



ALTERNATIVE MEDICINE ASSOCIATES  
1230 Slaughter Road, Suite E  
Madison, AL 35758  
256-325-0955

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

E-mail: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name: \_\_\_\_\_  
Last Name First Name MI

Sex (please circle): Male or Female

Home: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Are you a minor: Yes or No

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please Circle: Single Married Divorced Separated Widowed Partnered for \_\_\_\_ Years

Employer/School: \_\_\_\_\_

Employer/School Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer/School Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

How did you hear about us? : \_\_\_\_\_

### **ADDITIONAL INFORMATION**

Spouse's Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Employer: \_\_\_\_\_

Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### **EMERGENCY INFORMATION**

Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy  Chiropractic Care  None

Other: \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition: \_\_\_\_\_



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## CONSENT AGREEMENT CONCERNING PATIENT ASSESSMENT & NUTRITIONAL THERAPY

Alternative Medicine Associates offers medical evaluative and treatment services for the purpose of nutritional assessment of the patient. Since a nutritional deficiency may or may not be associated with a specific disease, or it may be the cause of the disease, or it may occur as a result of the disease, it is important for you to understand that our sole concern in your case will be your nutritional program and your ability to metabolize and utilize the nutrients that you consume.

We will not diagnose, treat or cure any specific disease, and the nutritional recommendations we make based on lab tests, physical and clinical findings, history and symptoms does not constitute treatment for any disease or affliction, real or imagined by you. In the event that any vitamin, mineral, food, or other nutritional substance is prescribed or administered in your case, we want you to understand that its purpose will be for the following: Improvement of your overall nutritional status, improvement in your metabolism, improvement of your sense of wellbeing, improvement of your appetite, gain or reduction in weight or possible remission or reduction of pain where present.

However, you must understand that you may not receive any of these benefits because they do not occur predictably with every patient and in some cases may not occur at all. Also understand that this office may choose to use not only oral routes of administrations of nutritional products, but we may also use injectable routes (IM, Sub-Q, IV) or Nebulizers.

According to the Federal Food, Drug and Cosmetic Act, as amended Section 201 (g) (1), the term "DRUG" is defined to mean, "Articles intended for use in Diagnosis, Cure, Mitigation, Treatment or Prevention of Disease." A vitamin is not a drug; neither is a mineral, trace element, amino acid, herb or homeopathic remedy. Although a vitamin, a mineral, trace element, amino acid, herb or homeopathic remedy may have an effect in any disease process or symptoms, this does not mean that it can be misrepresented or be classified as a drug by anyone. Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as primary treatment and or therapy for any disease or particular bodily symptom. Nutritional counseling, vitamin recommendations nutritional advice and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biochemical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of body functions.

I have read and understand the above:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_





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**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

1. This is to inform you that Alternative Medicine Associates may use and disclose your health information that identifies you, and that consist of your past, present, or future physical or mental health condition. The provision of your healthcare; and the past, present or future payment for the provision of your healthcare (this health information is referred to herein as "PROTECTED HEALTH INFORMATION").
2. The use and disclosure of your protected health information will be to carry out treatment, payment and healthcare operations for Alternative Medicine Associates.
3. You have the right to request that Alternative Medicine Associates be restricted from using or disclosing your protected health information in carrying out treatment, payment or healthcare operations; however Alternative Medicine Associates is not required to agree to your requested restrictions. If Alternative Medicine Associates does agree to your requested restrictions, then it will comply with your request.
4. You have the right to revoke this consent. This revocation must be made in writing to Alternative Medicine Associates. This revocation will be valid except to the extent that Alternative Medicine Associates has taken action in reliance on this consent.

Further, I hereby authorize and give my consent to Alternative Medicine Associates to communicate any of my protected health information to the following persons:

Name:	Relationship:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

\_\_\_\_\_ I, Acknowledge receipt of this notice of privacy practices from which details how protected health information may be used and disclosed, and how I may access that information.

\_\_\_\_\_  
Patient Name (Please print)

\_\_\_\_\_  
Authorized Representative

\_\_\_\_\_  
Patient Signature & Date



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### Policy for Missed Appointments

**Missed appointment or failure to provide 24 hour notice to cancel/reschedule:**

A minimum of 24 hour notice is required to cancel or reschedule appointments/services. Failure to provide 24 hour notice will result in a missed appointment fee.

Missed appointment with physician: \$75

Missed IV therapy appointment: cost of IV

Missing appointments may result in dismissal from the practice or requiring prepayment for office visits/services.

I have read and understand the above:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date







Name \_\_\_\_\_

Date \_\_\_\_\_

Please list any **prescription medications** you are currently taking or have taken in the last year:

Currently taking?	Medication	Diagnosis	Quantity and Frequency
yes / no			
yes / no			
yes / no			
yes / no			
yes / no			
yes / no			
yes / no			
yes / no			
yes / no			

Please list any **over-the-counter medications** you are currently taking or have taken in the last year:

Currently taking?	Product	Symptom	Quantity and Frequency
yes / no			
yes / no			
yes / no			
yes / no			
yes / no			
yes / no			

Please list any **vitamins, supplements, herbs, or homeopathic** medicines you are currently taking or have taken in the last year: (Use other side if needed.)

Currently taking?	Product	Symptom	Quantity and Frequency
yes / no			
yes / no			
yes / no			
yes / no			
yes / no			
yes / no			
yes / no			
yes / no			
yes / no			
yes / no			
yes / no			

Check the following items which apply to you and indicate the amount used:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Coffee _____           | <input type="checkbox"/> Artificial Sweetner _____ | <input type="checkbox"/> Ice Cream _____     |
| <input type="checkbox"/> Tea _____              | <input type="checkbox"/> Antacids _____            | <input type="checkbox"/> Alcohol _____       |
| <input type="checkbox"/> Soft Drinks _____      | <input type="checkbox"/> Laxatives _____           | <input type="checkbox"/> Cigarettes _____    |
| <input type="checkbox"/> Diet Soft Drinks _____ | <input type="checkbox"/> Candy _____               | <input type="checkbox"/> Other Tobacco _____ |

How many desserts do you have in an average week? \_\_\_\_\_