**Vitality Integrative Medicine**

**Health & Nutrition History**

Please complete this questionnaire in preparation for your consultation. Your careful consideration of these questions will provide for more effective use of your scheduled consultation time and will help identify priorities.

***General Information*** Date:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| First Name: Last Name: | |  | | Preferred Name | | | |
| Date of Birth |  |  | Age: | | Sex: M F | | |
| Genetic Background | African American  Native American  Mediterranean | Hispanic  Caucasian  Northern European | | | | | Asian  Other *(please note)* |
| Address: Apt#: | | City: | | | | Zip: | |
| Cell Phone |  |  | | Work Phone | | | |
| Home Phone |  |  | | Fax | | | |
| Email |  |  | |  | | | |

Best Way to Reach?

|  |  |  |
| --- | --- | --- |
| Which method(s) of contact may we use to leave confidential messages? | |  |
| Job Title/Employer |  |  |
| Nature of Business |  |  |
| Primary Physician |  | Phone: |
| Address |  |  |
| Referred by |  |  |
| Emergency contact relationship: |  |  |
| Emergency contact phone number: |  |  |

# *Main Health Concerns*

What do you hope to achieve in your visit?

Please list your three main health concerns.

|  |  |  |  |
| --- | --- | --- | --- |
| **1**  **2**  **3** |  | | |
|  | | |
|  | | |
| When was the last time you felt well? | |  | |
| Did something trigger your change in health? | | |  |

Inflammatory Bowel Disease

Crohn’s Disease

Ulcerative Colitis

Gastric or Peptic Ulcer Disease

GERD (reflux/heartburn)

Celiac Disease

Hepatitis C or Liver Disease

Other Digestive:

Rheumatoid Arthritis

Lupus SLE

Poor Immune Function

*(*

*frequent infections*

*)*

Severe Infectious Disease

Herpes

-

Genital

Multiple Chemical Sensitivities

Gout

O

ther:

|  |  |  |
| --- | --- | --- |
| What makes you feel better? | |  |
| What makes you feel worse? | |  |
| Notes: |  | |

***Allergy Information*** Please list food, drug, supplement or environmental allergies and symptoms that you experience from each.

|  |  |  |
| --- | --- | --- |
| FOOD allergies |  | *Symptoms:* |
| DRUG allergies |  | *Symptoms:* |
| SUPPLEMENT allergies |  | *Symptoms:* |
| OTHER: allergies |  | *Symptoms:* |

# *Medical History*

# *Please check those health conditions that your doctor has diagnosed (provide the date of onset)*

|  |  |  |  |
| --- | --- | --- | --- |
|  | **GASTROINTESTINAL** |  | **INFLAMMATORY/AUTOIMMUNE** |
|  | Irritable Bowel Syndrome |  | Chronic Fatigue Syndrome |

**CARDIOVASCULAR METABOLIC/ENDOCRINE**

Heart Disease (heart attack) Diabetes Type 1 or Type 2

Stroke Metabolic Syndrome (insulin resistance)

Elevated Cholesterol Hypoglycemia

Irregular heart rate – Pacemaker Hypothyroidism (low thyroid)

High Blood Pressure Hyperthyroidism (overactive thyroid) Mitral Valve Prolapse/heart murmur Polycystic Ovarian Syndrome (PCOS)

Other Heart & Vascular: Other:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **RESPIRATORY** | | | | | **MUSCULOSKELETAL/PAIN** | | | | |
|  |  | Asthma  Chronic Sinusitis  Pneumonia  Sleep Apnea |  | Bronchitis  Emphysema Tuberculosis Other: |  |  | Osteoarthritis Chronic Pain Other: |  | Fibromyalgia Migraines |
|  |  |  |  |
|  |  |  |  |
|  |  |  |
|  |  |

***Medications*** (Please list all prescribed medications you are taking, dose and note reason.)

ABO

Blood Type (if known)

(

circle one)

**O A B AB**

Have you ever had a blood transfusion?

**Y N**

|  |  |  |
| --- | --- | --- |
| *Name:* | *Dose:* | *Reason:* |
| *Name:* | *Dose:* | *Reason:* |
| *Name:* | *Dose:* | *Reason:* |
| *Name:* | *Dose:* | *Reason:* |
| *Name:* | *Dose:* | *Reason:* |
| *Name:* | *Dose:* | *Reason:* |

N ***Medical Symptoms Questionnaire (MSQ)***

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.) Motrin, Aspirin?

Y

Have you had prolonged or regular use of Tylenol?

Y

N

Have you had prolonged or regular use of acid

-

blocking drugs (Tagamet, Zantac, etc.)?

Y

N

Frequent antibiotics >3 times per year?

Y

N Long term antibiotics?

Y

N

***Surgeries/Hospitalizations***

Please list any surgeries or hospitalizations (include dates).

***Please check symptoms you* CURRENTLY/RECENTLY *experience***

# HEAD

\_\_\_\_ Headaches

\_\_\_\_ Faintness

\_\_\_\_ Dizziness

\_\_\_\_ Insomnia

# EYES

\_\_\_\_ Watery or itchy eyes

\_\_\_\_ Swollen, reddened/sticky eyelids

\_\_\_\_ Bags, dark circles \_\_\_\_ Blurred or tunnel vision *(does not include near or far-sightedness)*

# EARS

\_\_\_\_ Earaches, ear infections

\_\_\_\_ Drainage from ear

\_\_\_\_ Ringing /hearing loss

# NOSE

\_\_\_\_ Stuffy Nose

\_\_\_\_ Sinus problems

\_\_\_\_ Hay fever

\_\_\_\_ Sneezing attacks

\_\_\_\_ Excessive mucous

# MOUTH/THROAT

\_\_\_\_ Chronic coughing

\_\_\_\_ Gagging/throat clearing

\_\_\_\_ Sore throat, hoarseness

\_\_\_\_ Swollen/discolored tongue, gums, lips

\_\_\_\_ Canker sores

# HEART

\_\_\_\_ Irregular /skipped beats

\_\_\_\_ Rapid/pounding beats

\_\_\_\_ Chest pain

# SKIN

\_\_\_\_ Acne

\_\_\_\_ Hives, rashes, dry skin

\_\_\_\_ Hair loss

\_\_\_\_ Flushing, hot flashes

\_\_\_\_ Excessive sweating

# LUNGS

\_\_\_\_ Chest congestion

\_\_\_\_ Asthma, bronchitis

\_\_\_\_ Shortness of breath

\_\_\_\_ Difficulty breathing

# DIGESTIVE TRACT

\_\_\_\_ Nausea, vomiting

\_\_\_\_ Diarrhea

\_\_\_\_ Constipation

\_\_\_\_ Bloated feeling

\_\_\_\_ Belching, passing gas

\_\_\_\_ Heartburn

\_\_\_\_ Intestinal/stomach pain

# URINE

\_\_\_Painful urination

\_\_\_Urination at night

\_\_\_Blood in urine

\_\_\_Frequent urination

\_\_copious \_\_scanty urine \_\_\_Retention of urine or difficulty urinating \_\_\_Urgent urination

\_\_\_Incontinence

\_\_\_Prolapse of bladder or uterus

# JOINTS/MUSCLE

\_\_\_\_ Pain or aches in joints

\_\_\_\_ Arthritis

\_\_\_\_ Stiffness/limited movement

\_\_\_\_ Pain or aches in muscles

\_\_\_\_ Feeling of weakness or tiredness

# WEIGHT

\_\_\_\_ Binge eating/drinking

\_\_\_\_ Craving certain foods

\_\_\_\_ Excessive weight

\_\_\_\_ Compulsive eating

\_\_\_\_ Water retention

\_\_\_\_ Underweight

# ENERGY/ACTIVITY

\_\_\_\_ Fatigue/sluggishness

\_\_\_\_ Apathy, lethargy

\_\_\_\_ Hyperactivity

\_\_\_\_ Restlessness

# IMMUNE SYSTEM

\_\_\_Fever/chills

\_\_\_Frequent colds/flus

\_\_\_Lymph node swelling (i.e. "swollen

glands") \_\_\_Frequent illness \_\_\_Bone pain

# SEXUAL HISTORY

Sexually active Y / N

\_Syphilis \_Gonorrhea \_Chlamydia

\_\_\_Genital sores/discharge/itch

\_\_\_HPV

\_\_\_Herpes (oral/genital)

\_\_\_Testicular pain/swelling

\_\_\_Erection issues

\_\_\_pain w/intercourse

# FEMALE REPRODUCTIVE HISTORY

Date of Last menstrual period:

\_\_\_Spotting

\_\_\_Irregularity

\_\_\_PMS (symptoms:\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_menstrual pain

\_\_\_menopause

\_\_\_heavy periods

\_\_\_scanty periods \_\_\_early periods \_\_\_late periods pale/bright red/dark red blood \_\_\_blood clots

# of: pregnancies\_\_\_ births\_\_\_ abortions\_\_\_ living children\_\_\_ \_\_Leukorrhea (vaginal discharge)

# MIND

\_\_\_\_ Poor memory

\_\_\_\_ Confusion, poor comprehension

\_\_\_\_ Poor concentration

\_\_\_\_ Poor physical coordination

\_\_\_\_ Difficulty making decisions

\_\_\_\_ Stuttering or stammering

\_\_\_\_ Slurred speech

\_\_\_\_ Learning disabilities

# EMOTIONS

\_\_\_\_ Mood swings

\_\_\_\_ Anxiety, fear, nervousness

\_\_\_\_ Anger, irritability, aggressiveness

\_\_\_\_ Depression

## Family History

Please note any family history of the following diseases: *heart disease, cancer, stroke, high blood pressure, overweight, lung disease, liver disease, kidney disease, diabetes, autoimmune disease, mental illness or addiction.*

|  |  |
| --- | --- |
| *Mother’s Health Conditions:* |  |
| *Father’s Health Conditions:* |  |
| *Other Family member:* | *Health Condition:* |
| *Other Family member:* | *Health Condition:* |

## Dental History

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Do you have any silver/mercury amalgam fillings? | | | | | | | |  | | Y | | |  | | N If **Y**, how many? | | | | |
| Do you have any |  | Tooth extractions | | |  | Root canals | | | | | |  | Implants | | |  | Bridges |  | Crowns |
| Do you have any |  | Tooth pain |  | Bleeding gums | | | | | | |  | Gingivitis | | | |  | Chewing problems | | |
| Do you visit a dentist regularly (twice per year)? | | | | | | |  | | Y | | |  | | N | | | | | |

***Nutrition History***

Do you currently follow a special diet or nutritional program?

Y

N

*Please describe:*

Please list all **nutritional supplement/herbs** you currently take daily. Please include brand names and dosages (amount per time and times per day). Use a separate page if necessary.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | |  | | | | | | | | |  |
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|  |  | |  | | | | | | | | |  |
|  |  | |  | | | | | | | | |  |
| Do you drink alcohol? |  | Y |  | N If yes, how many drinks per week? | | | | | | | | |
| Do you drink coffee or other caffeinated beverages? | | | | | | | |  |  | Y |  | N If yes, # daily? |
|  |  |  |
| Do you have (or had) any eating disorders? | | | | |  | Y |  |  | N If yes, please describe. | | | |

***Exercise & Lifestyle*** Please note any physical activities that you engage in regularly along with the intensity, frequency and duration.

|  |  |  |  |
| --- | --- | --- | --- |
| **ACTIVITY** | **TYPE/INTENSITY**  *(low-moderate-high)* | **# DAYS/WEEK** | **DURATION**  *(minutes)* |
| Cardio/Aerobic | / |  |  |
| Strength Training | / |  |  |
| Yoga/Stretching | / |  |  |
| Sports or Leisure | / |  |  |

Note any problems that limit your physical activity:

|  |  |  |  |
| --- | --- | --- | --- |
| Do you smoke? Y N | Packs per day? | How many years? | Other exposure? Y N |
| Is there excess stress in your life? Y N | | Do you easily handle stress? Y N | |

Daily Stressors: *Rate on a scale of 1 (low) to 10 (high)*

Work\_\_\_\_ Family\_\_\_\_ Social\_\_\_\_ Finances\_\_\_\_ Health\_\_\_\_ Other:\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Average number of hours you sleep per night **during the week**? \_\_\_\_\_\_ **Weekends**? \_\_\_\_\_\_ | | | | | | | | | | | Trouble falling asleep?  Trouble staying asleep? | | |  | Y  Y |  | N  N |
|  |  |
| If you wake up during the night, note how many times and the cause: (if known): | | | | | | | | | | | | | | | | | |
| Do you feel rested upon waking? | | | | | | |  | Y |  | N | Other: | | | | | | |
|  |  |
| ***Environmental Information*** | | | | | | | | | | |  | | | | | | |
| Do you have known adverse reactions or environmental | | | | | | | | | | | If yes, please describe symptoms. | | | | | | |
| sensitivities? | | |  | Y |  | N | | | | |
| Are you exposed regularly to any of the following? *(check all that apply)* | | | | | | | | | | | Please note any regular exposure to harmful chemical/substances. | | | | | | |
|  |  | Cigarette smoke  Auto exhaust/fumes  Dry-cleaned clothes  Nail polish/hair dyes  Heavy metals  Chemicals | | | | | | | | |  |  | Perfumes  Paint fumes  Mold  Pesticides  Fertilizers  Pet dander | | | | |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| Do you use any recreational drugs? If so, please note. | | | | | | | | | | |  | | | | | | |

## Readiness Assessment

*Rate on a scale of 5 (very willing) to 1 (not willing)* In order to improve your health, how willing are you to:

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Significantly modify your diet |  |  | 5 |  | 4 |  | 3 |  | 2 |  | 1 |
|  |  |  |  |  |
| Take several nutritional supplements each day |  |  | 5 |  | 4 |  | 3 |  | 2 |  | 1 |
|  |  |  |  |  |
| Keep a record of everything you eat each day |  |  | 5 |  | 4 |  | 3 |  | 2 |  | 1 |
|  |  |  |  |  |
| Modify your lifestyle (e.g., work demands, sleep habits, exercise) |  |  | 5 |  | 4 |  | 3 |  | 2 |  | 1 |
|  |  |  |  |  |
| Practice a relaxation technique |  |  | 5 |  | 4 |  | 3 |  | 2 |  | 1 |
|  |  |  |  |  |
| Engage in regular exercise/physical activity |  |  | 5 |  | 4 |  | 3 |  | 2 |  | 1 |
|  |  |  |  |  |
| Have periodic lab tests to assess your progress |  |  | 5 |  | 4 |  | 3 |  | 2 |  | 1 |
|  |  |  |  |  |

***Thank you for completing this questionnaire. Please send back to Vitality Integrative Medicine prior to your appointment.***

**Vitality Integrative Medicine**

**CONSENT FOR TREATMENT**

I hereby authorize Vitality Integrative Medicine and its doctors, clinicians and assistants to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

**General Diagnostic Procedures** including but not limited to venipuncture and phlebotomy, pap smears, speculum exams, imaging studies, and blood and urine laboratory analysis, general physical exams, neurological and musculoskeletal assessments)

*Health education and health counseling, therapeutic exercise, breathing and relaxation exercises*

**Minor office procedures** including dressing a wound, ear cleansing

**Herbs/Natural Medicines**  includes the prescribing of various therapeutic substance including plant, mineral and animal materials. Substances may be given in the form of teas, pills, powders, tinctures (may contain alcohol); topical creams, pastes, plasters, washes; suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.

**Dietary Advice and Therapeutic Nutrition** includes the use of foods, diet plans or nutritional supplements for treatment.

**Therapeutic Administration of Medicines-** includes oral, nasal, auricular, ocular, rectal, vaginal, intramuscular, intradermal, joint, transdermal, subcutaneous or intravenous administration of medicines.

**Soft Tissue and Osseous Manipulation** includes the use ofmassage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction, stretching, resistance, and joint play examination.

**Electromagnetic therapy, Thermal therapy and Hydrotherapy Therapies** includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, and microcurrent stimulation, other forms of electromagnetic energy, hot and cold hydrotherapies, sauna therapy, colon hydrotherapy

**Devices** including durable medical equipment, barrier contraception, and therapeutic devices

**Chinese medicine procedures** including tongue and pulse assessment, treatment with therapeutic insertion of acupuncture needles, cupping, direct and indirect moxa, use of Chinese herbal/animal/mineral medicines

***Potential Risks:*** Pain, discomfort, blistering, discolorations and minor bruising, bleeding, infection, burns (from thermal therapies and moxibustion), broken needle, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed medicines; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

***Potential benefits:*** Restoration of health and the body’s maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

***Notice to Pregnant Women:*** All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Vitality Integrative Medicine or its doctors. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

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

Guardian/Personal Representative’s Name (PRINT) Patient’s Name (PRINT)

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

Guardian/Personal Representative’s Signature Patient’s Signature

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

Relationship/Representative’s Authority Date

**Vitality Integrative Medicine**

**Patient Payment Policy**

Vitality Integrative Medicine is not contracted with any insurance company. The patient agrees to be responsible for paying the costs associated with any visits or labwork, whether the lab fees are billed by the clinic or by the lab itself. At the patient’s request, a superbill may be provided, which the patient can submit to their insurance company for potential reimbursement. No reimbursement is guaranteed, as this is dependent upon the terms of the patient’s individual health insurance plan. All fees are to be paid at the time of the visit.

Reviewing labwork and creating a treatment plan (including the prescribing of medications) based on that labwork constitutes a medical consultation/evaluation, and the doctor therefore bills for his/her time in doing so. Please understand that, if you are receiving IV treatment, although the doctor may listen to your medical details while in the IV room with you, the IV treatments are a separate service from medical consultations/evaluations, and they are therefore billed separately.

Vitality Integrative Medicine has instituted a 24 hour cancellation policy, in order to reduce the losses incurred from last-minute cancellations. When the office isn’t notified in advance of a change in scheduling, this prevents the doctor from seeing another patient at that time. As the time of the doctor is valuable, and the room and doctor are reserved for one patient at a time, and quite a bit of time is reserved for each patient, the clinic therefore requires patients to notify Vitality Integrative Medicine 24 hours of business days,or more, in advance of any appointment if they are not going to be able to come to their scheduled appointment time**. If the appointment falls on a Monday, 24 hours in advance of business days falls on Friday since the weekend days are not considered business days**. No-shows and last-minute cancellations will be subject to the 24 hour cancellation policy.

In order to secure your appointment time, please supply your credit card information, which will be securely maintained on file, and utilized only in the event of a no-show or cancellation within 24 hours of business days of the appointment time (last minute cancellations), or non-payment of services, in order to pay for the services that have been booked. These no-shows or last minute cancellations will be charged for the full price of the type of visit and/or service that was booked. For IV treatment, as IV formulas must be prepared before the visit, in the case that the IV treatment had already been agreed upon with the patient, the charge will be for the scheduled IV. If no specific IV has been scheduled, the charge will be for the IV drip of least cost, which is $169 as of June 16th, 2024. Initial consultation is $350, up to 90 minutes. Extended Initial Consultation is $500.00 up to 120 minutes. Standard follow-up consults are maximum 45 minutes, $198. Extended follow-up consults of a maximum of 70 minutes are $275, or for a maximum of 90 minutes, $350, with no fractional pricing in between noted prices. Costs for visits of durations beyond those noted here are available Prices may be updated as needed at future dates after the signing of this form.

Cardholder’s name as written on the card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of card (AMEX, Mastercard, Discover, Visa, are all accepted. NO DEBIT): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3 digit security code (4 digits for AMEX): \_\_\_\_\_\_\_\_ ; Zip code on the account: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , consent to the payment policy, and to having my card on file charged as per the policy described above, in the event that Vitality Integrative Medicine is not notified of a change in appointment status of the patient within 24 hours of business days from the scheduled appointment time, or to pay for unpaid services/products received.

Cardholder’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Guardian/Personal Representative’s Name (PRINT) Patient’s Name, if different from that of cardholder (PRINT)

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

Guardian/Personal Representative’s Signature Patient’s Signature, if different from that of cardholder

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

Relationship/Representative’s Authority Date

**s NOTICE OF PRIVACY PRACTICES**

**ACKNOWLEDGEMENT**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it *Notice of Privacy practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private* *Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

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

Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

# OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: Initials: Reason: