ARIZONA WELLNESS CENTER

PATIENT'S NAME: _____DATE OF BIRTH:_____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

WOULD YOU LIKE TO RECEIVE EMAILS REGARDING MONTHLY SPECIALS? _____ YES _____ NO

MARITAL STATUS: S M D W IF MARRIED SPOUSE'S NAME: _____

AGE:_____ SEX: M/F HEIGHT:_____ WEIGHT:_____

DO YOU HAVE CHILDREN?:_____ HOW MANY?_____

HOW WOULD YOU RATE YOUR CURRENT HEALTH?: EXCELLENT AVERAGE POOR

WHAT ARE YOUR 3 GREATEST HEALTH GOALS?

1._____

2._____

3._____

PHARMACY:_____ PHONE:_____

PHARMACY ADDRESS:_____

EMERGENCY CONTACT:

NAME: _____ PHONE: _____

RELATION TO PATIENT:_____

How did you her about us:_____

I certify that I have read and agree to Arizona Wellness Center payment policy. A $35.00 returned check fee will be charged for checks returned due to insufficient funds. A $50 charge will be applied for "no show" appointment. We need 24 hours' notice to cancel an appointment.

There are many restraints, restrictions and continual changes dictated by insurance companies. After a lot of thought and evaluation we have concluded that it is best to NOT accept insurance for our services which include not being able to do prior authorization for prescriptions. In doing such we can serve you with quality individual care at a reasonable cost. We strive to provide you with the most current medical information that is based on peer reviewed medical journals and evidence based medicine.

If you are concerned your insurance won't cover your blood work, please talk to us about our discounted rates.

PATIENT'S SIGNATURE: _____ DATE: _____

Patient History Form

Date_____

This is a confidential record and is maintained in our office. The information will not be released without your permission to do so.

Name: _____ **Date of Birth**:_____

Ethnicity: _____ **Occupation**:_____

Are you allergic to any medicine? Please list medicine and reaction_____

Past Medical History

Have **YOU** or anyone in your family (parents, grandparents or siblings) had any of the following? **Please list whom.**

[You] [Family] [Who]

Yes No Blood disorder_____ _____
Yes No Heart disease, stroke, heart attack before age 60 _____ _____
Yes No High blood pressure _____
Yes No Diabetes _____
Yes No Colon Cancer_____
Yes No Breast Cancer _____
Yes No Prostate Cancer _____
Other medical problems _____
_____

List medications, vitamins, hormones and/or any supplements that you are currently taking
_____ _____
_____ _____
_____ _____

List any other surgeries:_____

List any other hospitalizations and reason:_____

Social History

Do you currently smoke? **Y N** How long have you smoked?_____ When did you quit?_____

Do you drink alcohol? **Y N** How much?_____ How often?_____

Do you currently use recreational drugs? **Y N** In past? **Y N**

Women only: First day of last menstrual period? _____
Number of pregnancies_____ Live births_____ Miscarriages _____
Date of last mammogram _____ Location:_____
Date of Pap smear _____ Name of Provider_____
Have you had a hysterectomy_____Date:_____

Men only: Last PSA_____
Date of last digital rectal exam_____Provider_____
Do you use Viagra, Cialis, Levitra or any other erectile enhancement drug?_____

Review of Systems

Do you *REPEATEDLY* have any of the following issues related to the following systems? Please circle and rate the symptom from 1-10 (1 being the worst and10 being the best)

WOMEN Scale (1-10)

Weight Gain _____
Fibrocystic Breast _____
Hot Flashes _____
Dry Skin/ Hair _____
Anxiety _____
Depression _____
Night Sweats_____
Headaches _____
Vaginal Dryness
Irritability _____
Mood Swings_____
Breast Tenderness _____
Sleep Disturbances _____
Cramps _____
Fluid Retention _____
Breakthrough Bleeding _____
Fatigue _____
Loss of Memory_____
Harder to Reach Climax _____
Decreased libido_____
Hair Loss_____
Urinary Incontinence_____
Brain fog_____
Acne_____
Hangry_____
Joint pain_____
Bloating_____
Constipation_____
Loose bowels_____
Food allergies_____
Lack of sweating_____

MEN Scale (1-10)

Weight Gain _____
Dry Skin/ Hair_____
Anxiety_____
Depression_____
Headaches_____
Irritability_____
Sleep Disturbances_____
Fatigue_____
Loss of Memory_____
Joint Pain_____
Loss of drive/ competitive edge _____
Harder to Reach Climax_____
Decreased libido_____
Hair Loss_____
Erectile dysfunction_____
Decreased firmness of erections_____
Brain fog_____
Acne_____
Hangry_____
Joint pain_____
Bloating_____
Constipation_____
Loose bowel_____
Food allergies_____
Lack of sweating_____
Food allergies_____

Patient Signature:_____ Date:_____

Are you interested in:

Coolsculpting: _____ Botox: _____
Fillers:_____ Microneedling:_____
Chemical Peels:_____ Vampire hair (PRP):_____
Vampire face lift(PRP):_____ ED treatments:_____

NOTICE OF PRIVACY PRACTICE

To our patients: This notice describes how health information about our patients may be used and disclosed. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996. (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.
5. If you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or a law enforcement official.
8. For Workers Compensation and similar programs.
9. To remind you of needed appointments in the near future by way of a mailed postcard.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in the patient's care, such as family members or friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, please ask the front desk receptionist.
4. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable laws.

If you have any questions regarding this notice please **let us know!!!**

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices for Arizona Wellness Center.

Signature of Patient _____

Name of Patient_____ Date_____

Patient Record of Disclosures

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

[ ] Home Telephone _____
[ ] Ok to leave message with detailed information
[ ] Leave message with call back number only

[ ] Ok to email _____
[ ] Ok to mail to my home address
[ ] Ok to mail to my work/office address

[ ] Work Telephone_____
[ ] Ok to leave message with detailed information
[ ] Leave message with call back number only

[ ] Other _____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests the PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

DATE	Disclosed to who Address or Fax number		By whom Disclosed	