NATURAL HEALTH PRACTICES
4904 Clyde Morris Blvd. Suite A, Port Orange, FL 32129
(386) 307-8207

PATIENT INFORMATION FORM

Full Name:	Nickname:
Mailing Address:	Apt #:
City and State:	Zip:
Email Address:	Phone:
Have you connected with us on social media (circle all that apply): Facebook Instagram YouTube	Preferred primary method of contact (circle one): Email Phone Call Text Message
How did you first hear about us?	Whom may we thank for referring you to us?

Occupation:		Employer:		
Date of Birth:	Age:	Sex: M / F	Height:	Weight:
Your overall health (circle one): Excellent Good Fair Poor		Do you (circle all that apply): Use Tobacco Products Drink Alcohol Drink Tap Water		
Main health concern (reason you are here):				
Current medications:		Current nutritional supplements:		
List any major illnesses, accidents, or injuries with approximate dates:		List any surgeries and out-patient procedures with approximate dates:		
Are you currently under the care of a physician or another healthcare professional? (If yes, please give names and dates of most recent visits):				

Marital status and name of spouse if applicable:		Do you have any pets?	
Names of Immediate Family Members	Gender	Age	Current Health Status
1.	M / F		
2.	M / F		
3.	M / F		
4.	M / F		

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PLEASE BE AS SPECIFIC AS POSSIBLE

List your major health concerns in order of severity (from most to least bothersome)	How bad is it on a scale from 1-10? (10 is the worst)	When was it first noticed?	Is it worsening or improving since then?	Does anything make it better or worse? Be specific.	What treatment have you received for this health concern?
1.					
2.					
3.					
4.					
5.					

How are your health problems affecting your life?
Where will you be in the future if you don't handle these health problems?
What do you hope to achieve by starting a natural healthcare program? Why is this important to you?
Is there anything you're unwilling to change in order to reach your health goals?
How would you describe your spiritual health?
Is there anything else you'd like us to know?

Print Name _____ Sign Name _____ Date _____

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PERMISSION AND AUTHORIZATION REGUARDING YOUR NATURAL HEALTH IMPROVEMENT PROGRAM

I authorize Natural Health Practices Inc. to develop and implement a health improvement program for me, which may include dietary recommendations, nutritional supplements, and other natural healing techniques and remedies in order to assist me in improving my health, and not for the treatment or cure of any disease. I understand that only safe, non-invasive, natural methods of analyzing my body's physical and nutritional needs and that not following the recommendations of my practitioner may result in worsening of various health problems. I understand that Nutrition Response Testing and the other analysis tools used by the Natural Health Practices staff are not methods for diagnosing or treating any disease including conditions of cancer, AIDS, infections, or other medical conditions. No promise or guarantee has been made regarding the results of this testing or any natural health, nutritional, or dietary recommendations. I understand that I am to adhere to the Natural Health Practices program guidelines, which will be reviewed with me before commencing my program. **I understand that if I do not fully comply to the guidelines and recommendations presented to me, that I may not get the results I'm hoping for.**

CONSENT TO CHIROPRACTIC TREATMENT

Natural Health Practices Inc. maintains equipment, personnel, and facilities to assist in the delivery of chiropractic adjustments and related therapeutic procedures with the goal of supporting the natural physiology of the body. As with any comparable intervention, chiropractic treatment may involve a calculated risk of complication, injury, or even death, and no guarantee has been made as to treating, curing, or preventing the occurrence of disease. Chiropractic adjustments and procedures are therefore not performed on patients unless and until a patient has been examined and thus had an opportunity to discuss his or her concerns with the doctor. Each patient reserves the right to receive or refuse any proposed procedure or therapy based upon the prescription or explanation received. Care plans are specifically designed for each patient. Details of the care plan will be covered with you prior to the commencement of services. The success of a care plan is largely due to your ability to follow the treatment plan as it is prescribed, however no action will take place without your full consent. Your initiation of the care plan is the agreement that you will complete the plan for the recommended duration regardless of whether payments are made in full or multiple payments are made. **As with any proceedure, there are risks involved with chiropractic manipulation such as fractures, dislocations, sprains, strains, TIA, and stroke.**

OFFICE POLICIES

If you are unable to make a scheduled appointment, we request that you cancel or reschedule a minimum of 24 hours in advance, so your appointment time can become available for another patient. **By cancelling at least 24 hours in advance, you can avoid a cancellation fee of $25,+which will be charged to your account or paid upon your next office visit.** Naturally, our desire is to make appointment time available to other patients and not to collect missed appointment fees. If you are unable to make a scheduled appointment, please be sure to reschedule the missed appointment within the same week, so you can stay on the treatment schedule that has been prescribed to you by the doctor. Office staff are not permitted to change your treatment prescription, only the doctor.

PAYMENT OF BILLS

You are responsible for payment of services and there is no guarantee your insurance company will reimburse you for services or products sold at our office. However, **if you have been involved in an auto accident and you have coverage for treatment through your auto insurance policy, we will submit your insurance claims to your auto insurance company on your behalf.** If you are a Florida resident with auto insurance, this may be a great benefit to you. However, please keep in mind that insurance is an agreement between you and your insurance company and not between you and Natural Health Practices Inc. **All sales are final and cannot be refunded, exchanged, or transferred to other accounts once a purchase has been completed.**

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In addition to the above treatment and office policies, your signature constitutes your acknowledgement that: (1) You have read a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and have been advised that a full copy of this office's HIPAA Compliance Manual is available upon request; (2) You understand that this office reserves the right to revise its Notice of Privacy Practices at any time and it will be available to patients upon request; (3) You consent to the use of your protected health information in a manner consistent with State and Federal Law, this office's Notice of Privacy Practices, and the HIPAA Compliance Manual. Upon final or discharge of care, any medical records requested will only be provided to another doctor or attorney with a signed medical release form.

I have read and understand the foregoing. I understand that my signature below applies to all subsequent office visits, consultations, and treatments at Natural Health Practices.

_____	_____	_____
Print Name	Sign Name	Date