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**PATIENT INFORMATION--APPLICATION FOR CARE**

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. (PLEASE PRINT)

Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Home Phone Work Phone Cell Phone E-Mail Address Address City State Zip

Sex: □Male □Female Age Birth Date

Marital Status: S M W D

Your Employer Occupation Years on Job Employer Address City State \_\_ Zip Social Security # \_

Driver’s License # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exp: \_\_\_\_\_ /\_\_\_\_\_\_\_/ \_\_\_\_\_\_\_

Name of Spouse or Parent

Their Birth Date\_

Spouse Employed By \_ Occupation Years on Job Employer Address City State \_\_\_Zip Office Phone # \_\_\_\_\_\_\_\_\_

How did you hear about us? If referred by someone, who? How payment will be made:

Cash Check Credit Card

I (we) agree to pay for services rendered to the above mentioned patient as the service and charge is incurred. I understand that I am financially responsible for all charges. I understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable as of the date of service. I agree that any unpaid balance is subject to a 1.5% monthly finance charge. I understand that should my account go to collections, I am responsible for all costs associated with collections and any costs charged by the collection company.

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the medical provider.

## Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:**

**Initial Confidential Patient Case History**

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

|  |  |  |
| --- | --- | --- |
| **O – OCCASIONAL F – FREQUENT** | **O F C**  **GASTRO-INTESTINAL** | **O F C**  **CARDIO-VASCULAR** |
| **C – CONSTANT**  **O F C** | * Belching or gas * Colitis * Colon trouble | * Hardening of arteries * High blood pressure * Low blood pressure |
| **GENERAL**   * Allergy * Chills * Convulsions * Dizziness * Fainting * Fatigue * Fever * Headache * Loss of sleep * Loss of weight * Nervousness/depression * Neuralgia * Numbness * Sweats | * Constipation * Diarrhea * Difficult digestion * Distension of abdomen * Excessive hunger * Gall bladder trouble * Hemorrhoids * Intestinal worms * Jaundice * Liver trouble * Nausea * Pain over stomach * Poor appetite * Vomiting * Vomiting of blood | * Pain over heart * Poor circulation * Rapid heart beat * Slow heart beat * Swelling of ankles   **RESPIRATORY**   * Chest pain * Chronic cough * Difficult breathing * Spitting up blood * Spitting up phlegm * Wheezing   **SKIN**   * Boils * Bruise easily |
| * Tremors   **MUSCLE & JOINT**   * Arthritis * Bursitis * Foot trouble * Hernia * Low back pain * Lumbago * Neck pain or stiffness * Pain between shoulders   Pain or numbness in:   *  Shoulders *  Arms *  Elbows *  Hands *  Hips *  Legs *  Knees *  Feet * Painful tail bone * Poor posture * Sciatica * Spinal Curvature * Swollen joints | **EYES, EARS, NOSE &THROAT**   * Asthma * Colds * Crossed eyes * Deafness * Dental Decay * Earache * Ear discharge * Ear noises * Enlarged glands * Enlarged thyroid * Eye pain * Failing vision * Far sightedness * Gum trouble * Hay fever * Hoarseness * Nasal obstruction * Near sightedness * Nosebleeds * Sinus infection * Sore throat * Tonsillitis | * Dryness * Hives or allergy * Itching * Skin eruptions (rash) * Varicose veins   **GENITO-URINARY**   * Bed-wetting * Blood in urine * Frequent urination * Inability to control kidneys * Kidney infection or stones * Painful urination * Prostate trouble * Pus in urine   **FOR WOMEN ONLY**   * Cramps or backache * Excessive menstrual flow * Hot flashes * Irregular cycle * Menopausal symptoms * Painful menstruation * Vaginal discharge * Yes No Are you pregnant? |

**HABITS**

Alcohol Coffee Tobacco Drugs Exercise Sleep Appetite

Heavy















Moderate

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

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Light

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

None

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





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

**CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:**

* Alcoholism
* Anemia
* Anorexia
* Appendicitis
* Arteriosclerosis
* Bulimia
* Cancer
* Candidacies
* Chorea
* Cold sores
* Depression
* Diabetes
* Diphtheria
* Drug Abuse
* Eczema
* Emphysema
  + Epilepsy
  + Fever Blisters
  + Goiter
  + Gout
  + Heart disease
  + Hypoglycemia
  + Influenza
  + Lumbago
* Malaria
* Measles
* Miscarriage
* Multiple sclerosis
* Mumps
* Pleurisy
* Pneumonia
* Polio
* Psychiatric Disorder
* Rheumatic Fever
* Recreational Drugs
* Scarlet fever
* Stroke
* Tuberculosis
* Typhoid fever
* Ulcers
* Venereal disease
* Whooping cough

If you answered YES to any of the above conditions, please explain:

\_ Have you ever been hospitalized or been under medical care for any operation/psychiatric care/alcohol or drug rehab? Yes No If yes, please explain:\_

**ALLERGIES/INTOLERANCES**

* None X-Ray Dye Sulfa Pollen Food Soaps/Lotions Environment Adhesives
* Medication Other: (List Substance and reaction)\_

What is your major complaint?

List surgical operation and years:

**FAMILY HISTORY: Please specify members of your family including extended family who have these illnesses.**

CANCER: HYPOTHYROIDISM: HIGH BLOOD PRESSURE: HYPOGLYCEMIA: OBESITY: HEART DISEASE:

**Current Medications**: Prescriptions Only

|  |  |  |
| --- | --- | --- |
| Medication/Dose/How often | Reason for Taking | Prescribing M.D. |
|  |  |  |
|  |  |  |
|  |  |  |
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**HIPAA FORM**

##### Introduction

At **CLINIC NAME**, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective March 31th, 2003 and applies to all protected health information as defined by federal regulation.

##### Uses and Disclosures

1. We use your health information to document and plan treatment, progress, planning, etc.
2. We use your health information for payment. For instance, we need to send health information including procedures done and diagnoses to your insurance company.
3. We use your health information for regular health operations. For example, our compliance officer regularly chooses medical records for audits. This practice ensures that we are constantly working towards improved quality and effectiveness.
4. There are services provided in our organization through contacts with business associates. Examples include outside labs, x-ray, transcription services.
5. We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care, your location, and general condition.

The following are examples of other purposes for which **CLINIC NAME** is permitted or required to disclose confidential information without the individual’s written authorization.

1. Uses and disclosures for public health activities;
2. Reporting victims of abuse, neglect, or domestic violence;
3. Disclosures for judicial and administrative proceedings;
4. Disclosures for law enforcement purposes;
5. Uses and disclosures for cadaveric organ, eye or tissue donation purposes;
6. Disclosures to avert a serious threat to health or safety; and
7. Uses and disclosures for specialized government functions.

Separate Statements for Certain Uses or Disclosures **CLINIC NAME** may contact patients with appointment reminders, requests for the patient to contact **CLINIC NAME** for appointments, notices and letters concerning medical findings. **CLINIC NAME** may also contact the patient about treatments alternatives or other health related benefits and services that may be of interest to the individual. Effective Date of this notice is April 1, 2003; Updated April 10, 2008.

##### Individual Rights

Although your health record is the physical property of **CLINIC NAME**, the information belongs to you. You have the right to:

1. The right to request restrictions on certain uses and disclosures of your information;
2. The right to revoke your authorization to use or disclose health information except to the extent that action has already been taken.
3. The right to receive confidential communications;
4. The right to obtain a copy or inspect your health information;
5. The right to amend protected health information;
6. The right to receive an accounting of disclosures of protected health information.

##### CLINIC NAME’s Rights

1. **CLINIC NAME** has 30 days with which to comply with a patient’s request to review or copy their health information. **CLINIC NAME** is allowed an additional 30 days if the record is off site. **CLINIC NAME** may charge a fee for copying the health record.
2. The physicians have the right to review the record and remove any information that they deem to be harmful to either the patient or to another individual;
3. The patient will be supervised by Medical Center staff during any review of the record. Supervision is allowed and required to prevent the removal or altering of the medical record. **CLINIC NAME** will charge staff time for this service.

##### CLINIC NAME’s Duties

1. **CLINIC NAME** is required by law to maintain the privacy of confidential information and provide individuals with notice of its legal duties and privacy practices with respect to such information;
2. **CLINIC NAME** is required to abide by the terms of this Notice; and
3. **CLINIC NAME** reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all confidential information that it maintains. Revisions to this Notice will be posted in the patient waiting area.

Name:\_ Date of Birth:\_

Signature:\_ Date:\_

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**PATIENT’S RELEASE OF THE PROVIDER OF SERVICE AND THE CLINIC**

The undersigned hereby represents that I have disclosed all my pertinent information regarding my health profile to the provider of service during my examination. Patient further represents and guarantees that I have disclosed all medications that I am currently consuming to this provider of service during my examination and from whom, if any, I am obtaining my medications.

I understand that this provider of services makes a determination based on full disclosure from the patient.

I acknowledge that this provider of services reserves the right to limit any patient’s medications to an appropriate amount based on the disclosed information from the patient during the examination.

Should information be obtained that in any way suggest false representation were made to this provider of service by the patient, I, without reservation, waive any and all rights to any claim, of any type or nature whatsoever including but not limited to monetary damages, which I have now or in the future may accrue against the provider of service and this clinic.

**I understand that if I lose my medications, which are handed out on a bi-weekly or monthly basis, I will not be able to obtain a new supply until the following office visit whether it be bi-weekly or monthly.** As a patient I also understand that if I go to another provider of service during the time frame of treatment at this clinic, I am to notify this clinic and its representatives immediately of any other medications I might be receiving and that said notification must be made in writing by and between this clinic and or its representative and myself. As the patient, I will also receive a copy of this notification after it is awarded.

**Please be advised that CLINIC NAME requires that all patients have a yearly diet panel drawn to give us a thorough perspective of our patient’s general health.** We also require all new patients and returning patients have a diet panel drawn within the first two weeks of their initial visit and **will not dispense any further medications until this is done**; however, extenuating circumstances will be taken into consideration. This is to protect our patients and allow us to provide safe, effective assistance for weight loss and lifestyle change.

**As the patient, I have read and understand this release. I also understand that this release constitutes a legal and binding document.**

Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Permission to verbally discuss Protected Health Information**

**\*Completion of this form is optional. To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_

I give permission to CLINIC NAME to verbally discuss the following medical and billing information about me (check all boxes that apply):

* Scheduling/Appointment information
* Medical information, including my symptoms, diagnose, medications and treatment plan.
* Lab/Test results
* Billing and Payment information
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLINIC NAME has my permission to discuss the above checked information with:

|  |  |  |
| --- | --- | --- |
| Name | Phone | Relationship to Patient |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Emergency Contact | Phone | Relationship to Patient |
|  |  |  |
|  |  |  |

I understand that I can cancel this permission at any time in writing to CLINIC NAME, but cancelling will not affect any information that has already been released.

**This authorization expires:**

* When I cancel it in writing
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Specify date)
* I decline permission to verbally discuss medical information

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_