ALTERNATIVE MEDICINE ASSOCIATES

1230 Slaughter Road, Suite C
Madison, AL 35758
256-325-0955

Date: _____/_____/_____

E-mail: _____ Date of Birth: ____/____/_____

Name: _____ Sex (please circle): Male or Female
Last Name First Name MI

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: _____

ALTERNATIVE MEDICINE ASSOCIATES

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:_____

ALTERNATIVE MEDICINE ASSOCIATES

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

ALTERNATIVE MEDICINE ASSOCIATES

CONFIDENTIAL

REQUEST FOR RELEASE OF MEDICAL RECORDS

Date:

Requested from:

_____

_____

_____

I hereby authorize you to release medical records on:

_____

(Patient Name and Date of Birth)

_____

(Address of Patient)

INFORMATION NEEDED:

_____ All Records
_____ Hospital Stay
_____ Hospital Discharge Summary
_____ Immunization Only
_____ Laboratory/X-ray Reports
_____ Operative Report
_____ Pathology Report
_____ Sexually Transmitted Disease/HIV
_____ Psychiatric History

_____

(Patient Signature and Date)

PLEASE REMIT RECORDS BY FAX OR BY MAIL TO:
1230 Slaughter Road, Suite C
Madison, AL 35758
Fax: 256-325-2560

ALTERNATIVE MEDICINE ASSOCIATES

1230 Slaughter Road, Suite C
Madison, AL 35758
256-325-0955

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

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

I have read and understood the above:

_____ _____
Signature Date

ALTERNATIVE MEDICINE ASSOCIATES

Have you had any of the following?

	Yes	No
AIDS/HIV		
Anxiety		
Appendicitis		
Chicken Pox		
Depression		
Dislocations		
Emphysema		
Falls		
Fibromyalgia		
Fractures/Broken Bones		
Head Injury		
Herniated Disk		
Hernia		
Herpes		
Measles		
Pacemaker		
Pinched Nerve		
Pneumonia		
Polio		
Prostate Problem		
Scarlet Fever		
STD		
Tonsillitis		
Typhoid Fever		
Ulcers		
Vaginal Infections		
Wooping Cough		
Current Alcohol Consumption		
How many drinks weekly?		
Current Tobacco Use		
How much each day?		

Have you or a family member had any of the following?

	Self	Sibling	Parent	Grand-parent
Alcoholism				
Anemia				
Arthritis				
Asthma				
Bleeding Disorder				
Breast Lump				
Bronchitis				
Cancer/Tumor/Growth				
Cataracts				
Chemical Dependency				
Diabetes				
Eating Disorder				
Epilepsy				
Glaucoma				
Gout				
Heart Disease				
Hepatitis				
High Blood Pressure				
High cholesterol				
Kidney Disease				
Liver Disease				
Migraine Headaches				
Miscarriage				
Mononucleosis				
Multiple Sclerosis				
Osteoporosis				
Parkinson's Disease				
Psychiatric Care				
Stroke				
Suicide Attempt				
Thyroid Problems				
Tuberculosis (TB)				
Rheumatoid Arthritis				

Have you had surgery?	
Date	Type of Surgery

What are you allergic to?

Other:

ALTERNATIVE MEDICINE ASSOCIATES

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			
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:

- ☐ Coffee
- ☐ Tea
- ☐ Soft Drinks
- ☐ Diet Soft Drinks
- ☐ Artificial Sweetener
- ☐ Antacids
- ☐ Laxatives
- ☐ Candy
- ☐ Ice Cream
- ☐ Alcohol
- ☐ Cigarettes
- ☐ Other Tobacco

How many desserts do you have in an average week? _____