Medical History and Colonic Intake Form

Date _____ **Email Address**_____

Name (First, MI, Last)_____ **Date of Birth**_____ **Age** _____

Street Address_____

City_____ **State** _____ **Zip** _____ **Marital Status:** M / W / S / D

Home Phone (_____)_____ **Cell Phone** (_____)_____ **Work Phone** (_____)_____

Emergency Contact Name _____

Phone Number_____ **Relationship** _____

Name of Physician who referred you_____

How did you hear about us? ( ) **Groupon** ( ) **Physician Referred** ( ) **Facebook** ( ) **Friend/Relative**

Medications/Supplements currently taking _____

_____

Allergies ( ) **YES** ( ) **NO if yes, please list (medication, food, environmental, etc.)** _____

_____

Health and History (Check all that apply)

_____Headaches
_____Constipation
_____Fainting spells
_____History of seizures
_____Fatigue
_____Thyroid Disease
_____Cirrhosis
_____Double/Blurred Vision
_____Rectal bleeding
_____High/Low Blood Pressure
_____Angina (chest pain)
_____Poor Circulation
_____Rapid/Irregular heart beat
_____Congestive Heart Failure
_____Cancer

_____Colitis
_____Chronic cough
_____Crohn's disease
_____Ulcerative colitis
_____Diverticulitis/diverticulosis
_____Gall bladder disease
_____Inflamed appendix
_____Kidney infection/stones
_____Painful urination
_____Arthritis
_____Bursitis
_____Back Pain
_____Neck Pain
_____Prostate Dysfunction

_____Shortness of breath
_____Kidney failure
_____Emphysema
_____Bronchitis
_____Asthma (wheezing)
_____ Diarrhea
_____Hemorrhoids
_____Ulcers
_____Hernias
_____Cysts/ Fibroids/ Tumors
_____Water Retention

What would you like to accomplish with your visit today? _____

How many bowel movements do you have? _____**x per day** _____**x per week** _____**x per month**

Do you use a stool softener, laxative or herbal laxative? ( ) **YES** ( ) **NO Name of product(s)**_____

If yes to the above question, how often?_____**x per day** _____**x per week** _____**x per month**

Have you ever had rectal bleeding? ( ) **YES** ( ) **NO if yes, when?** _____

_____ _____

Patient/Legal Guardian Signature **Date**

With signing this intake form, you acknowledge all of the information provided is correct to the best of your knowledge. You are also consenting to the performance of Colon Hydrotherapy treatments rendered by a Licensed Hydrotherapist employed by Diverse Medical Care

Phone Message Consent

Unless Diverse Medical Care has your written permission to do so, we will not:

- Leave messages with anyone except the patient.
- Leave information on an answering machine.
- Send emails and/or fax.

I,_____, give *Diverse Medical Care* permission to leave phone messages, send emails or fax information regarding my medical care. I fully understand that this consent will stay in effect until otherwise documented in writing.

Cell phone (_____)_____

Home phone (_____)_____

Work phone (_____)_____

Fax (_____)_____

Email _____

I also give permission for my medical information to be released to the following:

1._____at (_____)_____
Name of person / Relationship Best phone number

2._____at (_____)_____
Name of person / Relationship Best phone number

_____ _____
Patient/Legal Guardian Signature Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and 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 rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse your personal health information.

Diverse Medical Care must use and disclose or share your health information as necessary for treatment, payment and health care operations to provide you with quality health care.

We are permitted to use and release your health information without authorization from you. Treatment includes sharing information with other health care providers involved in your personal care. We may also use your health information as required by your health insurance to determine eligibility or to obtain payment for your treatment.

Your health information may be used for the following purposes unless you otherwise ask for restrictions on specific uses or disclosures:

- Family members or close friends involved in your care or payment for treatment. *
- Disaster relief agency if you are involved in a disaster relief effort. *
- Appointment reminders
- Law enforcement, as required by federal, state or local law.
- Health oversight activities, such as audits, inspections and licensures.
- Lawsuits and disputes, in response to a court or administrative order, subpoena, discovery request or another law request.
- Coroners and medical examiners.

Note: Statements with the asterisk symbol (*) indicate communications about your health information you are able to refuse.

Contact the office if:

- You have any questions about this notice;
- You wish to request restrictions on uses and disclosures for health care treatment, payment and/or operations; or
- You wish to obtain a copy of this notice

Notice of Privacy Practices Acknowledgement

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices which explains how your health information may be handled in various situations including your treatment, payment of services and our healthcare operations.

( ) I have received and read the Notice of Privacy Practices

_____ _____

Patient/Legal Guardian Signature Date

FOR OFFICE USE ONLY

Was the patient given a copy of the Notice of Privacy Practices? ( ) YES ( ) NO

Please explain why the Notice of Privacy Practices was not signed and our efforts to try and obtain the patient's signature.

_____

_____

_____

_____

_____

_____ _____

Signature/Title Date

No Show and Cancellation Policy

We understand that situations arise in which you must cancel or reschedule your appointment. It is therefore requested that if you must cancel or reschedule, that you provide more than 24 hours notice. This will enable for another patient who is waiting for an appointment to be scheduled in that appointment slot. With cancellations of less than 24 hours notice, we are unable to offer that appointment slot to other patients.

Office appointments which are cancelled with less than 24 hours notification will be subject to a $35.00 cancellation fee. Colonic cancellations with less than 24 hour notification will be subject to a $50.00 cancellation fee.

Patients who do not show up for their appointment without a proper call to cancel an office appointment or Colonic will be considered as a *NO SHOW*. Patients who No-Show for an office appointment may also be subject to a $35.00 fee and $50.00 for a Colonic No-Show.

The cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patients next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Please sign that you have read, understand and agree to our Cancellation and No Show Policy.

Patient/Legal Guardian (Print Name)	Date of Birth
Patient/Legal Guardian (Signature)	Date