Living Health
Holistic Health Care

REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

First Name:	Middle:	Last:	Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Email:	D.O.B.	Age:	Sex: [ ] Male [ ] Female

Street Address:

City:	State:	Zip Code:

Home phone:	Cell phone:	
Occupation:	Employer:	Employer phone:

Referred by / How you heard about us:

Other family members seen here:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship:	Cell phone:

Patient/Guardian signature

Date

General Consent for Care and Treatment Consent

TO THE PATIENT:

You have the right, as a patient, to be informed about your condition and the recommended Diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary examinations, testing and treatment. By signing below, you are indicating that:

(1) You intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended

(2) You consent to treatment at this office or any other satellite office under common ownership.

The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your practitioner about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request the health care providers or the designees as deemed necessary, to perform reasonable and necessary examination, testing and treatment for the condition which has brought me to seek care at this practice.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative____

Printed Name of Patient or Personal Representative ____

Relationship to Patient_______________________________*Date*_____________________________

Cancellation Policy

If you need to cancel or reschedule an appointment, please give 24 hours advance notice to ensure you will not be charged for the appointment. If less than 24 hours notice is given and we are unable to fill your time slot, you will be charged for the appointment. (Remember, our confirmation texts do not receive replies. You must call or email to change or cancel an appointment.)

Return Policy

All supplement sales are final.

I have read and understand the Cancellation and Return Policies.

Signature of Patient or Personal Representative

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NOTICE OF PRIVACY PRACTICES

Effective January 2003

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

Your Health Information & Rights

Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment and a plan for future care or treatment. This information is referred to as your health or medical record. This Notice of Privacy Practices describes how we use or disclose your health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law.

Although your health records are the property of the practice, this information belongs to you. You have the right to:

1. Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
2. Obtain a paper copy of this notice of privacy practices
3. Inspect and request a copy of your medical record as provided for in 45 CFR 164.524
4. Amend your health record as provided in 45 CFR 164.526
5. Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
6. Request communications of your health information by alternative means and locations

Living Health's Responsibilities:

1. Maintain the privacy of your health information
2. Provide you with this notice as to our legal duties and privacy practices with respect to your health information
3. Abide by the terms of this notice
4. Notify you if we are unable to agree to a requested restriction

We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. The current Notice of Privacy Practices can be reviewed by contacting us and requesting that a revised copy be sent to you in the mail. We will not use or disclose your health information without your authorization, except as described in this notice.

<u>For more information or to report a problem:</u>

If you have questions and would like additional information, you may contact the office at (830) 632-5906. If you believe that your privacy rights have been violated, you can file a complaint with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Care Operations:

Living Health will use your health information for treatment. Your health information may be released to other healthcare professionals with the hospital and the community for the purpose of providing you with quality healthcare. For example: information obtained by one of our staff including providers, nurses and administrative staff will be recorded in your record and used to determine the course of treatment that should work best for you. We will also provide your physician or a subsequent healthcare provider, such as a nursing home, home health care agency or physical therapy office, with copies of various reports that will assist them in treating outside of this office as necessary.

We will use your health information for payment. For example: a bill may be sent to your insurance company or other third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, tests and supplies used in the course of your care in our office.

If you understand the above notice and information contained within, we ask that you sign and date that you acknowledge receipt of this information from our office. We will keep a copy of this signed notice in your medical record and provide you a copy for your own records if requested.

Disclosures

Business Associates: There are some services provided in our clinic through contracts with business associates. Examples include physician services in the emergency department and radiology, certain lab tests, transcription services and billing companies. Through a signed agreements, we require all business associates to comply with HIPPA laws and requirements to safeguard your health information.

Notification: We may use or disclose information to notify a family member, personal representative, or other person responsible for your car, your location and general condition.

Communication with Family: Our staff, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Food & Drug Administration: We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized to comply with Texas laws relating to the workers compensation program.

Public Health: As required by Texas law we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.
Communicable Disease: We may disclose health information as required by Texas law to a person who may have been exposed to communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Abuse or Neglect: We may disclose health information to a health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the government agent authorized to receive such information.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing & Patient Satisfaction Surveys: We may contact you to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you. We may also contact you to obtain your opinion about our services.

Law Enforcement: We may disclose health information for law enforcement purposes as required by Texas law or in response to a valid subpoena or court order.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Military & Veterans: If you are a member of the armed services, we may disclose health information as required by military command authorities.

Signature of Patient (or legal representative) Date

New Patient Gynecology Form

Today's Date: ______________________________

Name: ___________________________________ Date of Birth: _____________________Age: ______

Primary Care Physician: __________________________ Telephone: ___________________________

Pharmacy: ___________________________________ Pharmacy Address: ______________________

Menstrual History:

First day of last menstrual period_________________________

Age at first menstrual period (years)______________________

Number of days from the start of one period to the start of the next (days)______________________

Number of days that you bleed_____________________________

Describe the amount of menstrual flow (circle one) light / moderate / heavy / clots

How many tampons or pads do you use on your heaviest day? ________________________________

Describe the amount of menstrual discomfort (circle one) none / mild / moderate / severe

Do you bleed in between your periods? Yes No

Do you bleed after intercourse? Yes No

If you stopped menstruating, at what age did you stop? (years)________________________________

Have you had bleeding or spotting since your periods stopped? Yes No

Contraceptive and Sexual History:

Present birth control method: ____

Birth control methods used in the past:

METHOD LENGTH OF USE REASON FOR DISCONTINUATION

1)____

2)____

Have you ever been sexually active (had intercourse)? Yes No

Have you had a new sexual partner in the past three months? Yes No

How many sexual partners have you had in the past 3 months? _________________________________

Is/Are your partner(s) male, female, or both? Male / Female / Both

Do you experience pain or discomfort with sexual intercourse? Yes No

Would you like to discuss sexual activity or birth control today? Yes No

Gynecological History:

Have you been vaccinated for Human Papilloma Virus (HPV) – Gardasil Yes No

Last Pap Smear____

Last Mammogram____

Last Bone Density (DEXA)____

Last Colonoscopy____

Have you ever been on hormone therapy (estrogen / progesterone/ testosterone)? Yes No

Any personal history of:

Abnormal Pap Smears? Yes No Sexually transmitted diseases? Yes No

List:

Fibroids? Yes No Endometriosis? Yes No

Infertility? Yes No Urinary incontinence? Yes No

Obstetrical History:

Please record the number of:

Pregnancies_________Living Children__________Vaginal Births_________C-Sections__________Ectopic_________

Miscarriages_________Abortions____________________

List any complications of pregnancies____

Medical History:

Please check if you or a blood-relative have had any of the following:

	Myself	My Family		Myself	My Family
Anemia			Urinary Tract Infection		
High Blood Pressure			Lupus		
High Cholesterol			Arthritis		
Heart Disease			Back Injury		
Stroke			Osteoporosis		
Diabetes			Liver Disease / Hepatitis		
COPD / Emphysema			Gall Bladder Disease		
Asthma			Blood clots in veins/lungs		
Seizures			Blood Transfusion		
Thyroid problems			Breast Cancer		
Mental Illness			Colon Cancer		
Depression			Uterine Cancer		
Anxiety			Ovarian Cancer		
Eating disorder			Other Cancer, specify:		
Migraine Headaches			Other Medical Problems (list all):		

Surgical History: Please list any operations, including the year, or your age when you had it:

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Personal / Social History:

Occupation___________________________________ Marital Status_______________________________

Do / Did you use tobacco products? Yes No How much? ________________________________

Do / Did you drink alcohol? Yes No How many drinks per week? ___________________________

Do / Did you use illicit/street drugs? Yes No Which drugs? ________________________________

Have you ever been tested for HIV? Yes No Year and result: ______________________________

Have you ever been a victim of physical, verbal, emotional or sexual abuse? Yes No

Medications:

Please list any medications you take, including over-the-counter medicines

MEDICINE	DOSE	HOW OFTEN	MEDICINE	DOSE	HOW OFTEN

Please list any allergies to medications: ____

Current Medical Concerns:

Please circle if you have had any of the following this week:

Weight change Yes No | Abnormal bleeding Yes No | Abnormal hair growth Yes No

Problems with urination Yes No | Nausea / Vomiting Yes No | Bowel changes Yes No

Anxiety / Panic Yes No | Depression Yes No | Trouble sleeping Yes No

Night sweats / Hot flashes Yes No | Breast problems Yes No

Is there any other information you feel we should have?

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_________________________________ _________________________________

Patient Signature Date