vitality
WELLNESS CLINIC

New Patient Intake

Please fill out as much information as possible. You can either type your responses, save the pdf and then email the completed form to us at **office@vitalitynhc.com**. Or, you can print out the form, write your answers and then bring it with you on your next visit.

Today's Date: _____ Patient Name: _____

DOB: _____ Social Security: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (Cell) _____ (Other) _____

Email: _____ Would you like to receive our Monthly Specials? ☐Y/ ☐N

Emergency Contact Name: _____ Number: _____

Referred by: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____ Pharmacy Fax: _____

Primary Physician: _____ Phone: _____

Credit Card Number: _____

Expiration: ___/ ___/ ___ Card Type: _____ CVC: _____

List your health concerns in order of importance:

1) _____

2) _____

3) _____

4) _____

Family History

	Father	Mother	Siblings	Grand-parents	Spouse	Children
Age If Living:						
Age When Died:						
Reason for Death:						
Cancer Type:						

	Father	Mother	Siblings	Grand-parents	Spouse	Children
High Blood Pressure:	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N
Heart Attack/ Stroke:	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N
Heart Disease:	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N
Asthma/Allergies:	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N
Mental Illness:	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N
Tuberculosis:	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N
Auto-Immune Disease:	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N
Diabetes Mellitus:	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N
Osteoporosis:	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N	☐Y / ☐N

List All Surgeries & Hospitalizations, including date occurred:

1) _____ 2) _____

3) _____ 4) _____

Please note when & why you have had each of the following:

X-Rays: _____ MRI/Cat Scans: _____ Ultrasounds: _____

Accidents: _____ TB Test: _____ HCV: _____

HIV: _____ Last Dental Visit: _____ Last Eye Exam: _____

Did you have the following Disease (D), Get Immunized (I), or Neither (N):

Measles: ☐ D / ☐ I / ☐ N

Chicken Pox: ☐ D / ☐ I / ☐ N

Hemophilus (Hib): ☐ D / ☐ I / ☐ N

Rubella: ☐ D / ☐ I / ☐ N

Whooping Cough: ☐ D / ☐ I / ☐ N

Mumps: ☐ D / ☐ I / ☐ N

Hepatitis B: ☐ D / ☐ I / ☐ N

Any vaccination reactions: _____

Check Yes (Y), No (N) or Past (P) regarding use of the following:

Antacids: ☐ Y / ☐ N / ☐ P

Steroids: ☐ Y / ☐ N / ☐ P

Analgesics: ☐ Y / ☐ N / ☐ P

Laxatives: ☐ Y / ☐ N / ☐ P

Smoking: ☐ Y / ☐ N / ☐ P

Packs per day & number of years: _____

Coffee: ☐ Y / ☐ N / ☐ P

Cups per day if Yes/Past: _____

Soda: ☐ Y / ☐ N / ☐ P

Oz per day if Yes/Past: _____

Alcohol: ☐ Y / ☐ N / ☐ P

How often & how much if Yes/Past: _____

Any Alcohol Addiction: ☐ Y / ☐ N / ☐ P

Any Alcohol Treatment: ☐ Y / ☐ N / ☐ P

Recreational Drugs: ☐ Y / ☐ N / ☐ P

Any Drug Addictions: ☐ Y / ☐ N / ☐ P

Any Drug Treatment: ☐ Y / ☐ N / ☐ P

List all Prescription Medicines & Nutrient Supplements that you are taking (including dosage):

_____ _____

_____ _____

_____ _____

_____ _____

Review of Systems

Present Weight: _____ Weight one year ago:_____ Height: _____

Max. weight & when: _____ Min. weight (as adult) & when: _____

Ideal Weight: _____

REGARDING THE NEXT LONG SECTION: Please check (Y) if you have the problem NOW, (N) if you've NEVER had the problem, (P) if you had the problem in the PAST.

Good Energy: ☐ Y / ☐ N / ☐ P

Fatigue: ☐ Y / ☐ N / ☐ P

If you have fatigue, when is it the worst? Morning, afternoon, or evening? _____

If you have fatigue, can you do what you need to do during the day? ☐ Y / ☐ N

Skin

Rash: ☐ Y / ☐ N / ☐ P

Color Change: ☐ Y / ☐ N / ☐ P

Hives: ☐ Y / ☐ N / ☐ P

Lump: ☐ Y / ☐ N / ☐ P

Psoriasis/eczema: ☐ Y / ☐ N / ☐ P

Itchy: ☐Y / ☐ N / ☐ P

Dry: ☐ Y / ☐ N / ☐ P

Warts/moles: ☐ Y / ☐ N / ☐ P

Cancer: ☐ Y / ☐ N / ☐ P

Perspiration: ☐ Y / ☐ N / ☐ P

Head

Headache: ☐ Y / ☐ N / ☐ P

Migraine: ☐ Y / ☐ N / ☐ P

Dandruff: ☐ Y / ☐ N / ☐ P

Head Injury: ☐ Y / ☐ N / ☐ P

Oily/Dry Hair: ☐ Y / ☐ N / ☐ P

Hair Loss: ☐ Y / ☐ N / ☐ P

Nose

Frequent Colds: ☐ Y / ☐ N / ☐ P

Nosebleeds: ☐ Y / ☐ N / ☐ P

Congestion: ☐ Y / ☐ N / ☐ P

Post Nasal Drip: ☐ Y / ☐ N / ☐ P

Polyps: ☐ Y / ☐ N / ☐ P

Seasonal Allergies: ☐ Y / ☐ N / ☐ P

Eyes

Dry/Watery: ☐ Y / ☐ N / ☐ P

Blurry Vision: ☐ Y / ☐ N / ☐ P

Double Vision: ☐ Y / ☐ N / ☐ P

Cataracts: ☐ Y / ☐ N / ☐ P

Glaucoma: ☐ Y / ☐ N / ☐ P

Styes: ☐ Y / ☐ N / ☐ P

Strain: ☐ Y / ☐ N / ☐ P

Discharge: ☐ Y / ☐ N / ☐ P

Itchy: ☐ Y / ☐ N / ☐ P

Dark Under Eyelid: ☐ Y / ☐ N / ☐ P

Mouth/Throat

Canker Sores: ☐ Y / ☐ N / ☐ P

Cold Sores: ☐ Y / ☐ N / ☐ P

Sore Throat: ☐ Y / ☐ N / ☐ P

Gum Disease: ☐ Y / ☐ N / ☐ P

Dentures: ☐ Y / ☐ N / ☐ P

Cavities: ☐ Y / ☐ N / ☐ P

Loss of Taste: ☐ Y / ☐ N / ☐ P

Hoarseness: ☐ Y / ☐ N / ☐ P

Neck

Stiffness: ☐ Y / ☐ N / ☐ P

Swollen Glands: ☐ Y / ☐ N / ☐ P

Full Movement: ☐ Y / ☐ N / ☐ P

Tension: ☐ Y / ☐ N / ☐ P

Musculoskeletal

Weakness: ☐ Y / ☐ N / ☐ P

Arthritis: ☐ Y / ☐ N / ☐ P

Stiffness: ☐ Y / ☐ N / ☐ P

Leg Cramps: ☐ Y / ☐ N / ☐ P

Tremors: ☐ Y / ☐ N / ☐ P

Pain: ☐ Y / ☐ N / ☐ P

Nervous

Paralysis: ☐ Y / ☐ N / ☐ P

Sciatica: ☐ Y / ☐ N / ☐ P

Tingling/numbness: ☐ Y / ☐ N / ☐ P

Carpal Tunnel Syndrome: ☐ Y / ☐ N / ☐ P

Seizures: ☐ Y / ☐ N / ☐ P

Fainting: ☐ Y / ☐ N / ☐ P

Mental/Emotional

Depression: ☐ Y / ☐ N / ☐ P

Anger/Irritability: ☐ Y / ☐ N / ☐ P

Suicidal: ☐ Y / ☐ N / ☐ P

High-strung/Tense: ☐ Y / ☐ N / ☐ P

Anxiety: ☐ Y / ☐ N / ☐ P

Fear/Panic: ☐ Y / ☐ N / ☐ P

Eating Disorder: ☐ Y / ☐ N / ☐ P

Psych Hospitalization: ☐ Y / ☐ N / ☐ P

Respiratory

Cough: ☐ Y / ☐ N / ☐ P

Shortness of Breath w/ Exertion: ☐ Y / ☐ N / ☐ P

Shortness of Breath Sitting: ☐ Y / ☐ N / ☐ P

Shortness of Breath Lying Down: ☐ Y / ☐ N / ☐ P

Wheezing: ☐ Y / ☐ N / ☐ P

TB: ☐ Y / ☐ N / ☐ P

Bronchitis: ☐ Y / ☐ N / ☐ P

Pneumonia: ☐ Y / ☐ N / ☐ P

Asthma: ☐ Y / ☐ N / ☐ P

Painful Breathing: ☐ Y / ☐ N / ☐ P

Cardiovascular

High Blood Pressure: ☐ Y / ☐ N / ☐ P

Low Blood Pressure: ☐ Y / ☐ N / ☐ P

Arrhythmias: ☐ Y / ☐ N / ☐ P

Edema: ☐ Y / ☐ N / ☐ P

Rheumatic Fever: ☐ Y / ☐ N / ☐ P

Murmurs: ☐ Y / ☐ N / ☐ P

Palpitations: ☐ Y / ☐ N / ☐ P

Chest Pain: ☐ Y / ☐ N / ☐ P

Urinary Tract

Incontinence: ☐ Y / ☐ N / ☐ P

Frequent Infections: ☐ Y / ☐ N / ☐ P

Urgency: ☐ Y / ☐ N / ☐ P

Pain w/ Urination: ☐ Y / ☐ N / ☐ P

Kidney Stones: ☐ Y / ☐ N / ☐ P

Discharge/Blood: ☐ Y / ☐ N / ☐ P

Gastrointestinal

Heartburn: ☐ Y / ☐ N / ☐ P

Indigestion: ☐ Y / ☐ N / ☐ P

Bloating: ☐ Y / ☐ N / ☐ P

Nausea: ☐ Y / ☐ N / ☐ P

Bowel Movement Freq: _____

Recent BM Change: ☐ Y / ☐ N / ☐ P

Diarrhea/Constipation: ☐ Y / ☐ N / ☐ P

Hemorrhoids: ☐ Y / ☐ N / ☐ P

Vomiting: ☐ Y / ☐ N / ☐ P

Change in Appetite: ☐ Y / ☐ N / ☐ P

Pancreatitis: ☐ Y / ☐ N / ☐ P

Gall Bladder Disease: ☐ Y / ☐ N / ☐ P

Liver Disease: ☐ Y / ☐ N / ☐ P

Ulcer: ☐ Y / ☐ N / ☐ P

Female Genitalia

Age Period Began: _____

How Often Period Occurs: _____

How Long Period Lasts: _____

Heavy Menstrual Bleeding: ☐ Y / ☐ N / ☐ P

Menstrual Cramping: ☐ Y / ☐ N / ☐ P

Menstrual Pain: ☐ Y / ☐ N / ☐ P

PMS: ☐ Y / ☐ N / ☐ P

Food Cravings: ☐ Y / ☐ N / ☐ P

Times Pregnant: _____

How Many Births: _____

Miscarriages: _____

Abortions: _____

Last Pap Smear: _____

Sexual Orientation: _____

Any abnormal paps: ☐ Y / ☐ N / ☐ P

When Was Abnormal: _____

Menopausal Since What Age: _____

Use of Hormones: ☐ Y / ☐ N / ☐ P

Type of Hormones Used: _____

Healthy Libido: ☐ Y / ☐ N / ☐ P

Dry Vagina: ☐ Y / ☐ N / ☐ P

Sexually Active: ☐ Y / ☐ N / ☐ P

Pain w/ Intercourse: ☐ Y / ☐ N / ☐ P

Vaginitis: ☐ Y / ☐ N / ☐ P

S.T.D.: ☐ Y / ☐ N / ☐ P

Mammography: ☐ Y / ☐ N / ☐ P

Bone Density Test: ☐ Y / ☐ N / ☐ P

If Yes, what were results: _____

Please list any birth control used and ages used: _____

_____

Male Genitalia

Testicular pain/swelling: ☐ Y / ☐ N / ☐ P

Hernia: ☐ Y / ☐ N / ☐ P

Discharge: ☐ Y / ☐ N / ☐ P

Impotency: ☐ Y / ☐ N / ☐ P

Sexually Active: ☐ Y / ☐ N / ☐ P

S.T.D.: ☐ Y / ☐ N / ☐ P

Prostate Disease: ☐ Y / ☐ N / ☐ P

Sexual Orientation: _____

Exercise

How often do you exercise? _____

What type of exercise? _____

For how long? _____

Hobbies: _____

Sleep

How long per night? _____

If you wake up frequently, what is the reason? _____

Nightmares: ☐ Y / ☐ N / ☐ P

Must Nap During the Day: ☐ Y / ☐ N / ☐ P

Grind Teeth: ☐ Y / ☐ N / ☐ P

Wake Refreshed: ☐ Y / ☐ N / ☐ P

Sleep Walk: ☐ Y / ☐ N / ☐ P

Snore: ☐ Y / ☐ N / ☐ P

Diet

Breakfast: _____

Lunch: _____

Dinner: _____

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? _____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing?

Are you particularly sensitive to perfumes, gasoline or other vapors? _____

Do you use pesticides, herbicides or other chemicals around your home? _____

Other

Enjoy your job?: ☐ Y / ☐ N / ☐ P Hours worked per week: _____

Highest Level of Education: _____

Spiritual practice: ☐ Y / ☐ N / ☐ P Quality of significant relationship: _____

History of sexual, mental/emotional, physical abuse: ☐ Y / ☐ N / ☐ P

What is your greatest health concern: _____

How does it limit you the most: _____

How committed are you towards making valuable changes: ☐ Little / ☐ Moderately / ☐ Very

List all known Allergies (food, drugs, environment): _____

_____

Additional Information

Please list any additional information that you believe is important we address during your office visit:

_____

_____

_____

Authorization for the Release of Information

Name: _____ Date of Birth:___ / ___ / ___

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

Phone: _____ Social Security Number: _____

I authorize for this office and any of its employees to release and/or disclose the medical information as indicated below to the following person(s), entity, or person I have indicated below:

_____

Patient Health Information authorized to be disclosed: _____

For the specific purpose of (describe in detail): _____

DURATION: This authorization shall become effective immediately and shall remain in effect until (date)_____ , or for 1 year from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous relevance on the use or disclosures pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by his authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document it will not condition my treatment, payment enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information

_____ _____

Signature of Patient or Patient's Authorized Representative **Date**

_____ _____

Authorized Signature of Facility **Date**

Informed Consent Regarding Nutritional and Herbal Supplements

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201(g) (1), the term drug is defined as an "article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." Technically vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effect on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding the use of these substances in order to upgrade the quality of foods in a patient's diet and supplement nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

Sale of Nutritional Supplements at Vitality Natural Health Care, you are under no obligation to purchase nutritional supplements at our office.

As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering (1) the quality of science behind the product and (2) the quality of the product components. The brands of supplements that we carry in our center are those that meet our high standards and tend to produce predictable results.

While these supplements may come at higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body) and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality with over the counter. There is a lack of stringent testing requirements for dietary supplements over the counter, therefore, product quality varies widely.

If you have concerns about this issue, please discuss them with our staff.

I, _____ , have read and understand the above

statement on _____ (date).

Health Agreement

The path to complete wellness is a journey that is traveled by both the patient and the practitioner. The practitioner is a guide whose job is to help the patient find the cause and a cure for the imbalances that have led to the manifestation of a disease. The practitioner is also a teacher, hence the term Doctor, Docere in Latin (meaning teacher), whose duty is to teach the patient how to live a more balanced life that leads to long term wellness. The patient plays an integral part in this journey and without the full commitment, active participation and intention of the patient to walk this path, complete wellness cannot be achieved.

Dr. Judy Hinojosa understands the importance of the patient-doctor relationship and what it takes to achieve complete health. We honor our commitment to helping you walk this path in achieving your goals and we ask that you honor yourself and your commitment to your own journey to wellness. As alternative practitioners we treat the whole person and not the disease. We believe that all aspects of your life must be addressed to achieve your goals, including a person's physical, mental, emotional and spiritual wellness as well a person's social and environmental wellbeing.

We are committed to addressing all aspects of your life. We understand the journey to health is unique to each person and it will vary for each patient depending on the complexity of the case. We ask that you set your intentions and commitment to helping us as a partnership achieve your goals. To help you get well we must walk the journey together. We thank you for the trust and commitment you place in Vitality Natural Health Care as we set the intentions for complete wellness and healing.

Patient _____ **Date** _____

Practitioner _____ **Date** _____

Notice of Privacy Practices

This notice describes how private health information about you may be used and disclosed, and how you may access this information. Our Healthcare Practice takes patient privacy matters seriously. We work hard to always be respectful regarding the protection and privacy of your health records in our office. We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this NOTICE about our privacy practices, our duties, and your rights concerning your personal health information. We must follow the privacy practices described in this Notice while it is in effect. This Notice takes effect immediately, and will remain in effect until we replace it. You may request a copy of our Notice at any time, and may request additional copies, as needed, by contacting our office.

HOW WE DISCLOSED HEALTH INFORMATION

Specialist Referrals:

We use and disclose health information about you for treatment within our practice, for general healthcare operations, and payment collection. That means your information is available to our immediate staff and to other practitioners who we may refer you to for additional treatment. This includes, but is not limited to, other healthcare specialists such as other doctors, laboratories and the like. We will exercise our judgment in only distributing the minimum necessary information to any outside associates.

General Business Operations:

Your information may be reviewed in the course of general healthcare operations for activities such as conducting quality reviews, conducting training programs, licensing, accreditation, and other business related evaluations to help us in improving our delivery of healthcare to our patients.

Payment and Collection:

Your health information may be sent to third party payers at your request to assist with your insurance collection. Additionally information may be used from time to time as necessary to secure payment for services. We will use our professional judgment and experience with common practice to make decisions on what information to disclose to secure payment

Family, Friends, Personal Representatives and Others:

We may disclose your health information to a family member, friend or other persons to the extent necessary to help with your healthcare or with payment of your healthcare. You may, however request that we not disclose to anyone other than yourself, of which we will abide. An example where we might disclose to a family member or friend might be when someone drives you to the practice and we are reporting on progress and time remaining before completion, or where a family member desires to pick up a supplement or x-rays on your behalf. We will use our professional judgment and experience with common practice when disclosing your health information to others who may be involved in your health care and are trying to ascertain your general condition.

Marketing, Health-Related Services:
We will not use your health information for marketing communications without your written authorization. Under Federal Privacy Rules, we will send you updated information about our practice, and send you information regarding programs and products we offer to further enhance your care and treatment. We will never provide your name to an outside organization for marketing.

When the Law Requires Us to Disclose:
We may disclose your health information to government agencies or others, as required by law. Examples of this include, but are not limited to, law enforcement, required state agency reporting, and to military authorities for purposes such as national security.

Abuse and Neglect:
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence, or are the victim of possible other crimes. We disclose to the extent necessary to avert further harm to you or others

PATIENT RIGHTS

Access to Records:
You have a right to look at copies of your health information. You may request photocopies and copies of x-rays. We will use the format you request, unless we are unable to practically do so. You must make your request for your health information in writing to our practice. We can provide you with a form to do this, or you may do it by writing a letter specifying exactly what you want to view. If we provide photocopies, we will charge you a set amount for each page copied.

Check with the office for the current fee schedule. If you request an alternate format, we will charge you per the expenses we incur to satisfy your request. You may prefer to ask for a summary rather than receive all of the pages in your file. We can prepare a summary depending on what you are seeking to obtain. The fee for summation will vary depending on time to compile. We have up to 30 days (and sometimes longer) to respond, depending on what is required to meet your request. Specifics will be provided upon request.

Restrictions:
You have the right to place additional restrictions on our use or disclosure of your health information. We are not required to agree to these restrictions, however if we do agree, we will abide by our agreement except in certain emergency situations.

Communications to You:
You may request we communicate with you about your health information by alternative means or alternative locations, when you make the request in writing. You must specify the alternative means or locations and provide satisfactory explanation how payments will be made under the alternative means or location.

Amendment of Your Records:
You have the right to request that we amend your health information when requested in writing. We may deny your request, however we will note in your records your request to amend and reason. We cannot delete anything from the formal record, but we can add addendum to the record that may be able to meet your amendment request.

I have received a copy of this office's Notice of Privacy Practices:

Print Name	Sign Name	Date

Vitality Wellness Clinic Care Policies

Payment Policy:
All services and product payments are due upon completion of services or purchase of products. For all phone consultations payment must be received by the end of the service, we must have your credit card on file, which will be charged at the end of the consult. For product shipment and phone orders payment must be done with a credit card.

Payment types we accept: Cash, Checks, Debit cards, Visa, MasterCard, American Express, and Discover.

Returns:
Returned items should be unused and must be returned within 30 days of purchase in original packaging with any enclosed documentation. We will issue a credit to your account with Vitality Natural Health Care for future use either for services or product purchases. A 25% restocking fee will be charged for all products and testing kits.

Cancellation Policy:
We must receive notice 48 hours prior to your appointment if you wish to cancel your new patient visit. After your first appointment, cancellations must be made within 24 hours. All cancellations done under the 24/48 hour notice will be automatically charged a $75.00 cancellation fee for new patient visits and a $100.00 cancellation fee for every visit following, which will be submitted to the credit card on file.

Disability Forms, FMLA, etc:
A $95.00 fee will be collected each time forms are presented to Vitality Natural Health Care for completion.

By signing this document, I acknowledge that I have read the policy agreements and I will be held responsible for all payments.

Print Name	Sign Name	Date

Patient Financial Responsibility Form

Thank you for choosing Vitality Natural Health Care as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. To that end, we strive to keep our patients informed about any changes we are aware of that may impact their choices when it comes to making decisions tied to health care services and the costs associated with those services. We ask that you read through the following document and sign off on each paragraph indicating your acknowledgement and understanding as it relates to patient financial responsibilities and the services we provide.

In the state of Arizona, Insurance Companies have declined to contract with Naturopathic Physicians to cover medical services. These include doctor visits, medical procedures, hormone therapy, intravenous therapy, injection therapy, and acupuncture as well as any functional lab testing such as Food Allergy Panel, Detox Panels and Heavy Metal testing.

This inability for Naturopathic Physicians to contract with Insurance Companies prevents Naturopathic Physicians from being able to submit for services rendered or collect on behalf of the Insurance Companies any co-pay's associated with such services. What this means for the patient is that upon completion of the visit, payment is due in full for all services provided.

Vitality Natural Health Care will provide each patient with a SuperBill detailing the diagnosis codes and procedure codes Insurance Companies use to associate services with billing. It is then up to the patient to submit a copy of this SuperBill on their own behalf to their Insurance Company requesting reimbursement of payment. Due to changes in laws and Federal regulations, including the new Obama Care act, Vitality Natural Health Care has seen Insurance Companies start to pay for fewer services than they previously used to. Patients should understand that a submission of a SuperBill and request to their Insurance Company does not guarantee reimbursement, that is dependent on the Insurance Company and the services they have agreed to cover as part of the patients insurance coverage.

As a service to our patients, Vitality Natural Health Care will provide our main lab companies (Lab Corp and Sonora Quest) with the patients' insurance information when labs are drawn in our office. These labs will submit billing claims exclusively for the services they perform to your insurance for reimbursement.

For any lab services Vitality Natural Health Care does the draw and collects insurance information for, the patient is responsible for any charges incurred through the lab companies (Sonora Quest and Lab Corp). Providing us with the most correct and update information helps to ensure that claims are not denied by Insurance Companies due to missing or incorrect information about the patient.

While some lab testing may be covered, coverage is subject to individual health plans is ultimately the patients' responsibility for any uncovered lab services.

I, _____ , have read, understand, and agree to the provisions of this Patient Financial Responsibility Form.

_____ _____

Signature of Patient or Legal Guardian **Date**

Patients Financial Responsibility
For Lab Services

Thank you for choosing Vitality Natural Health Care as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

As a service to our patients at Vitality Natural Health Care, we can draw your blood and send it for blood testing to our main labs Sonora Quest or LabCorp. Before we can draw your blood, we are required to have a copy of your current driver's license and if possible your insurance card. If you are unable to provide, or do not have insurance, all lab work performed by Sonora Quest and/or LabCorp will be billed at cash pay to the patient directly.

For those patients who do have insurance, we advise them to be informed about what is covered by their insurance plan. Laboratories such as LabCorp and Sonora Quest will submit a claim, although this doesn't guarantee reimbursement. It is, ultimately, the patient's responsibility for all charges and/or claims not covered by insurance.

At Vitality Natural Health Care, we are not equipped to handle any billing inquires as we are not contracted with insurance companies. If you wish to submit your own claim, we will provide you with the CPT codes and diagnosis codes to do so

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I, _____ , have read, understand, and agree to the provisions of this Patient Financial Responsibility Form.

_____ _____

Signature of Patient or Legal Guardian **Date**