NATURAL HEALTH PRACTICES NEW PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY

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 Twitter Google+	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:		
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: Single Married Divorced Widowed		Name of Spouse:	
Names of Immediate Family Members	Gender	Age	Current Health Status
1.	M / F		
2.	M / F		
3.	M / F		
4.	M / F		
Do you have any pets you or your family members are in close contact with?			
Is there anything you are unwilling to change in order to reach your health goals?			
How would you describe your spiritual health?			
What can we do to make you happier?			

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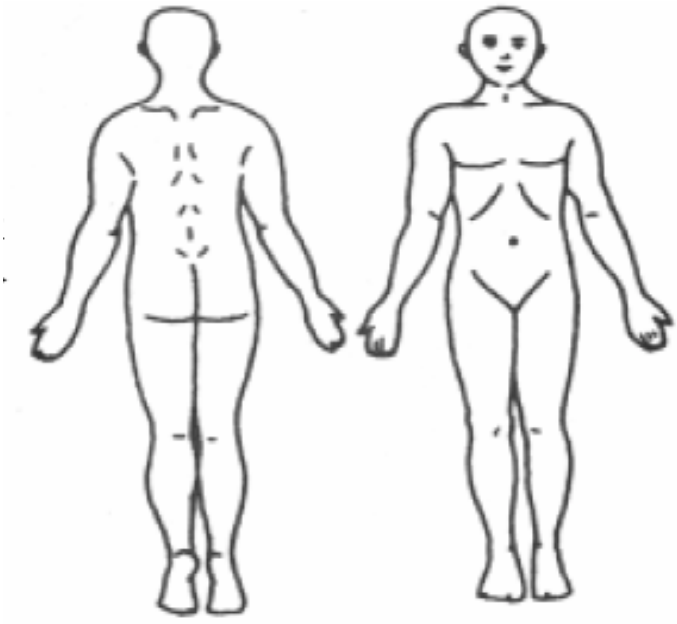
List any major illnesses, accidents, or injuries with approximate dates:	List any surgeries or operations (include out-patient or "routine" procedures) with approximate dates:

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?	What treatment have you received for this health concern?
1.					
2.					
3.					
4.					
5.					

Please mark up this diagram as much as necessary to indicate the location and type of symptoms you're experiencing.

Also, indicate the location of injuries, surgeries, and scars.



Patient Signature: _____ Today's Date: _____

NATURAL HEALTH PRACTICES

4904 Clyde Morris Blvd. Suite A, Port Orange, FL 32129

PERMISSION AND AUTHORIZATION REGARDING THE USE OF NUTRITION RESPONSE TESTING

I authorize practitioners at Natural Health Practices Inc. to perform a Nutrition Response Testing analysis and to develop a natural health improvement program for me, which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, and not for the treatment of any disease.

I understand that Nutrition Response Testing is a safe, non-invasive, natural method of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems. I understand that Nutrition Response Testing is not a method for "diagnosing" or "treating" any diseases including cancer, AIDS, infections, or other medical conditions.

No promise or guarantee has been made regarding the results of Nutrition Response Testing or any natural health, nutritional, or dietary programs recommended, but rather I understand that Nutrition Response Testing is a means by which the body's natural organ responses can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

CONSENT TO CHIROPRACTIC TREATMENT

Natural Health Practices Inc. maintains equipment, personnel, and facilities to assist in the delivery of chiropractic adjustments, therapeutic procedures, and recommendations of whole food nutritional supplements with the goal of supporting the natural physiology of the body. As with any comparable intervention, these adjustments, procedures, and supplements 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. These 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.

OFFICE POLICIES

We believe that you alone are responsible for your health choices and not your insurance company. Insurance companies and their representatives have become increasingly selective in denying reimbursement for services while also increasing deductibles and copays. Knowing this, many doctors across the country are choosing to forego insurance. Our office operates as a private pay practice, which allows us to offer affordable care to patients without interference or influence from a third party company.

If you are unable to make a scheduled appointment, we respectfully request that you cancel 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 – not to collect missed appointment fees.

Your signature below constitutes your acknowledgement that: (1) You have read and agreed to the above treatment and office policies and; (2) The procedures and possible alternate means of therapy have been adequately explained to you by your doctor; (3) You consent to additional procedures and tests arising from presently unforeseen conditions which your doctor may suggest in the course of treatment; (4) You understand that certain exams may require a patient gown for which a chaperone may be enlisted at either party's discretion; (5) Your attendance/attention is required for patient education and to clarify at-home requirements of your individual treatment plan; (6) You acknowledge that you are responsible for payment at time of service and that there is no guarantee your insurance company will reimburse you for exams, services, or supplements; (7) You agree not to publish misrepresentative or libelous statements about Natural Health Practices Inc. or Dr. Seidenberg on any social media or public internet website.

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.

I have read and understand the foregoing. This permission form applies to subsequent visits and consultations.

Patient Signature: _____ Today's Date: _____