Print Clear Form

absolute health

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

New Patient Information

Last Name _____ First Name _____ Date _____

Address _____ City _____ State _____ Zip Code _____

Telephone: Home _____ Cell _____ Work _____

Date of Birth _____ Age _____ Email Address _____

How would you like to be contacted from Absolute Health? _____ Phone _____ Email

Employer _____ Occupation _____

Emergency Contact Name _____Phone Number_____ Relation_____

Who referred you to Absolute Health? _____

Please select: Female (●) Male ( ) Please select: Married ( ) Divorced ( ) Separated ( ) Single ( ) Widowed (●)

List your health problems in order of importance:

1) _____
2) _____
3) _____
4) _____
5) _____

Medical conditions you have been diagnosed with: _____
_____
_____

Medical conditions that run in your family: _____
_____
_____

Medications you are taking: _____
_____
_____

Supplements/vitamins you are taking: _____
_____
_____

Allergies to medications or foods: _____

Are you or your spouse/companion trying to conceive(become pregnant) now or in future? YES ◯ NO ◉

Date of most recent lab work: _____

Expectations for today's visit: _____
_____
_____
_____

The clinic has a 24-hour cancellation policy. Late cancellations or noshows will incur a charge of $50.00.Please arrive 10 minutes prior to your appointment time. Late arrivals may be rescheduled and will incur a charge of $50.00. Payment is due at the time services are rendered. I certify this information to be true and correct. I assign my benefit payments to be paid directly to Absolute Health LLC. However, I understand that I am ultimately responsible for payments of services rendered. I also authorize the release of any information which is required for payment.

_____	_____	_____
Patient or Guardian Signature	Date	Witness

Informed Consent for Naturopathic Medicine

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

I understand that the evaluation, diagnosis and treatment by a Naturopathic physician, and specifically by the Naturopathic physicians at Absolutee Health, may include but is not limited to:

Interview (history taking), Physical examination, All Ozone IV therapies , All Nutrient IV therapies, Dietary advice and therapeutic nutrition (e.g. the therapeutic use of foods, diet plans, nutritional supplements, intravenous and intramuscular injections), Acupuncture (using sterilized, disposable, stainless steel acupuncture needles), Botanical medicines and nutraceuticals/supplements (including plan, mineral, and animal materials. Substances may be given in the form of teas, pills, tinctures which may contain alcohol, creams, powders, suppositories, topical creams, or other forms.), Homeopathic remedies (highly dilute substances made from plant, mineral or animal sources), Over-the- counter medications, Prescription medications to be filled at a pharmacy, Botox Injections, PRP Micropen Therapies, Prolotherapy/Prolozone Therapies, All Injection Therapies, HCG, Vein Therapies, and Fillers

As with all forms of medicine, I understand and I am informed that in the practice of Naturopathic medicine there are risks and benefits with evaluation, diagnosis, and treatment, including but not limited to:

- **Potential Risks:** discomfort or minor bruising frominjections, IV Therapies, Acupuncture or cupping; allergic reactions to prescribed herbs, supplements, or prescriptions medications; a temporary aggravation of pre-existing symptoms.
- **Potential Benefits:** restoration of the body's optimal functioning capacity, relief of pain and/or disease symptoms, assistance in disease or injury recovery, and prevention of disease progression or recurrence.
- **Notice to Pregnant Women:** all female patients must alert the provider if they know or suspect they are pregnant, as certain therapies could pose a risk to the pregnancy.

Financial Policy:

Thank you for selecting Absolute Health LLC for your health care needs. We are honored to be of service to you and your family. Please be advised that payment for all services will be due at the time services are rendered. If you should desire to submit costs associated with your care to your insurance company, Absolute Health LLC will provide you with the necessary codes, but Absolute Health LLC does not guarantee that your insurance will reimburse any of those expenses.

We do not offer any refund on deposits or payments made for any services/supplements or lab kits. Please be aware labs are not covered by Medicare/Medicaid, AHCCCS and HMO insurances when ordered by a Naturopathic Physician. If you choose to use your insurance you will be responsible for any bill received to us.

Cancellation Policy:

We have a 24-hour cancellation/reschedule policy. If you do not call Absolute Health LLC at least 24-hours prior to your scheduled appointment time to cancel or reschedule, you will be charged a $50 fee for the appointment.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs. I have read and understand all of the above and have agreed to these statements. By signing below, I understand and agree to the patient payment and cancellation policy. I guarantee payment of all charges incurred as a patient of Absolute Health LLC.

I acknowledge that I have received a copy of Absolute Health LLC's Notice of Privacy Practices.

By signing below, I (print name) _____ (DOB_____) acknowledge that I have been provided ample opportunity to read this form, or that it has been read to me. I also understand that it is my responsibility to request that the provider explain all therapies and procedures to my satisfaction. I further acknowledge that no guarantees have been offered to me concerning the results intended from the treatment. I intend for this consent form to cover the entire course of treatments for my present condition, as well as any future conditions for which I may seek treatment.

_____ _____ Patient/Guarantor Signature
Date

_____ _____ Witness/Office Staff Date

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

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:*** _____