Life's Medicine

New Patient Information Sheet

Check Services of Interest

Weight Loss____	Slim Shot/ Energy Shot ____	Cryotherapy ____
Athletic Biomarker ____	MetaCheck ____	Other____

Today's Date:_____

Name:_____ D.O.B._____ Age:_____

Address: _____ City:_____ State: _____ Zip: _____

Phone: (___)_____ E-Mail:_____

How did you hear of us?_____

Gender: ___Male ___Female Height:_____ Weight:_____

LMP:_____ Primary Care Physician:_____ Phone:_____

Surgeries:_____

_____

List any medication/ hormone/ supplement you are taking now and the respective doses:

_____

_____

_____

List any allergies you have to drugs, food or other items:

_____

_____

_____

Are you currently under medical care for any reason? If yes, please explain:

_____

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Do you use tobacco? Yes__ No____How often and how much? _____
Do you use alcohol? Yes__ No____How often and how much? _____
Do you use caffeine? Yes__ No____How often and how much? _____

Please check if you suffer from any of the conditions listed below

High Blood Pressure:____
Stroke:____
Joint Disease:____
Respiratory Diseases:____
Areas of Numbness:____
Paralysis:____
Kidney Disease:____
Migraines:____
Tension Headaches:____
Heart Disease:____
Diabetes:____
Joint or muscle injuries:____
Areas of Chronic Pain:____
Skin Disease:____
Digestive Disease:____
Infectious Disease:____

Other serious illness or medical conditions (Please Explain):

For Cryotherapy patients only

Please indicate your interest in the following benefits of whole body Cryotherapy
(1 indicates great interest, 5 little interest)

Tension release 1 2 3 4 5

Recovery from injury, illness or surgery 1 2 3 4 5

Relaxing treatment 1 2 3 4 5

Improvement of athletic performance 1 2 3 4 5

Relief of pain and stiffness 1 2 3 4 5

Signature:_____ Date: _____

Life's Medicine HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, and healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected Health Information, or PHI, is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operations of the physicians practice, and any other use required by law.

Treatment

We will only use and disclose your protected health information to provide, coordinate, or manage your healthcare and related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you, or provide it to a physician whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your protected health information will be used as needed to obtain payment for your healthcare services.

Healthcare Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include but are not limited to quality assessment, employee review, training of medical students, and licensing. For example, we may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments.

We may use or disclose your protected health information in the following situations without your authorization: as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, and national security. Under the law, we must also make disclosures to you, and when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted & Required Uses and Disclosures

Disclosures will be made only with your authorization or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Individual Rights:

1. You have the right to inspect and receive a copy of your protected health information. Our practice will accept such requests in writing. Under federal law, however, you may not inspect or receive a copy of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.
2. You have the right to request a restriction on the disclosure or your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends whom may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of our protected health information, your health information will not be restricted. You then have the right to use another healthcare professional.
3. You have the right to request to receive confidential communications from us by an alternative means or at an alternative location.
4. You have the right to obtain a paper copy of this notice from us.
5. You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will post any changes in our waiting areas. You then have the right to object as provided in this notice.

Life's Medicine Receipt of Notice of Privacy Practices

Life's Medicine reserves the right to modify the privacy practices outlined in this notice. By signing below, I am indicating that I have received a copy of the Notice of Privacy practices for Life's Medicine.

Printed Name: _____ Patient Signature: _____

Life's Medicine Authorization to Release and Disclose Protected Health Information

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we communicate with you directly regarding various issues including, but not limited too, our products and/or services we currently offer or which we intend to provide, and promotions and/or prizes. This form authorizes us, as well as our business associates who are working on our behalf, to utilize your protected health care information, such as your name, address, email, and phone number to communicate with you. You are not required to sign this authorization as a condition of eligibility as a Life's Medicine patient.

This authorization is completely voluntary and shall remain in effect until thirty-six (36) months after your last visit. You may revoke the authorization at any time. However, the revocation will not be effective to the extent that we have already acted in reliance on this authorization.

By signing below, you are acknowledging that you have read this authorization carefully and you are authorizing us to utilize your confidential protected health information to communicate with you. You understand that by communicating with you through mail, email, or by phone there is a potential for your protected health care information to become re-disclosed and utilized by the recipient without your knowledge or consent and therefore the privacy of your personal and health information will no longer be protected by federal privacy regulation.

Authorization to Release and Disclosure Protected Health Information:

Printed Name: _____

Signature: _____

Notice: As of August 1st, 2013, Life's Medicine began enforcing a cancellation policy. A non-refundable fee ($50 for regular visits/$25 for short visits) will be charged to patients who do not cancel within 24 hours of their appointment.

By signing below, you agree that you have read and understand this change in policy.

Printed Name _____

Signature _____

Date _____