Release of Medical Information

I, ______________________, direct New Hope Integrative Medicine to disclose my protected health information described below to:

Name: ______________________ Relationship: ______________________

Address: ____

Phone # ______________________ Please Circle One: Home Cell Work

Email: ____

Health Information to be disclosed upon request of the person above:
(Check either A or B)

- ◯ A. **Disclose** my complete health record (including but not limited to diagnoses, lab test, prognosis, treatment, billing and appointment dates and time) **OR**
- ◯ B. **Disclose** my health records, as above, **BUT DO NOT Disclose** the following information (check all appropiate)
  - ◯ Mental Health Records
  - ◯ Comunicable Diseases (including HIV and AIDS)
  - ◯ Other (please specify):

____

____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ◯ Hard Copy
- ◯ Other: ______________________

This authorization shall be effective until (check one):

- ◯ All past, present and future periods, OR
- ◯ On this Date or in the event: ______________________

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care provider in writing.)

______________________ ______________________
Print Name of the Individual Giving this Authorization Date of Birth

______________________ ______________________
Signature of the Individual Giving this Authorization Date

______________________ ______________________
Print Witness Name Date

____
Witness Signature

Note: HIPAA Authority for Right Of Access: 45 C.F.R. § 164.524

Consent to Release / Receive Confideltial Information

I, ______________________________ , authorize ______________________________ to:
Patient Name (Please Print) — Physician Name (Please Print)

MD check all that apply

- ◯ Receive my medical history information from the following physician(s):
  (Name, Address) ______________________________
  (Name, Address) ______________________________

- ◯ Receive my treatment records from the following therapist:
  (Name, Address) ______________________________

- ◯ Release my treatment information/records to the following healthcare professional:
  (Name, Address) ______________________________

- ◯ Release my treatment information to the health insurance company listed below, for billing purposes:
  (Name, Address) ______________________________

The informations is for the following purposes (any other use is prohibited): ______________________________

I understand that I may withdrawl this consent at any time, either verbally or in writing, except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opiod dependence by the physician specified above unless I withdrawl my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or drug dependence. These records may also contain confidential information about communicable diseases, including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2), which prohibits the recipient of these records from making further disclosures to thirds parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

Patient Name (Please Print)	Patient Signature	Date
Parent/Guardian Name (if applicable) (Please Print)	Parent/Guardian Signature	Date
Witness Name (Please Print)	Witness Signature	Date

Patient Resposibility Form

1. **Patients Financial Resposibility**
   - I understand that I am financially resposible for my health insurance deductible, coinsurance, copay, or non-covered service.
   - Copayments/Co-Insurance are due at time of service.
   - If my plan requires a referral, I must obtain it prior to my visit.
   - In the event that my health insurance plan determines a service "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
   - If I am unisured or self pay, I agree to pay for the medical services rendered to me at the time of service.
   - I understand that I will be responsible for any laboratory services provided at the office.
2. **Insurance Authorization for Assigment of Benefits**
   - I hereby authorize directpayment of medical services to New Hope Integrative Medicine on my behalf for any services furnished to me by the providers.
3. **Authorization to Release Records**
   - I hereby authorize New Hope Integrative Medicine to release to my insurer, governmental agencies, or any any other entity financially resposible for my medical care, all information, including diagnosis and the records of any treatments or examination rendered to me needed to substantiate payment for such medical services as well as information requiredfor precertification, authorization or referral to other medical provider.
4. **Medicare Request for Payment**
   - I request payment of authorized Medicare benefits to me or on my behalf for any services furnished to me or in New Hope Integrative Medicine. I authorize any holder of medical or other information about me to release to Medicare and its agents any information neededto determine these benefits or benefits related services.

Signature of Patient, Authorized Representative, or Resposible Party	Date
Print Name of Patient, Authorized Representative, or Resposible Party	Date

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment, or health care operations.

The Practice Has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.

The practice reserves the right to change the Notice of Privacy Practices.

The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.

The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

The Practice may condition receipt of treatment upon the execution of this Consent.

____ ______/______/______

Printed Name-Patient or Responsible Party DOB

____ ______/______/______

Patient Signature or Responsible Party Date

____

Relationship to patient (if other than patient) Witness

____ ____

Printed Name-Practice Representative Practice Representative Signature

New Patient Information

Name: ______________________ Maiden Name: ______________________

DOB: ______________________ SSN: ______ / ______ / ______

Gender (circle one): Male Female Transgender-Male Transgender-Female Other ______________

Enthnicity/Race: ______________________ Preffered Language: ______________________

Highest Level of Education: ______________________

Address: ______________________
Street City State Zip Code

Home: ( ) ______________________ Cell: ( ) ______________________

Work: ( ) ______________________ Best way to reach you: ______________________

E-mail: ______________________

Emergency Contact: ______________________ Relationship: ______________________

Home: ( ) ______________________ Cell: ( ) ______________________

Address: ______________________
Street City State Zip Code

Insurance Information

Primary Insurance	
Insurance Name	
Subscriber's Name	
Subscriber's DOB	/ /
Subscriber's SSN	- -
Relationship to Patient	
Policy ID #	
Group #	

Secondary Insurance	
Insurance Name	
Subscriber's Name	
Subscriber's DOB	/ /
Subscriber's SSN	- -
Relationship to Patient	
Policy ID #	
Group #	

I certify that the above information I have provided is current and correct.

______________________ ______ / ______ / ______
Print Patient Name, Patient Representative or Responsible Party Date (MM / DD / YYYY)

______________________ ______________________
Signature of Patient, Patient Representative or Responsible Party Relationship to Patient

Medical History Form Today's Date: ______

Patient Name: ______ Date of Birth: ______

Current occupation and employer, if applicable: ______

Reason for Today's Visit: ______

Gynecological History

First day of your last menstrual period: ______

How old were you when your menses started? ______

Are you still having menstrual periods? ☐ Yes ☐ No

If so, periods are: ☐ Light ☐ Moderate ☐ Heavy ☐ Bleed through protection

How many days between your periods? ______

How many days of menstrual flow? ______

Do you have any pain with your periods? ☐ Yes ☐ No

Are you regular? ☐ Yes ☐ No

Do you pass any clots in menstrual flow? ☐ Yes ☐ No

Do you have more than 35 days in-between periods? ☐ Yes ☐ No

Do you get less than 6 periods per year? ☐ Yes ☐ No

Do you have bleeding in-between periods? ☐ Yes ☐ No

Do you have bleeding after intercourse? ☐ Yes ☐ No

Do you have a history of anemia? ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No

Have you ever been diagnosed with fibroids? ☐ Yes ☐ No

Have you ever been diagnosed with polyps inside the uterus? ☐ Yes ☐ No

Are you suffering from pre-menstrual syndrome (PMS)? ☐ Yes ☐ No

Do you have a history of endometriosis? ☐ Yes ☐ No

Do you have a history of pelvic pain? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Life Partner ☐ Separated ☐ Divorced ☐ Widowed

Spouse / Partner name (if applicable): ______

Are you sexually active now? ☐ Yes ☐ No

With ☐ One Partner, if so ☐ Male ☐ Female

With ☐ Multiple Partners, if so ☐ Male ☐ Female ☐ Both

What age did you first become sexually active? ______

Lifetime Partners: How many sexually partners have you had? ______

Do you have any questions about sex you would like to ask? ☐ Yes ☐ No

Are you satisfied with your current sexual function? ☐ Yes ☐ No

If you answered "no", how long have you been dissatisfied with your sexual function? ______

Indicate which of the following problems apply:

Little or no interest in sex ☐ Yes ☐ No

Decreased genital sensation ☐ Yes ☐ No

Decreased vaginal lubrication ☐ Yes ☐ No

Problem reaching an orgasm ☐ Yes ☐ No

Problem with pain during sex ☐ Yes ☐ No

Other: ______

Would you like to talk about it with your doctor? ☐ Yes ☐ No

Current method(s) of birth control (select all that apply):

☐ Nothing ☐ Pill ☐ Patch ☐ Nuvaring ☐ Rhythm ☐ Implant ☐ Condom ☐ Tubal Ligation ☐ Vasectomy
☐ Hysterectomy ☐ Mirena IUD (progesterone-containing, 5 years) ☐ Copper T IUD (hormone free, 10 years)
☐ Depo-Provera Injections every 3 months ☐ Essure Hysteroscopic Sterilization ☐ Other: ____________

Past method(s) of birth control (select all that apply):

☐ Nothing ☐ Pill ☐ Patch ☐ Nuvaring ☐ Rhythm ☐ Implant ☐ Condom ☐ Tubal Ligation ☐ Vasectomy
☐ Hysterectomy ☐ Mirena IUD (progesterone-containing, 5 years) ☐ Copper T IUD (hormone free, 10 years)
☐ Depo-Provera Injections every 3 months ☐ Essure Hysteroscopic Sterilization ☐ Other: ____________

Please indicate if you are presently experiencing birth control side-effects or if you have in the past:

____

Future childbearing plans: ☐ I do not desire children in the future ☐ I desire children in the future
☐ I would like to ask a question about this ☐ Other: ____________

Date of last Pap smear: ____________________ Result: ____________________

Abnormal Pap Smears - Have you ever had an abnormal Pap or Colposcopy? ☐ Yes ☐ No

Have you had any treatments to your cervix?

☐ No ☐ Cryosurgery ☐ Laser Surgery ☐ LEEP ☐ Conization ☐ Other: ____________

Have you ever had a sexually transmitted disease? ☐ Yes ☐ No

☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Syphilis ☐ HIV ☐ Trichomonas

Would you like to be tested for a sexually transmitted disease today? ☐ Yes ☐ No

Do you have frequent yeast infections? ☐ Yes ☐ No

Do you have recurrent vaginal infections? ☐ Yes ☐ No

Menopause (if applicable) - Age of menopause (last menstrual period)? ☐ Yes ☐ No

Are you currently experiencing:

☐ Hot Flashes ☐ Vaginal Dryness ☐ Sleep Interruptions ☐ Abnormal/Irregular Periods
☐ Post-Menopausal Bleeding ☐ Other: ____________

Do you experience any of the following:

- Loss of urine when coughing, sneezing, or laughing? ☐ Yes ☐ No
- Frequent urination? ☐ Yes ☐ No
- Pain during urination? ☐ Yes ☐ No
- Need to urinate with little warning? ☐ Yes ☐ No
- Do you ever lose urine before reaching the toilet? ☐ Yes ☐ No
- Difficulty passing urine? ☐ Yes ☐ No
- Frequent bladder infections? ☐ Yes ☐ No
- Frequency of nighttime urination? ☐ 0-1 ☐ 2 or more
- Frequency of daytime urination? ☐ 8 or less ☐ 9-15 ☐ 16+
- Do you still feel full after urination? ☐ Yes ☐ No
- Do you feel pain, pressure, "ball" in the vagina? ☐ Yes ☐ No
- Do you feel like your bladder or uterus is low/dropped? ☐ Yes ☐ No
- Have you ever experienced pelvic organ prolapsed? ☐ Yes ☐ No

Do you have a history of ovarian, cervical or uterine cancer? ☐ Yes ☐ No

Past Operations/Hospitalizations

Please indicate the year and reason for operation/hospitalization

____

____

____

____

____

Pregnancy History

Please indicate the following details for each Pregnancy:

Date of Outcome or Delivery	Full Term	Premature	Delivery Type: VAG, C/S, or VBAC	Weeks of Gestation at Birth	Was Baby Healthy?	Abortion	Miscarriage	Other (Ectopic, Tubal, or Molar)

Medical History

Please list your medical problems and the date of diagnosis (for example: high blood pressure, diabetes, etc.)

____

____

____

____

____

____

Allergies to Medications (please list medication and what type of reaction you had):

____

____

____

____

Current Medications:

(Please list all medicine and over-the-counter medicine prior to gynecological visit, including hormones, vitamins, and herbs)

Medication Name (Brand/Generic)	Dose	Frequency	Start Date	End Date	Prescribed By	Initials of Reviewer

Social History

Current and Past Alcohol Intake (drinks per week): ____________________

Do you use recreational drugs? ☐ Yes ☐ No

Have you ever received treatment for substance abuse? ☐ Yes ☐ No

Do you use Tobacco? ☐ Yes ☐ No ☐ Past use

If yes, what age did you start or how many years? ____________________

If yes, what type of Tobacco? ☐ Cigarettes ☐ Cigars ☐ Oral ☐ Second Hand ☐ Other: __________

If yes, number of times Tobacco used per day? __________

Exercise (type, frequency, duration): ____________________

Describe your diet: ____________________

Are you losing weight? ☐ Yes ☐ No

Personal Safety

Do you feel safe at home? ☐ Yes ☐ No

Has anyone, including your partner, ever forced you to have sex? ☐ Yes ☐ No

Have you ever been sexually, physically or emotionally abused? ☐ Yes ☐ No

Health Maintenance and Screening (if you've had and know the results):

Date and result of last mammogram: Date: __________ Result: __________

Have you ever had an abnormal mammogram, breast ultrasound or breast biopsy? ☐ Yes ☐ No

Do you do self breast exams? ☐ Yes ☐ No

Date and result of last colonoscopy or sigmoidoscopy (50+): Date: __________ Result: __________

Date and result of last thyroid function test: Date: __________ Result: __________

Date and result of last cholesterol test: Date: __________ Result: __________

Date and result of last diabetes test: Date: __________ Result: __________

Date and result of last bone density test: Date: __________ Result: __________

Date and result of last HIV test: Date: __________ Result: __________

Date of last HPV vaccine: Date: __________ Result: __________

If you had, did you receive all three shots? ☐ Yes ☐ No

Date of last tetanus immunization: Date: __________ Result: __________

Do you have another primary care provider (family doctor, internist, nurse practitioner) who is taking care of you for regular check-ups? ☐ Yes ☐ No

If yes, please provide name and contact number: ____________________

Family History

Please mark an "X" in the appropriate box for family member pertaining to:

	Mother	Maternal Grandmother	Maternal Grandfather	Father	Paternal Grandmother	Paternal Grandfather	Sister	Brother	Child
Breast Cancer									
Ovarian Cancer									
Uterine Cancer									
Colon Cancer									
Diabetes									
High Cholesterol									
High Blood Pressure									
Heart Disease									
Osteoporosis									
Premature Menopause									
Alzheimer's Disease									

Please list any other family history details: ______________________________

____

Review of Biological Systems: Are you experiencing any of the following?

1. Constitutional

Fatigue ☐ Yes ☐ No
Fever ☐ Yes ☐ No
Unintentional Weight Loss ☐ Yes ☐ No
Unintentional Weight Gain ☐ Yes ☐ No

2. Ears/Nose/Mouth/Throat

Frequent Nosebleeds ☐ Yes ☐ No
Bleeding Gums ☐ Yes ☐ No
Sore/Ulcer in the Mouth ☐ Yes ☐ No

3. Cardiovascular

Chest Pain ☐ Yes ☐ No
Calf Pain or Shortness of Breath with Walking ☐ Yes ☐ No
Palpitations ☐ Yes ☐ No
Swelling in the Feet and/or Ankles ☐ Yes ☐ No
Rapid Heart Rate ☐ Yes ☐ No

4. Respiratory

Exposure to Tuberculosis	☐ Yes ☐ No
Sudden Onset of Painful and Difficult Breathing	☐ Yes ☐ No
Wheezing	☐ Yes ☐ No
Shortness of Breath	☐ Yes ☐ No

5. Gastrointestinal

Acid Reflux/Heartburn	☐ Yes ☐ No
Bloating	☐ Yes ☐ No
Constipation	☐ Yes ☐ No
Diarrhea	☐ Yes ☐ No
Nausea/Vomiting	☐ Yes ☐ No
Change with Bowel Movements	☐ Yes ☐ No

6. Musculoskeletal

Joint Pain/Back Pain	☐ Yes ☐ No
Muscle Weakness	☐ Yes ☐ No
Joint Stiffness	☐ Yes ☐ No

7. Skin

Acne	☐ Yes ☐ No
Atypical Moles	☐ Yes ☐ No
Breast Tenderness	☐ Yes ☐ No
Breast Skin Changes/Masses	☐ Yes ☐ No
Nipple Discharge	☐ Yes ☐ No

8. Neurological

Headaches	☐ Yes ☐ No
Seizures	☐ Yes ☐ No
Tremors	☐ Yes ☐ No
Trouble Walking	☐ Yes ☐ No

9. Hematological

Easy Bruising	☐ Yes ☐ No
Cuts that do not stop bleeding	☐ Yes ☐ No
Enlarged/Swollen Lymph Nodes	☐ Yes ☐ No

10. Endocrine

Heat/Cold Intolerance	☐ Yes ☐ No
Excessive Hair Growth	☐ Yes ☐ No
Abnormal Thirst	☐ Yes ☐ No

11. Psychiatric

Anxiety	☐ Yes ☐ No
Crying Spells	☐ Yes ☐ No
Depression	☐ Yes ☐ No
Feeling Stressed	☐ Yes ☐ No
Loss of Interest in Pleasurable Activities	☐ Yes ☐ No
Poor Concentration	☐ Yes ☐ No
Prolonged Sadness	☐ Yes ☐ No
Sleep Disturbances	☐ Yes ☐ No
Suicidal Thoughts	☐ Yes ☐ No

Date Reviewed: ______________________ Physician Signature: ______________________