Print Clear Form

absolute health

8360 E Raintree Dr. Suite 135
Scottsdale, AZ 85260
(480) 991-9945

NEW PATIENT INFORMATION

In order to receive the best possible treatment, it is important to read and understand the following information:

- Some cases may require treating preliminary items that are contained within a substance, such as vitamins, minerals, phenolics and/or sugars. For example, sugar may need to be addressed before proceeding with alcohol, grains or fruit.
- After addressing any preliminary items, patients may choose what order remaining substances are treated.
- It is possible to treat numerous items in one treatment if they are in the same family. For example, all dairy products (milk, cheese and yogurt) and calcium may be treated together. But dairy and wheat, or tomatoes and pollens may not be
- addressed in the same session. The treatment will not be successful.
  We cannot guarantee how many sessions each substance will require to reduce the symptoms associated with that item.
- When addressing a condition instead of a single substance or family of substances, multiple items may be contributing to the symptoms. Therefore such conditions may require multiple sessions to relieve the symptoms of the condition.

Please adhere to the following guidelines:

- As a courtesy to our other patients who may have strong sensitivities, please do not smoke or wear perfume or fragrances prior to coming in to the clinic.

- Do not eat candy or chew gum during the session.

Office Policies

- The clinic has a 24-hour cancellation policy. Late cancellations or no-shows will incur a charge of $35.00.
- Please arrive 10 minutes prior to your appointment time. Late arrivals may be rescheduled and will incur a charge of $35.00.
- Re-treatments are free but there is a $65.00 office visit fee. Price subject to change.
- Payment is due at the time services are rendered.

Initial Allergen Evaluation for

Patient's Name _____

	Food Phenolics	☐	Corn	☐	Pollens	☐	
	Eggs	☐	Yeast Mix	☐	Trees	☐	
	Chicken	☐	Caffeine	☐	Grasses/Weeds	☐	
	Protein	☐	Coffee Mix	☐	Flowers	☐	
	Calcium	☐	Chocolate	☐	Plants	☐	
	Milk / Dairy	☐	Soy	☐	Plant Phenolics	☐	
	Vitamin C	☐	Glutamates	☐	Molds/Mildew	☐	
	B-Complex	☐	Amines	☐	Fungus/Sinus Fungus	☐	
	Vitamin A	☐	Salicylates	☐	Dust/Dust Mites	☐	
	Iron	☐	Artificial Preservatives	☐	Cats	☐	
	Mineral Mix	☐	Artificial Colors	☐	Dogs	☐	
	Sugar Mix	☐	Artificial Flavors	☐	Cockroaches	☐	
	Salt Mix	☐	Acids	☐			
	Grain / Wheat Mix	☐	Enzymes	☐			

PATIENT INFORMATION

Last Name _____ First Name _____ Date _____

Address _____ Zip Code _____

Telephone Home _____ Work _____ Cellular _____

Email Address: _____

Age _____ DOB _____ Occupation _____

Who to reach in case of an emergency _____

How did you hear about our clinic? _____

Are you currently receiving health care? Please Select: Yes ◯ No ◯

If yes, name of physician: _____

Condition being treated: _____

What are your most important health concerns?

1 _____

2 _____

3 _____

Please list tested or suspected allergies and related symptoms:

Foods _____

Seasonal _____

Drug / other _____

Current Medications: Please list any prescription medications or over-the-counter medications you are taking.

_____

Daily Dosage _____

Do you have a current medical condition(s) (e.g. Epilepsy, Pregnant)? _____

Do you smoke? Please circle: Y N

◯ ◯

Please read the New Patient Information form. Sign below when you have finished.

Yes, I have read and understand the items listed on the New Patient Information form and Notice of Privacy Practices for Protected Health Information

Signature _____ **Date** _____

(If under the age of 18, must be signed by Parent or Legal Guardian.)

WAIVER AND RELEASE

I _____ (the "Undersigned"), hereby consent to treatment at
Absolute Health LLC, 8360 E Raintree Dr. Suite 135 Scottsdale, AZ 85260

I understand that such procedures are non-invasive.

Absolute Health LLC and all of its employees assume no responsibility for medical conditions requiring the attention of a medical doctor, or necessary adjustments to prescribed medications during or after the completion of treatments.

I understand the unpredictable nature of allergies and related symptoms and that the clinic cannot guarantee any results in the reduction of symptoms. The clinic cannot guarantee that new reactions will not develop in the future. While the treatment can address many symptoms associated with allergies and sensitivities some cases do not respond to the treatment.

I also understand that the only known risk factor with the treatment of symptoms associated with allergies or sensitivities, including immunotherapy, is the possibility of increased sensitivity. I assume all responsibility for unpredictable reactions which may lead to increased symptomatology. In this event, I agree to seek immediate medical attention.

I have read and understand the items listed on the Notice of Privacy Practices for Protected Health Information

I understand that the Clinic does not treat cases of anaphylaxis and I agree to fully disclose all information regarding any life-threatening allergies or allergies resulting in anaphylaxis.

◯ **No, I do not have any life threatening allergies.**

◯ Yes, I have the following allergies that may cause anaphylaxis:

_____

_____

_____

I agree to pay the clinic the standard fee for any and all treatments administered.

IN WITNESS THEREOF, the undersigned executed the Agreement as of

DATE _____

_____ _____
Signature of Undersigned Signature of Practitioner

_____
Signature of Parent or Legal Guardian

Absolute Health
8360 E. Raintree Drive, Suite 135
Scottsdale, AZ 85260
Phone 480-991-9945
Fax 480-948-3204

MEDICAL RECORDS RELEASE

Patient's Name: _____

Date: _____

DOB: _____

Phone Number: _____

I hereby authorize you to release to/from ABSOLUTE HEALTH LLC all medical records and information including the diagnosis and records of treatment or examination rendered to me.

Sensitive Information: I understand that this may include information relating to:

- Acquired Immunodeficiency Syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
- Behavioral health services, psychiatric care, mental health treatment
- Sexually transmitted diseases
- Diagnosis/treatment for alcohol and/or drug abuse
- Information for research purpose
- Blood Work

Date: _____ ***Patient/Insured Signature:*** _____

Date: _____ ***Staff Signature:*** _____

Absolute Health Sara Mancuso, DC / Elizabeth De La Torre Hogan, NMD

Patient Name: _____ Date: _____

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 describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

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

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care 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. For example, your health care information may be provided to a physician to 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 health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may 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 activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also 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 appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included 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, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, 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.

_____ _____
Signature of Patient or Representative Date

_____
Printed Name

Informed Consent for Chiropractic Care

8360 E Raintree Dr.
Suite 135
Scottsdale, AZ 85260
480-991-9945 Office
480-948-3204 Fax

Chiropractic care, like all forms of health care, offers considerable benefit. Effective chiropractic treatment, when delivered professionally, includes some level of risk. Most often, this level of risk is very minimal, though in rare cases, chiropractic care has led to injury. The types of complications that have been reported, secondary to chiropractic care, include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One complication associated with chiropractic care is a vertebral artery injury. Though the occurrence of this is very uncommon (happening at a rate between one instance per million, to one per two million cervical spine/neck adjustments), vertebral artery injury could lead to stroke.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are to be performed to assess your specific condition, your overall health, and in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examination or studies are needed. In addition, these examinations will help us to determine if there is any reason to modify your care, or provide you with a referral to another health care professional. All relevant findings will be reported to you along with a care plan prior to beginning care.

By signing below, you attest that you have read this form, and accept that there are risks associated with chiropractic care. You further give your consent to examinations that the doctor deems necessary, and to chiropractic care, including spinal adjustments, as reported in your initial assessment.

_____ _____

Patient Signature Parent or Legal Guardian Signature

_____ _____

Patient Name (printed) Relationship to Patient

_____ _____

Witness Signature (office staff) Date

Notice of Privacy Practices for Protected Health Information (PHI)

By signing below, I acknowledge having read, and understand the notice of HIPAA regulations upheld by Absolute Health and those affiliated in conducting business with Absolute Health. I understand a physical copy will be given to me at my request.

_____ _____

Patient or Parent/Guardian Signature Date