An Evidence-based Functional Healthcare Practice

PATIENT INTAKE FORM

Patient Information

Full Name: ____ Date: __________________
First MI Last

Address: __________________________________ City: _____________ State: ____ Zip: ________

Age: __________ Birth Date: ________________ Female Male SSN: _____-___-________

Phone: ______-______-__________ Home Work Cell OK to leave message? Yes No

Email: __________________________________

I am (circle) Under age 18 / Single / Married / Divorced / Widowed / Separated

Employer: __________________________________ Occupation: ______________________

Business Address: __________________________ City: _____________ State: ____ Zip: ________

Spouse's Name: _________________________________ Spouse's Date of Birth: ______________

Emergency Contact: __________________________________ Phone: ______-______-__________

Payment Information

Person Responsible for Payment: ____

SSN: _____-___-________ Phone: ______-______-_________ Date of Birth: ______________

Insurance Information

Do you have Health Insurance? Yes No

Primary Insurance Information

Insurance Company: ____

Policy Holder's Name: ___________________________ Relationship to Patient: _____________

Policy Holder's Birth Date: _____________

Group Number: ____________________ ID Number: _________________________________

Please have your insurance card and identification ready so they can be copied for the clinic's records.

Consent for Treatment

Assignment and Release – *By signing below, I authorize Center for Progressive Natural Health to release medical records required by my insurance company. I authorize my insurance company to pay benefits directly to Center for Progressive Natural Health, and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amouth for a patient for which I am the Guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected heatlh information for treatment, payment, and health care operations.*

By signing below, I give my consent for examination and the performance of any tests or procedures needed. If patient is a minor, by signing, I give consent for examination, tests, and procedures for the above minor patient.

Signed: ____ **Date:** _______________________

An Evidence-based Functional Healthcare Practice

Name: ______________________________ Date: __________

PAST HISTORY

Mark "**X**" if you ever had, or now have, the following conditions:

_______ Allergies
_______ Anemia
_______ Arthritis
_______ Colitis
_______ Diabetes
_______ Hypoglycemia
_______ Epilepsy
_______ Polio
_______ Ulcers
_______ Injuries (list):

_______ Dizziness
_______ Fainting
_______ Headaces
_______ Tremors
_______ Weakness
_______ Gallbladder Trouble
_______ Liver Trouble
_______ Thyroid Trouble
_______ HIV
_______ Pneumonia
_______ Nervousness
_______ Skin Problems (list):

_______ Hospitalization (list):

_______ Surgery (list):

_______ Weight Gain
_______ Weight Loss
_______ Chest Pain

_______ Breathing Difficulty
_______ Heart Trouble
_______ Rapid Heartbeat
_______ Hypertension
_______ High Cholesterol
_______ Abdominal Pain
_______ Swollen Joints
_______ Poor Appetite
_______ Constipation
_______ Diarrhea
_______ Nausea
_______ Vomiting
_______ Difficult Urination
_______ Paralysis
_______ Tumors or Lumps
_______ Cancer (type/s):

_______ Joint Pains
_______ Rheumatic Fever
_______ Breast Soreness
_______ Vaginal Problems
_______ Other

Doctor's Comments: __________
____
____
____
____
____
____
____
____
____
____
____

Are you a current or past smoker? Yes No
If "YES," how many packs per day? _______

Do you consume alcohol?
None 1/month 1/wk
1-2/day 2-3/day 4+/day

Medical Physician Name:
____
City: ________________________
Date of Last Physical Exam:
____

Current Medications:
____
____
____
____
____
____

Would you like us to review your medications for possible vitamin deficiencies? Yes No

____
____
____
____
____
____
____
____
____
____
____
____

An Evidence-based Functional Healthcare Practice

Name: ______________________________ Date: __________

FAMILY HISTORY

Please review the diseases/conditions listed below and indicate "C" for current health problems or "P" for past health problems. If an indicated family member is deceased, please indicate age and cause of death, if known. Leave blank those that do not apply. The bottom of this form may be used for additional information.

CONDITION	Father Age:	Mother Age:	Brother(s) Age(s):	Sister(s) Age(s):	Child(ren) Age(s):
Arthritis					
Asthma					
Back Problem					
Bursitis					
Cancer					
Constipation					
Diabetes					
Disc Problem					
Emotional Problem					
Emphysema					
Hayfever					
Headaches					
Heart Problem					
High Blood Pressure					
Insomnia					
Kidney Problem					
Liver Problem					
Migraine					
Nervousness					
Neuritis					
Pinched Nerve					
Scoliosis					
Sinus Problem					
Stomach Problem					
Other					

An Evidence-based Functional Healthcare Practice

HIPAA Notice of Privacy Practices

This notice describes how information about you may be used and disclosed, and how you can get access to this information. Please review carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record: You can ask to see, or get, an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we will tell you why in writing within 60 days.

Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone), or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share: You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for service or health care items out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we have shared information: You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting per year for free, but will charge a reasonable, cost-based fee if you request another within 12 months.

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you: If you have given someone medical power of attorney, or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave. S.W., Washington, D.C. 20201, calling 877-696-6775, or visiting ww.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against your for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission: Marketing purposes, sale of your information, sharing of psychotherapy services.

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

We typically use or share your health information in the following ways:

Treat you: We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services: We can use and share your health information to bill and receive payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues: We can share health information about you for certain situations, such as preventing disease; helping with product recalls; reporting adverse reactions to medication; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety.

Do research: We can use or share your information for health research.

Comply with the law: We will share information about you if state or federal laws require it, including the Department of Health and Human Services if it wants to see we are complying with federal privacy law.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a Medical Examiner or Funeral Director: We can share health information with a Coroner, Medical Examiner, or Funeral Director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you for worker's compensation claims; for law enforcement purposes or with a law enforcement official; with health oversight agencies for activities authorized by law; for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal action: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities: We are required by law to maintain privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your records. We must follow the duties and privacy practices described in this notice and give you a copy. We will not use or share your information other than as described here, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time by notifying us in writing. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

Contact Person: All questions concerning this notice, or requests made pursuant to it, should be addressed to The Center for Progressive Natural Health, 318 Memorial Drive, Suite 200, Crystal Lake, IL 60014. 815.455.1910

Patient Acknowledgment: I acknowledge that I have reviewed this office's Notice of Privacy Practices, that I may refuse to sign this acknowledgement if I wish, and agree to the liability limitations explained therein. I have the right to obtain a paper copy of this notice.

Patient Printed Name:_____________________________________ Date: _____________________________

Patient/Legal Representative Signature: ____________________________ Relationship: ________________