Innovative
HEALTH AND WELLNESS

PATIENT INFORMATION FORM

Name:_____ Date of Birth:_____
First Middle Last

Address: _____
Street City State Zip

Phone Number: _____ Email: _____

Soc Sec#:_____ Marital Status: SINGLE MARRIED DIVORCED WIDOWED SEPERATED

What is your preferred method of communication? Phone ☐ Email ☐ Mail ☐

Patient's Employer:_____ Work #: _____

Primary Care Doctor (PCP): _____ Phone number: _____

Emergency Contact: _____ Phone Number: _____

Do you have medical insurance? ☐ Yes ☐ No

Insurance Company: _____ Policy Number:_____

Group Number:_____ Policy Holder's Name:_____

Policy Holder's Date of Birth: _____ Relationship: _____

Who may we thank for referring you: _____

RESPONSIBLE PARTY

Name Responsible for Account: _____

Relationship to Patient: _____ Date of Birth: _____

Address: _____
Street City State Zip

Phone Number: _____ Email: _____

Patient Signature:_____ ***Date:***_____

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Female HRT

Patient Name: _____ DOB: _____ Date: _____
Primary Care Doctor (PCP): _____ Phone Number: _____
Pharmacy Number: _____ Date of Last Physical Exam: _____

If we could wave a "magic wand" and grant you exactly what you would like out of this program, what would it be? Try to be as honest and specific as possible.

Please list at least 3 different things

1. _____
2. _____
3. _____

Allergies: Please check all that apply.

_____ Penicillin _____ Morphine _____ Dye Allergies _____ Pet Allergies

_____ Codeine _____ Aspirin _____ Nitrate Allergy _____ Seasonal (Pollen)

_____ Sulfa Drug _____ Food Allergies _____ Unknown Allergies Other: _____

Please describe the allergic reaction you experienced and when it occurred.

_____
_____

Medical Conditions/Diseases: Please check all that apply to you.

_____ Heart Disease _____Blood Clotting Problems _____Ulcers (Stomach, Esophagus)

_____ High Cholesterol or Lipids _____ Diabetes _____ Epilepsy

_____ High Blood Pressure _____ Arthritis or Joint Problems _____Thyroid Disease

_____ Cancer _____ Depression _____Headaches/Migraines

_____Hormonal Related Issues _____Eye Disease _____ Lung Condition

Other: _____

Do you have a family history of any of the following?

_____ Uterine Cancer Family Member(s) _____

_____ Fibrocystic Breast Family Member(s) _____

_____ Breast Cancer Family Member(s) _____

_____ Heart Cancer Family Member(s) _____

_____ Osteoporosis Family Member(s) _____

_____ Thyroid Disease Family Member(s) _____

Have you ever used oral contraceptives? _____ No _____ Yes
Any Problems? _____ No _____ Yes
If YES, describe symptoms and problem(s).

_____

_____

How many pregnancies have you had? _____ How many children? _____
Any Interrupted Pregnancies? _____ No _____ Yes
Have you had a hysterectomy? _____ No _____ Yes (date) _____
Ovaries removed? _____ No _____ Yes
Have you had tubal ligation? _____ No _____ Yes (date) _____

Have you ever had any of the following tests performed? Check those that apply and note date of last test.

Mammography _____ No _____ Yes Date: _____
PAP Smear _____ No _____ Yes Date: _____

Since you first began having periods, have you ever had what you would consider to be abnormal cycles?
_____ No _____ Yes Date: _____

If YES, please explain (such as age when this occurred, symptoms):

_____

_____

_____

Where did you receive the information to consider Bio-identical Hormone Restoration Therapy?

_____ Doctor _____ Friend/Family Member _____ Book Other: _____
If by book, please list name and author of the book: _____

What are your goals for BHRT?

_____

_____

_____

List Hormones previously taken: Date Started Dated Stopped Reason Stopped

_____

_____

_____

Patient Signature: _____ ***Date:*** _____

Over the counter medications:
Please check all products that you use regularly or occasionally.

Pain Relievers:
_____ Aspirin
_____ Acetaminophen
_____ Anti-inflammatory
_____ Ibuprofen
_____ Naproxen
_____ Cough Suppressant
_____ Antihistamine Product
_____ Decongestant Product

Other:
_____ Sleep Aids
_____ Antidiarrheals
_____ Laxatives/Stool Softeners
_____ Diet Aids/Weight Loss Products
_____ Antacids
Other: _____
_____
_____

Supplements: Please identify and list the products you are using.

_____ Vitamins (examples: multiple or single vitamins such as B complex, E , C, beta carotene)
_____ Minerals (examples: calcium, magnesium, chromium, etc.)
_____ Enzymes (examples: digestive formulas, papaya, bromelain)
_____ Nutrition/Protein Supplements (examples: protein powders, amino acids, fish oils, etc.)

Others:
_____
_____
_____

List use of:

Tobacco _____ No _____ Yes Occasionally Daily Weekly Monthly

Alcohol _____ No _____ Yes Occasionally Daily Weekly Monthly

Caffeine _____ No _____ Yes Occasionally Daily Weekly Monthly

When was your last period? _____

How many days did it last? _____

Do you have or did you ever have Premenstrual Syndrome (PMS)? _____ No _____ Yes

Please list any questions and/or expectations you have about Bio-identical Hormone Restoration Therapy.

_____
_____
_____

Patient Signature: _____ ***Date:*** _____

Hormone Replacement Therapy Information Sheet

	Absent	Mild	Moderate	Severe
Fibrocystic Breast	☐	☐	☐	☐
Weight Gain	☐	☐	☐	☐
Heavy/Irregular Menses	☐	☐	☐	☐
Hot Flashes	☐	☐	☐	☐
Dry Skin/Hair	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Night Sweats	☐	☐	☐	☐
Vaginal Dryness	☐	☐	☐	☐
Headaches	☐	☐	☐	☐
Irritability	☐	☐	☐	☐
Mood Swings	☐	☐	☐	☐
Breast Tenderness	☐	☐	☐	☐
Sleep Disturbances/Insomnia	☐	☐	☐	☐
Cramps	☐	☐	☐	☐
Fluid Retention	☐	☐	☐	☐
Breakthrough Bleeding	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐
Loss of Memory	☐	☐	☐	☐
Bladder Symptoms	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Harder to Reach Climax	☐	☐	☐	☐
Decreased Sex Drive	☐	☐	☐	☐
Hair Loss	☐	☐	☐	☐

Patient Signature:_____ ***Date:***_____

ADDITIONAL INFORMATION

List all medications you are taking now including over the counter medication:

_____

_____

_____

Do you have or have you ever had any diseases or medical problems not listed? If so, please list:

_____

_____

_____

I have read the above information and certify that it is to be true and correct to the best of my knowledge, and hereby authorize this office to provide care, in accordance with state's statutes.

Patient or Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

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295 Molly Lane, Suite 150
Woodstock, GA 30189
Phone: 770-926-4646
Fax: 770-966-8870

3115 Piedmont Rd, Suite A102
Atlanta, GA 30305
Phone: 404-816-0222
Fax: 404-464-7699

ALLERGY IMPACT QUESTIONNAIRE

Patient's Name: _____ DOB: _____

Please answer all questions fully and circle all answers that apply.

- Do you think you suffer from allergies? Yes No
- Are the symptoms Year Long? Yes No Seasonal? Yes No
- How long are your symptoms per week? Less than 7 days All 7 days
- What time of the day are your symptoms worse? Morning Afternoon Night All day
- Are the symptoms worse in the spring, fall, or both? Spring Fall Both
- Do you have any sinus drainage issues? Yes No If Yes, when? AM PM All day
- Do you ever have watery or itchy eyes? Always Most Times Sometimes Never
- Do you cough or sneeze on a regular basis? Yes No If Yes, when? _____
- Do you have regular upper respiratory infections? Yes No If Yes, Less than 3 OR More than 3 per year
- Do you think you might be allergic to animals? Yes No
- Have you been diagnosed with asthma? Yes No If yes, when? _____
- Do you have a family history of asthma? Yes No
- How long have you lived in Georgia? _____ Years _____Months
- How long have you lived in your current residence? _____Years _____Months
- Did you have allergies in your previous residence or state? Yes No
- Do you wear a mask when you cut grass? Yes No
- Do you have a HEPA filter on your vacuum cleaner? Yes No
- Do you use an inhaler? Yes No
- Are you currently using any allergy medications? Yes No If yes, please list all medications including over the counter medications _____
- Are you currently taking any blood pressure medications? Yes No If yes, please list:

_____ _____ _____

Patient's Signature_____ **Date**_____

Office Staff Use Only: ICD 10 Codes For Patient: Medical Provider Please Circle All That Apply

H10.45 H65.90 J30.2 J30.81 J30.1 R21 T78.1XXA _____ Other

Based on these results and examination, I certify that allergy testing is indicated for the above-named patient and so ordered.

Physician's Signature:_____**Date:**

_____

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MEDICAL RECORDS RELEASE

To: _____ Fax # _____

Patient Name: _____ DOB: _____

I hereby authorize you to release records to Innovative Health and Wellness any information including the diagnosis and records of treatment or examination rendered to me for all care during the period of _____ to _____.

Signature of Patient: _____ Date: _____

Signature of Parent/ Guardian: _____ Date: _____

Witness Signature: _____ Date: _____

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Photo Release Form

I hereby grant Innovative Health and Wellness permission to use my likeness in a photograph in any and all of its publications, including website entries, without payment or any considerations.

I Understand and agree that these materials will become the property of the Innovative Health and Wellness and will not be returned.

I hereby irrevocably authorize the Innovative Health and Wellness to edit, alter copy, exhibit, publish or distribute this photo for purposes of publicizing the Innovative Health and Wellness programs or for any other lawful purposes. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of photograph.

I hereby hold harmless and release and forever discharge the Innovative Health and Wellness from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I am 21 years of age and am competent to contact in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impacted of this release.

_____ _____

(Signature) (Date)

_____ _____

(Printed Name) (Date)

If the person signing is under age21, there must be consent by a parent or guardian, as follows:
I hereby certify that I am the parent or guardian of _____,
Named above, and do hereby give my consent without reservation to the foregoing on behalf of this person.

_____ _____

(Parent/Guardian's Signature) (Date)

_____ _____

(Parent/Guardian's Printed Name) (Date)

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Patient Missed Appointment Policy

Definitions: Policy- a way of managing affairs so as to achieve some purpose.

Appointment- a meeting with someone at a certain time and place.

Missed- fail to keep, or be present at.

It is our wish that each and every one of our patients receive the very best care and service possible. Your treatment program consists of a specific series of treatment given over a pre-planned time span. If you do not follow this plan, then you will not receive the desired results.

1. Meet all your appointments. Arrange the activities in your life so that this can occur.
2. If you become ill, we still want you to come in, because treatment will help you recover.
3. If you are unable to make it in due to an emergency, please call us and let us know so we can schedule your appointment.
4. With exceptions of unexpected emergencies, we require that you notify us at least 24 hours in advance as to any appointment changes.
5. All cancelled or missed appointments must be rescheduled and made up within the week.
6. We have the right to charge 5.00 for no call/no show appointments.
7. There could also be a $20.00 charge for missing an appointment with the medical doctor.

I have read, understand, and agree to follow the above policy.

Patient's Name: _____ **DOB:** _____

Signature: _____ **Date:** _____

Staff Witness: _____

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FINANCIAL RESPONSIBLITIES

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I authorize payment directly from my insurance company to Innovative Health and Wellness. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are ultimately my personal responsibility. I also understand that if I suspend or terminate my care and treatment any fees for professional service rendered to me will be immediately due and payable.

If I have insurance, I am responsible for my insurance deductible, co-payments and any service rejected by my insurance company. I am also aware that is I have not made a payment on my outstanding balance within a 30 day period, a service fee of 2% will be added to my account. If I have an outstanding balance that may be served to a collection agency, there will be an additional fifty dollar fee added.

This office cannot promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, we will pursue on your behalf as far as we are able to. If unsuccessful, you will be expected to take responsibility for any outstanding balance.

I authorize this clinic to release any information pertinent to my case to any insurance company, adjuster and/or attorney involved in this case, and herby release this clinic of any consequences thereof.

Although our office will call to verify your insurance coverage, it is your responsibility to confirm and know your benefits. If you have limited coverage, you need to be aware of when your insurance will stop paying your claims.

I certify that the information provided in this three part form is correct to the best of my knowledge. I will not hold my doctor or any staff member of Innovative Health and Wellness responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient: _____ Date: _____

Patient Name (print)_____ D.O.B._____

Signature of Parent/ Guardian: _____ Date: _____

ACKNOWLEDGEMENT AND UNDERSTANDING

I acknowledge and agree to the following:

The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

Chiropractic is not a treatment for any condition or symptom. It is a care system that is aimed toward the reduction and correction of spinal subluxations so that your body as a whole may function better.

Although Chiropractic care is one of the safest forms of health care, it is associated with some minor risks and it is my responsibility to be informed about those risks by asking the doctor or a staff member prior to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a care for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another health care professional who we feel can further assist you.

I hereby authorize the doctors and staff affiliated with Innovative Health and Wellness treat my condition as deemed appropriate.

Signature of Patient: _____ Date: _____

Signature of Parent/ Guardian: _____ Date: _____

CONSENT OF TREATMENT OF A MINOR CHILD

I hereby authorize Dr. Orlando and whomever he may designate as assistance to administer chiropractic care as deems necessary to my _____ (indicate relationship to minor).

Name of Minor: _____ Date: _____

Signature of Parent/ Guardian: _____

Signature of Staff: _____ Date: _____

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Assignment of Health Plan Benefits and Rights as well as an Appointment as an ERISA*/PPACA** Representative Designation

I understand and agree that, regardless of whatever health insurance or medical benefits I have, I am ultimately responsible to pay **Innovative Health and Wellness, LLC** the balance due on my account for any professional medical and chiropractic services rendered and for any ancillary supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to **Innovative Health and Wellness, LLC** for medical/healthcare services rendered and for any ancillary supplies, tests, and medications provided.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, of to pursue any other remedies necessary in connection with same.

I hereby assign directly to **Innovative Health and Wellness, LLC** all rights to payments, benefits, and all other legal rights under, or pursuant to, any health plan, ERISA plan, PPACA plan, or insurance contract rights that I (or my child, spouse, or dependent) may have under my/our applicable health plans(s) or health insurance policy(ies). This assignment includes, but not limited to, a designation that **Innovative Health and Wellness, LLC** can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to **Innovative Health and Wellness, LLC** as a result of services rendered by **Innovative Health and Wellness, LLC** and to pursue any and all remedies to which I/we may be entitles, including the use of legal action against the health plan or insurer. This assignment and designation remains in effect unless revoked in writing and a photocopy or scan is to be considered as a valid and enforceable as the original.

Signed this _____day of _____20___

X_____
Patient Signature

X_____
Office Staff Signature

_____
Patient's Printed Name

_____
Signature of Guardian (if applicable)

*ERISA – Employee Retirement Income Security Act
**PPACA – Patient Protection and Affordable Care Act

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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's 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 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice has a 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 use of their information but the practice does not have to agree to the 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.

This consent was signed by: _____D.O.B._____

(Printed name of Patient or Representative)

Signature: _____ Date: _____

Innovative
HEALTH AND WELLNESS

295 Molly Lane. Suite #150
Woodstock, GA 30189

3115 Piedmont Road, A102
Atlanta GA 30305

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____DOB_____

I hereby acknowledge that I received the Notice of Privacy Practices statement of Innovative Health and Wellness, LLC

Signature: _____ Date: _____