ☐ Follow-up ☐ Other

Patient’s current location during tele-visit (city/state)

2. REASON FOR VISIT & HEALTH HISTORY

Main reason for visit / top three concerns

When did concerns begin? What makes them better or worse?

Current symptoms, frequency, severity, and changes over time

Diagnoses or ongoing health conditions

MAYBERRY NATUROPATHY & INTEGRATIVE MEDICINE

HEALTH HISTORY • MEDICATIONS • TELEVISIT SAFETY

113 Fairplay St, Rutledge, GA 30663 | 470-791-8230 | info@mayberryclinic.com

2. REASON FOR VISIT & HEALTH HISTORY (CONTINUED)

Past illnesses, hospitalizations, surgeries, and injuries

Family history (e.g., heart disease, diabetes, cancer, thyroid conditions)

3. MEDICATIONS, ALLERGIES & LIFESTYLE

Prescription medicines (name, dose, frequency)

OTC medicines, vitamins, herbs, and supplements

Allergies and reactions

Pregnant, possibly pregnant, trying to conceive, or breastfeeding? ☐ No ☐ Yes ☐ N/A

Tobacco / nicotine

Alcohol

Other substances (optional)

Typical sleep

Physical activity

Nutrition notes

4. TELEVISIT SAFETY & CONSENT

I understand that a tele-visit requires a working phone or internet connection and a private place where I can speak with the clinician. I will provide my current physical location and a callback number at the start of the visit in case the connection is lost. Some concerns require an in-person examination, testing, urgent evaluation, or referral; the clinician may recommend in-person care if a tele-visit is not appropriate. **Tele-visits are not for emergencies.** For a medical emergency, call 911 or go to the nearest emergency department.

PAYMENT POLICY — PLEASE READ: Televisit/virtual appointments must be paid in advance at the time of booking to confirm the appointment. In-person visits are payable at the close of the visit. Lab work, testing, medications, supplies, and other services may involve additional charges. Mayberry does not file insurance; contact the office with payment questions.

I consent to receive care by tele-visit when clinically appropriate. I understand the potential benefits and limitations of telehealth and may ask questions before proceeding. This form does not guarantee that every concern can be addressed virtually.

☐ I have read and understand the telehealth safety and payment policies above.

MAYBERRY NATUROPATHY & INTEGRATIVE MEDICINE

MEDICAL CONSENT • OFFICE POLICIES • SIGNATURE

113 Fairplay St, Rutledge, GA 30663 | 470-791-8230 | info@mayberryclinic.com

5. MEDICAL CARE DISCLOSURE, INFORMED CONSENT & OFFICE POLICIES

SCOPE OF CARE

This form describes general terms for medical services provided by appropriately licensed clinicians at Mayberry Naturopathy & Integrative Medicine. Each clinician provides care only within the scope of their professional license, training, and applicable law. The clinician's credentials and role will be explained upon request. This form does not expand any clinician's scope of practice or replace additional consent that may be required for a specific procedure, medication, test, or treatment.

MEDICAL HISTORY AND PATIENT RESPONSIBILITY

I agree to provide complete and accurate information about my symptoms, medical and surgical history, diagnoses, medications, over-the-counter products, supplements, allergies, pregnancy or breastfeeding status, and care received from other providers. I will promptly update the practice about changes in my health or medication use. I understand that incomplete or inaccurate information may affect clinical decisions and my safety. I may ask questions about my condition, proposed evaluation, treatment options, expected benefits, material risks, and alternatives before consenting to care.

MEDICAL CARE AND OUTCOMES

I understand that medical evaluation and treatment may involve risks, side effects, limitations, and uncertainty. No particular result or outcome is guaranteed. The clinician will use professional judgment based on the information available and will discuss recommendations appropriate to my circumstances. I may decline a recommendation or withdraw consent, subject to any immediate safety considerations, and I understand that doing so may affect my care. I will not stop or change a prescribed medication or another provider's treatment without discussing it with an appropriately qualified clinician.

RECORDS, PRIVACY, AND COORDINATION

The practice will maintain records of my care and handle my health information in accordance with applicable privacy laws and practice policies. Information may be used or disclosed for treatment, payment, healthcare operations, when I authorize it, or when disclosure is otherwise permitted or required by law. Coordination with my other healthcare providers may occur when appropriate and permitted by law; the practice may request a separate authorization when required. I may ask the office how to access its Notice of Privacy Practices and how to request access to my records.

TELEHEALTH LIMITATIONS AND EMERGENCIES

Telehealth may limit the clinician's ability to perform a physical examination or obtain certain measurements and tests. The clinician may determine that an in-person visit, diagnostic testing, referral, or urgent evaluation is necessary. Telehealth is not appropriate for every condition and must not be used for emergencies. If I believe I am experiencing a medical emergency, I will call 911 or go to the nearest emergency department. I will provide my current physical location and a reliable callback number at the beginning of each telehealth visit.

APPOINTMENTS, PAYMENT, AND FOLLOW-UP

Televisit/virtual appointments must be paid in advance at the time of booking to confirm the appointment. In-person visits are payable at the close of the visit. Lab work, testing, medications, supplies, and other services may involve additional charges, which will be explained as applicable. Missed appointments and late cancellations may be subject to a fee under the practice's scheduling policy; please provide at least 24 hours' notice when cancelling or rescheduling. Repeated missed appointments or failure to follow agreed care arrangements may lead to a discussion about whether the practice can continue to provide care, consistent with applicable law and continuity-of-care obligations. I am responsible for following up on test results, referrals, and recommended care as directed, and for contacting the practice if my condition worsens or I have questions.

I acknowledge that I have read this medical care disclosure and office policy section, have had the opportunity to ask questions, and understand that I may request clarification before signing. My signature indicates consent to evaluation and care as discussed with the clinician; it does not waive rights or remedies that cannot legally be waived.

6. ACKNOWLEDGMENT & SIGNATURE

By signing below, I confirm that the information I have provided is accurate to the best of my knowledge, I have had the opportunity to ask questions, and I acknowledge the medical consent language, telehealth terms, and office policies above. I understand that I may request clarification before signing.

Patient / client signature (type name or use a supported digital-signature workflow)

Date

Printed name

Phone

Parent / legal guardian (if minor)

Relationship

Guardian signature (if applicable)

Date

Practitioner / staff

Date received