core
Health Strategies

New Patient Intake Form

Name: Preferred Name:

(Last) (First)

Date of Birth: Birthplace: Sex: Male or Female

Address:

(Street Name and Number) (City) (State) (Zip)

Home Phone: Cell Phone:

Email: Occupation:

Single: Y/N Married/Partner: Y/N # of Times:

Spouse/Partner Name: Widower: Y/N Divorced: Y/N

In Emergency Notify: Phone:

Highest Level of Education (Circle One): High School/College/Graduate School

Height: Weight: Wt 1 yr ago: Max: When:

Date of last physical exam: / /

Primary Care Doctor: _____

Phone: _____

Fax: _____

Other practitioners and care team members:

_____

_____

Pharmacy Name and Phone Number:

Reason for visit:

We do not submit to insurance. At the time of your payment, you will receive an invoice and a receipt that you may submit to your insurance company for reimbursement.

Signature:		Date:	

Please rank your most troubling symptoms by level of concern to you.			
Problem	**Onset**	**Frequency**	**Severity**
1			
2			
3			
4			
5			
6			
7			
8			
What diagnosis or explanations have you been given in the past?			

Medication/Supplement List:

How many times and at what ages have you taken?

	Infancy	Childhood	Teen	Adulthood
Antibiotics				
Steroids				

	Medication Supplement	MG AMT IU AMT	Times Taken
Ex:	Aspirin	200 MG	once daily
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			

If you need more space please use the back of the last page and mark this box ☐

Referred by:

☐ Physician referral (name)

☐ Friend or family member (name)

☐ Other (name)

☐ Our website

Medication allergies:

Food allergies:

Food sensitivities:

Environmental allergies:

Environment Exposure:

New home(s)? Y/N Yrs: Lived in a manufactured home or cabin? Y/N Yrs:

House remodeling? Y/N Yrs: Manicures? Y/N How often?

Use of candles, scents, and/or home scents? Y/ N Personal fragrances? Y/N

Hobbies that included woodworking, wood restoration, welding, shot reloading, stained glass? Y/N

Water filtration? Y/N Type: Well water? Y/N Seasonal Allergies? Y/N

Plastic containers for cooking and/or reheating food? Y/N Change furnace filter regularly? Y/N

Gas or wood burning fireplace? Y/N Gas or electric stove? Y/N Indoor pets? Y/N Farming? Y/N

Carpeting throughout house? Y/N Shoes indoor? Y/N Dry cleaning? Y/N

Amalgams? Y/N #: Have you had any amalgams repaired or replaced? Y/N #:

Exposure History:

Alcohol:	Never	Occasional	Moderate	Daily
Type:				
Tobacco:	Never	Previous Smoker	Current Smoker	
Type:		Date Started:	# Packs/day	Quit:
Drug:	Never	Occasional	Moderate	Daily
Type:				

Personal History: PLEASE CIRCLE AND INDICIATE ANY AND ALL BELOW			
Constitutional		**Mouth**	
Nausea/Vomiting/Constipation/Diarrhea	Y/N	Tongue: Normal movement and speech	Y/N
Fever, Chills (shaking); Night Sweats (drenching)	Y/N	Tongue: Normal swallowing, No pain	Y/N
Recent Weight change	Y/N	Teeth: Restored, Repaired, Cosmetic, Pain	Y/N
Fatigue, Tired; Endurance depleted, Stamina lacking	Y/N	Teeth: Amalgams, Crowns, Caps, Braces	Y/N
Strength (decline) Exercise Tolerance (decreased)	Y/N	Teeth: Braces, Bridges, Root Canals	Y/N
Health (in general declining)	Y/N	Teeth: Extractions, Implants, Trays, Resins	Y/N
Head		Teeth: Amalgam removals or replacement	Y/N
Headaches: Tension, Migraine, Sinus, Cluster, Ictal	Y/N	Teeth: Dentures: Upper/Lower/Both	Y/N
Headaches: Back of neck, behind eye, Band-like	Y/N	Teeth: Full mouth extractions	Y/N
Vertigo: room spin/do you spin, dizziness, Meniere's	Y/N	Gums: Bleeding, Periodontal Surgeries	Y/N
Passing out, seizures	Y/N	TMJ: Pain, Surgery, Headaches	Y/N
Trauma: motor vehicle accident, loss of consciousness	Y/N	Jaw: Fractures	Y/N
Eyes		Jaw: Necrosis: Bisphosphonates, Radiation	Y/N
Vision: Normal, Corrected: [Glasses, Contacts, Lasik]	Y/N	**Neck**	
Tearing, dryness, pain	Y/N	Muscle: Stiffness, pain, Decreased flexibility	Y/N
Cataracts, retinal detachment, double vision	Y/N	Muscle: Motor vehicle accident; whiplash	Y/N
Loss of vision or blind spot in vision	Y/N	Bones: Arthritis, disc surgeries	Y/N
Glaucoma, Macular Degeneration [Wet/Dry]	Y/N	Bones: Degenerative disc disease	Y/N
Trauma, Surgery	Y/N	Tonsillectomy, difficulty swallowing	Y/N
Blindness: Color or Night	Y/N	Sensitivity gag reflex, hoarseness	Y/N
Ears		Recurrent laryngeal nerve injury	Y/N
Normal or Corrected: Hearing Aids or Cochlear Patch	Y/N	Polyps of the vocal cord	Y/N
Trauma, Pain	Y/N	Hypothyroidism, Hyperthyroidism	Y/N
Tinnitus, Bleeding, Vertigo, Meniere's	Y/N	Thyroid: Nodules: Hot or Cold; Goitre	Y/N
Infections: External, Middle, Inner	Y/N	Thyroid: Surgery, Cancer	Y/N
External ear: skin lesions, trauma, piercings, wax plugs	Y/N	Carotids: Artioventricular Septal Defect	Y/N
Nose and Sinsuses		Carotids: Stenosis, Bruits, Endarterectomies	Y/N
Loss of sense of smell	Y/N	Lymph nodes: Cervical enlargement	Y/N
Dry mouth	Y/N	**Breasts (Males and Females)**	
Nasal passages: open free breathing, discharge, snoring	Y/N	Skin: Peau d' Orange, Dimpling, Swelling	Y/N
Nasal passages: nose bleeds, runny nose	Y/N	Nipple: Discharge, Eczema, Palpable ducts	Y/N
Nasal septum: deviation, perforations, surgeries	Y/N	Breasts: Lumps, Swelling, Tenderness	Y/N
Sinuses: Tenderness, Allergies: Seasonal	Y/N	Breasts: Fribrocystic Breast Disease	Y/N
Sinuses: Allergies: Enviromental	Y/N	Exams, Mammograms, Ultrasounds, MRI, Biopsy	Y/N
Sinuses: Chronic medications, sprays, neti-pot	Y/N	Family History of Breast Cancer, Extra nipples	Y/N
Air Quality: do you use an air filter at home?	Y/N	Armpit: Masses, Lymphnode enlargement	Y/N
Neurologic		Surgery: Enlargement, Reductive, Reconstructive	Y/N
Weakness, Tremor, Seizure, Atrophy, Lack of body contro	Y/N	Meds: Birth Control, Hormone Replacement	Y/N
Changes in Memory (Recent/Past) or thought processing	Y/N	Breast fed children	Y/N
Trouble finding words, Behavior changes, Headaches	Y/N	**Psychiatric**	
Stroke, Brain Injury, Demyelinating Diseases, Brain Tumor	Y/N	Changes in mood and personality, Hallucinations	Y/N
Dementia, Encephalitis, Meningitis	Y/N	Anxiety, Depression, Changes in thought Content	Y/N
Balance and coordination difficulties	Y/N	Insomnia: Sleep: Falling, Staying, or Awakening	Y/N

Personal History Continued: PLEASE CIRCLE AND INDICIATE ANY AND ALL BELOW			
Respiratory		**Gastrointestinal**	
Cough, coughing up blood, wheezing, shortness of breath	Y/N	Appetite change, Difficulty Swallowing, Weight loss	Y/N
Difficulty breathing when climbing stairs, chest wall pain	Y/N	Abominal Pain	Y/N
Pleurisy, Exposure to second hand smoke	Y/N	Nausea, Vomiting, Diarrhea, Constipation	Y/N
Difficulty breathing when climbing stairs, chest wall pain	Y/N	Stool: #_____/day, Normal Consistency/Color	Y/N
Chest injury: fractures, pneumothorax	Y/N	Stool: Passed with/without straining or pain	Y/N
Tuberculosis exposure or abnormal test	Y/N	Bright red blood on toilet paper, Black/dark stools	Y/N
Pneumonia: Bacterial, Viral, Fungal	Y/N	Hemorrhoids: Internal/External, Anal Fissures	Y/N
Asthma: Inhalers, Environment, Allergies	Y/N	Anal spinchter intact/lax, Incontinence of stool	Y/N
Lung Cancer: NSCLC/SCLC; Mesothelioma (Asbestos)	Y/N	Heartburn, Painful swallowing, Food sticking	Y/N
Chest Xray, CT, MRI, Bronchoscopy, Pulmonary Function	Y/N	Esophagitis, GERD, Hiatal Hernia, Ulcers	Y/N
Bronchodilators, Steroids, O2 Cannula, Antibiotics	Y/N	Gallstones, Inflammed Gallbladder, Surgery	Y/N
Sleep Apnea: Obstructive Vs Central, BiPAP, CPAP	Y/N	Appendicitis, Appendectomy (Ruptured/Not)	Y/N
Cardiovascular		IBS, Crohn's, Celiac Sprue, Ulcerative Colitis	Y/N
Angina, Atypical chest pains, palpitations, passing out	Y/N	Gastric Bypass, Banding, or Stapling	Y/N
Shortness of breath, Difficulty breathing during exertion	Y/N	Obstructed bowel, Bowel resection	Y/N
Fatigue, Ankle/Calf Swelling, High Blood Pressure	Y/N	Pancreatitis, Cyst, Cancer, Exocrine/Endocrine Duct	Y/N
Severe shortness of breath and coughing attacks	Y/N	Hepatitis: A/B/C, HIV, Jaundice, Cirrhosis	Y/N
during the night		Dysbiosis, SIBO, Multiple Courses of Antibiotics	Y/N
Shortness of breath when lying down	Y/N	**Gynecologic**	
Heartattack, Congestive Heart Failure,	Y/N	Menses: Onset: _____ (age) LMP: _____	
Arteriosclerotic Cardiovascular Disease	Y/N	Cycle: Menses: _____ (days) Cycle: _____	
Angioplasty, Stenting, Coronary Artery Bypass Graft	Y/N	Flow: Heavy/Medium/Light, #Pads/Tampons ____	
Palpitations, Arrhthymias, Passing Out, Cardiac Arrest	Y/N	Birth Control: Y/N, Type: _____ Yrs Used: ____	
Defibrillation, Pacemaker, Ablation	Y/N	Menopause: _____ (age); Difficult transition?	Y/N
Rheumatic Fever, Rheumatic Heart Disease	Y/N	Hormone Replacemnent	Y/N
Valvular Heart Disease, Valve Replacement	Y/N	#Pregnancies: _____; # Deliveries: _____	Y/N
Myocardiopathy: Viral, Bacterial, Autoimmune	Y/N	Deliveries: Spontaneous or Cesarean	Y/N
Pericardial: Effusion, Tamponade	Y/N	Difficulty getting pregnant or pregnancy difficulties	Y/N
Pericardial: Effusion, Tamponade	Y/N	Ovaries: PCOS, Cysts, Tumors, Infections	Y/N
Genitourinary		Tubal ligations, Salpingectomy(s)	Y/N
Frequency, Urgency, Decreased Flow, Hesitancy	Y/N	Uterus: Endometriosis, Endometritis	Y/N
Straining to pass urine, Incontinence, Pain passing urine	Y/N	Uterus: Heavy bleeding, Ablation	Y/N
Intermittency, blood in your urine	Y/N	Uterus: Fibroid(s), Pain, Enlargement, Tumor	Y/N
Kidney: Infections, Stones, Tumors, Altered renal functior	Y/N	Uterus: Hystertectomy: Vaginal or Abdominal	Y/N
Bladder: Infections, Stones, Tumors, Incontience	Y/N	Cervix: Pap smears: Y/N. Atypical pap smear?	Y/N
Males		Cervix: Leep cauterization, Cryotherapy	Y/N
Prostate: Infections, Stones, Tumors, IPSS	Y/N	Vagina: Discharge: Odor, Copious, Yeast, Itching	Y/N
Testicles: Infections, Trauma, Tumors, Torsion, Hydrocele	Y/N	Vagina: Painful intercourse, Bleeding after? Drynes	Y/N
Epididymis: Varicosities, Infections	Y/N	Prolapse: Vagina, Uterus, Rectum, Bladder	Y/N
Scrotum: Infections, Rashes, Lesions	Y/N	Prolapse: Urethra, Small Bowel	Y/N
Penis: STDs, Peyronie's, Circumsized, Cancer, ED	Y/N	Labia: Atrophy, bleeding, Dryness	Y/N
Hernia: Inguinal, Femoral, Umbilical. Repairs?	Y/N	Hot flashes, Insomnia, Irritability	Y/N

Personal History Continued: PLEASE CIRCLE AND INDICATE ANY AND ALL BELOW			
Musculoskeletal		**Endocrine: Hypothyroidism**	
Muscles: Weakness, Atrophy, Tremors, Twitching	Y/N	Hypo: Fatigue, Hair loss, Constipation, Dry Skin	Y/N
Muscles: Continuous muscle contractions, Tics	Y/N	Slow Heart Rate, High Lipid Levels, Needing to nap	Y/N
Joints: Pain, Swelling, Tenderness, Dec/Increased Flexibilit	Y/N	Cold, Slow Thinking, Infertility, Elevated Glucose	Y/N
Joints: Infection, Gout, Rheumatism, Pseudo-gout	Y/N	Anxiety, Depressed Moods, Goiter, Swelling of Skin	Y/N
Joints: Degenerative Joint Disease, Psoriatic Arthritis	Y/N	**Endocrine: Hyperthyroidism**	
Bone: Osteopenia or Osteoporosis, Dexa Scan	Y/N	Hyper: Fatigue, Hair Loss, Diarrhea, Weight Loss	Y/N
Bone: Fractures, Necrosis, Metastasis	Y/N	Clammy Skin, Warm Feeling, Fast Heart Rate	Y/N
Spine: Scoliosis, abnormal curvature of low or upper back	Y/N	Abnormal heart beats or rhythms, Insomnia	Y/N
Varicosities, Deep Vein Thrombosis, Altered Gait	Y/N	Anxiety, Depressed Moods, Goiter, Swelling of Skin	Y/N
Dermatologic		Irritability, Bulging of the eyes	Y/N
Bruising, Bleeding, Rashes, Lesions, Tumors, Scratches	Y/N	**Endocrine: Glucose Metabolism**	
Skin Cancers: Basal Cell, Squamous Cell, Melanoma	Y/N	Pre-Diabetic, Syndrome X, Insulin Resistance	Y/N
Scratching of Skin, Itchy Areas, Thin Skin	Y/N	Diabetes Type II, Diabetes Type I, Insulin Use	Y/N
Dry, Oily, Pale, And/or Jaundiced Skin	Y/N	Drinking A Lot, Eating A Lot, Urinating A Lot	Y/N
Tanning Bed Use, Tattoo, Vitiligo	Y/N		Y/N
Burns: Thermal or Radiation	Y/N		

When was the last time you were in really good health?

Do you see yourself in good health again in the future?

Taking everything into consideration, are you: much worse / worse / the same / better much better than 6 months ago?

What has happened to you as a consequence of your illness?

What happened to your family as a consequence of your illness?

What are your future goals?

Operations:				**Diagnostic Studies:**	
	When:		When:	When have you had a(n):	
Tonsillectomy		Appendectomy		Mammogram	
Hysterectomy		Hernia		Pap smear	
Gall bladder		P.E. Tubes in ears		EKG	
Dental fillings		How many		Endoscopy	
Root canals		How many		Colonoscopy	
Caps		How many		Upper GI Series	
Other surgeries including date:				Barium Enema	
				Bone density	
Illnesses:				Chest X-ray	
	When:		When:		
Chicken Pox		Mononucleosis		Brain	
Measles		German Measles		Abdomen	
Mumps		Hepatitis		Spine	
Other illnesses including date:				Liver Scan	
				Neck X-ray	
Injuries:				**Immunizations:**	
	When:		When:	Pneumovax	/ /
Head injury		Broken		Hepatitis	/ /
Neck injury		Broken		Flu	/ /
Back injury				Completed Childhood Series	/ /
Other injuries including date:				Tetanus	/ /

Family History				
	If living: Age	Health	If deceased: Age	Cause
Father				
Mother				
Brother				
Brother				
Sister				
Sister				
Spouse				
Son				
Son				
Daughter				
Daughter				

Place an "X" in the appropriate column for any illnesses that your blood relatives have experienced.

Illnesses	Father	Grand-parents	Mother	Brothers	Sisters	Children
Alchoholism/Substance Abuse						
Allergies						
Anemia						
Appendicitis						
Arthritis/Rheumatism						
Asthma						
Birth Defects						
Bleeding						
Blood pressure - High						
Blood pressure - Low						
Bronchitis - Chronic						
Bursitis, Sciatica Lumbago						
Cholesterol - High						
Chronic Illness - Undiagnosed						
Cirrhosis						
Colon Problem						
Convulsions						
Depression						
Emphysema						

Illnesses	Father	Grand-parents	Mother	Brothers	Sisters	Children
Gall Bladder Disease						
Headache						
Heart Problem						
Hepatitis						
Hernia						
Hemorrhoids						
Hypoglycemia						
Jaundice						
Kidney or bladder problems						
Meningitis						
Menstrual Problems						
Mental Illness						
Miscarriage or Spontaneous Abortion						
Neurologic Disorder Obesity						
Pleurisy						
Pneumonia						
Polio						
Prostate Problems						
Rheumatic Fever						
Skin Problems						
Stroke						
Stomach or Small Intestinal Disease						
Suicide - Attempt Or Successful						
Surgeries						
Teeth/Gum Problems						
Transfusions						
Triglycerides - High						
Tuberculosis						
Ulcers						
Vaginal Problems						
Varicose Veins						
Veneral Disease						

Health Behaviors Profile								
	Health <----------						> Disease	
Drink 8 glasses of water	*	*	*	*	*	*	*	Drink very little water
Rarely salt food	*	*	*	*	*	*	*	Salt food a lot
Read food labels	*	*	*	*	*	*	*	Never read food labels
Chew food thoroughly	*	*	*	*	*	*	*	Chew food very little
Use glass, enamel, or stainless cookware	*	*	*	*	*	*	*	Use aluminum or reheat in plastic cookware
Regular bedtime	*	*	*	*	*	*	*	Irregular bedtime
Sleep 7- 8 hours	*	*	*	*	*	*	*	Sleep a lot or very little
Regular time to rise	*	*	*	*	*	*	*	Irregular rising time
2 or less alcohol drinks/day	*	*	*	*	*	*	*	More than 2 alcohol drinks/day
Never drive under the influence	*	*	*	*	*	*	*	Drive after drinking alcohol
Walk regularly	*	*	*	*	*	*	*	Don't walk regularly
Climb stairs when possible	*	*	*	*	*	*	*	Stay away from stairs when possible
Stand or take standing breaks during work	*	*	*	*	*	*	*	Sit at work
Breathe deeply and fully	*	*	*	*	*	*	*	Breathe shallowly
Daily stretching	*	*	*	*	*	*	*	Seldom stretch
Work on good posture	*	*	*	*	*	*	*	Seldom change posture
Daily sunlight exposure	*	*	*	*	*	*	*	Seldom outdoors
Satisfying job	*	*	*	*	*	*	*	Unsatisfying job
Satisfying marriage or partnership	*	*	*	*	*	*	*	Unsatisfying marriage or partnership
Cultivate good friendships	*	*	*	*	*	*	*	No good friends
Eat 2 raw vegetable salads per day	*	*	*	*	*	*	*	Eat no raw vegetables
Eat meals in a harmonious atmosphere	*	*	*	*	*	*	*	Much stress during meals
Mediation or relaxation daily practice	*	*	*	*	*	*	*	Never stop to relax or meditate
Rarely watch TV	*	*	*	*	*	*	*	Spend hours watching TV
Personal hobbies or recreation	*	*	*	*	*	*	*	Have no hobby or recreation
Financially stable	*	*	*	*	*	*	*	Financially unstable
Laugh several times daily	*	*	*	*	*	*	*	Seldom laugh
Compliment others	*	*	*	*	*	*	*	Never compliment others
Listen to body signals	*	*	*	*	*	*	*	Try to ignore signals
Stop eating when satisfied	*	*	*	*	*	*	*	Consistenly overeat
Read health articles	*	*	*	*	*	*	*	Never read health articles
Ask Dr. ?s when curious	*	*	*	*	*	*	*	Afraid to ask Dr. ?s
Evaluate and plan ahead	*	*	*	*	*	*	*	Rushed don't plan ahead

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NOTICE OF PRIVACY PRACTICES
(Medical)
THIS NOTICE DESCRIBES HOW MEDICAL INFROMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.
PLEASE REVIEW CAREFULLY.

The Health Insurance and Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders, information about treatment alternatives or other health related benefits, and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are requested to honor and abide by that written request, except to the extent that we have already taken action per your authorization.

You have the following rights with respect to you protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, such as those related to family members, other relatives, close personal friends or any person identifiable to you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of September 1st, 2012 and we are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post this document in a visible location within our office and you may request a written copy of the revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice. We will not retaliate against you for filing a complaint. For more information about HIPAA or to file a complaint, contact:

The US Dept. of Health and Human Services
Office of Civil Rights
200 Independence Ave. SW
Washington, DC 20201
(202) 619-0257 or 1-800-696-6775

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NOTICE OF PRIVACY ACKNOWLEDGEMENT (HIPAA)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 health care 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 acknowledge that I have received 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 its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing, that you restrict how my private information is used or disclose 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's Name Date

_____ _____
Signature Relationship to the Patient

(Office Use Only)

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

Date _____ Initials _____Reason_____

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FINANCIAL POLICY

Thank you for coming to Core Health Strategies, where we provide the best in integrative and naturopathic medicine by design. It is our office policy to assist patients in every way possible, to make necessary health care attainable and affordable. Charges for treatment, services, nutritional, injectable, herbal, and homeopathic products are **DUE and PAYABLE at the time service is provided** (on a per visit basis).

Method of payment: We accept cash, check, credit card (Visa, MasterCard and Discover), debit card (Visa and MasterCard) and HSA debit and credit cards (Health Saving Accounts).

Insurance: We do not accept insurance. Payment is due at the time services are rendered. Upon request, we will provide diagnostic and procedure codes which you can send in to your insurance company. We are considered out-of-network providers. Everyone has a different plan with their insurance company and we are not able to tell you if your specific plan has out-of-network coverage. If your plan does include out-of-network coverage, you will be directly reimbursed by your insurance company.

Personal Injury and Worker's Compensation: We will work on and with anyone who has a personal injury or worker's compensation injury claim. Payment is due at the time services are rendered. You will need to fill out the necessary paperwork and we will provide any information that is needed for your claim to be complete. All claims and reimbursement are to be handled between the patient and the insurance company they are working through.

Return check policy: In the event your check is returned by the bank (for whatever reason), $35 will be added to your total charges.

CANCELLATION POLICY: For NEW and EXISTING patients, we consider an appointment to be an agreement between you and our office. If for any reason you need to and do not cancel your appointment, we become unable to provide service to another patient during your scheduled time. **If you decide not to keep the appointment without giving the appropriate notice, you will be charged a cancellation fee of the full cost of the visit.** This policy applies to treatment appointments as well. For new patient appointments, we ask for a 48-business hour notice of cancellation. For established patient appointments, 24-business hours notice of cancellation. A credit card will be used to hold new patient appointments. Your credit card will not be charged unless you miss your appointment without giving the proper cancellation notice. Please note that insurance companies do not reimburse for missed appointments, should you decide to submit to your insurance. Our office policy requires a cancellation fee in the amount of the FULL appointment, if adequate notice is NOT given, or your appointment is MISSED altogether ($65 for 15 minute appointments, $150 for 30 minute appointments and $190 for 60 minute appointments).

If you cancel or miss 2 appointments in a row, that 3rd appointment scheduled, will have to be paid IN ADVANCE, IN FULL.

_____ _____

Patient's Signature Date

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Electronic Consent

E-mail offers an easy and convenient way for patients and doctors to communicate, but e-mail is not the same as calling our office nor should it be intended to replace an office visit as there is no guarantee that our two-way messages will be received or received appropriately. One cannot tell for certain when their message will be read, or even if their doctor is in the office when a response has been made. Nonetheless, we believe that the ease of e-mail communication provides a general benefit to your care. It will further assist us if you if you could identify the nature of your request in the subject line of your message. **If you have multiple questions we ask that a phone call to the office is placed so we can determine if a consult with your doctor is needed.**

- E-mail is never, ever, appropriate for urgent or emergency problems! If you have an emergency, please go quickly and directly to the nearest Emergency Department or call **911**.
- E-mail correspondence should be brief and concise, completely related to your medical care, and should focus on issues that are unlikely to require a lot of discussion. Core physicians are not able to respond via email to complicated questions that require a lengthy response. If you ask such a question, Core physicians will reply that we need to discuss such a question or issue in person at your next appointment. Appropriate uses of e-mail also include referrals and appointment scheduling requests and billing/insurance questions.
- Email should relate to existing issues or treatments that you have already discussed with your Core physician; emails should not regard any new medical issues or treatments.
- E-mails should not be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- E-mail is not confidential; it is akin to sending a postcard through the mail. Content should be limited to issues that are not sensitive to you or that will not compromise your privacy in a manner unacceptable to you. Our staff may read your e-mails to handle routine, non-clinical matters. You should also know that if sending e-mails from work, your employer may have a legal right to read your e-mail. We cannot guarantee the confidentiality of the messages that you send to me, or our messages sent to you.
- E-mail may become a part of the medical record; a copy may be printed and put in your chart.
- E-mails may be forwarded between staff members for handling, if appropriate.
- E-mail to the staff that requires a physician's input may take up to 4 business days for reply.

Finally, Core Health Strategies, PLLC or you can revoke permission to use the e-mail system at any time.

I DO want to communicate with Core Health Strategies, PLLC electronically. I have read the above information and understand the limitations of security on information transmitted. I understand that if I send an email and do not receive a response within two business days I will need to call **Core Health Strategies, PLLC** office regarding the email.

Name: _____ Date: _____

Signature: _____ E-mail:: _____

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Informed Consent for Intravenous Therapy

I, _____ consent to the procedure below to be performed at Core Health Strategies.

(Initials) _____ I have informed the doctor(s) and staff of any known allergies to drugs or other substances, or of any past reactions to anesthetics.
(Initials) _____ I have informed the doctor(s) and staff of all current medications and supplements.

Core Health Strategies provides facilities and medical personnel to assist in the performance of intravenous therapy. I understand I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not performed until you have had an opportunity to receive such information and to give your informed consent.

I understand that:

A. The procedure involves inserting a needle into your vein or muscle and injecting the formula described above by your doctor(s).
B. Alternatives to intravenous therapy is oral supplementation and/or dietary and lifestyle changes.
C. Risks of intravenous therapy include:
    i. Occasionally to commonly: Discomfort, bruising, and pain at the site of injection
    ii. Rarely: Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
    iii. Extremely rare: Severe allergic reaction, anaphylaxis, cardiac arrest, and death.
D. Benefits of intravenous therapy include:
    i. Injections are not affected by stomach or intestinal disease.
    ii. Total amount of infusion is available to the tissues.
    iii. Nutrients are forced into cells by means of a high concentration gradient.
    iv. Higher doses of nutrients can be given than possible by mouth, without intestinal irritation.

I am aware that other unforeseeable complications could occur. I do not expect the doctor(s) and staff to anticipate and or explain all risks and possible complications. I rely on the doctor(s) and staff to exercise judgement during the course of treatment with regards to my procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all my questions answered.

I understand I have the right to consent to or refuse any proposed treatment at any time prior to its performance. My signature on this form affirms that I have been given my consent of the procedure(s) described above with any different or further procedures which, in the opinion of my doctor(s), may be indicated.

I understand the information provided on this form and agree to the foregoing. I understand that there is no implied or stated guarantee of success or effectiveness of any treatment. I understand that I am free to withdraw my consent and to discontinue participation in intravenous therapy treatments at any time.

Your signature below means that:

A. You understand the information provided on this form and agree to the foregoing.
B. The procedure(s) set forth above has been adequately explained to you by the doctor(s).
C. You have received all the information and explanation you desire concerning the procedure.
D. You authorize and consent to the performance of the procedure(s).

Patient's Name - Print	Patient's Name - Signature	Date
Doctor Name - Print	Doctor Name - Signature	Date
Witness Name - Print	Witness Name - Signature	Date

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AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name: _____ Maiden/Other Name: _____

Date of Birth: _____ Phone: _____

I authorize release of information from:

_____

_____

_____

To be released to:
Core Health Strategies, PLLC
311 N. Mandan Street Suite 1
Bismarck, ND 58501
701.751.4464 (ph)
701.751.3947 (fax)
info@corehealthstrategies.com (email)

PURPOSE OF THIS REQUEST (required) __Medical Appointment_____ Date needed by: _____

INFORMATION TO BE RELEASED:

_____ last 2 years medical history & 1 year lab & x-ray reports

_____ other (please be specific) _____

Records that are of sensitive nature will not be released unless specifically authorized below.
Any patients 14 years or older must authorize the release of their own sensitive information.

Psychiatric/Mental Health/Chemical Dependency _____ Date: _____

Contraception/STDs (if ages 14-17) _____ Date: _____

I understand that if records are released to someone who is not a healthcare provider, health plan or health care clearinghouse, the health information released as a result of this authorization may no longer be protected by the federal privacy standards and the information may be further disclosed without obtaining my authorization.
I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed by this authorization form by contacting the staff of Core Health Strategies, PLLC at (701) 751-4464.
I understand that if I sign this authorization, I have a right to receive a copy of this form if requested.
I understand that I am under no obligation to sign this form and the action requested in the release will no be executed without a signature. However, our medical treatment of the patient is not conditional on the signing or failure to sign this form. This authorization is effective for one year unless otherwise specified as follows: _____.
I understand I may cancel this authorization at any time by written notification. I am aware that my withdrawal will no be effective to uses and/or disclosures of my health information that may have already been released. For information regarding how to withdraw my authorization or to receive a copy of it, I may contact the staff of Core Health Strategies, PLLC at (701) 751-4464.
I understand that Core Health Strategies, PLLC will not receive payment in connection with the use or disclosure of my health information, unless specified here: _____. This does not apply to a reasonable fee for copying and mailing when releasing records directly to the patient. There is no charge if medical records are released to a physician, hospital, clinic, or other medical facility for continued care purposes. Please ask the staff at Core Health Strategies, PLLC at (701) 751-4464 to see the printing fees for releasing records directly to the patient.

I have had an opportunity to review and understand the contents of this authorization. By signing this authorization, I am confirming that it accurately reflects my wishes. I release the staff of Core Health Strategies, PLLC from all liability pertaining to disclosure of any information in association with this release. A photocopy of this release is as valid as the original.

_____ Date: _____
Signature of Patient or Legal Representative

_____ _____
If not present, state relationship – proof may be required Witness