Healthcare History – Physical

Personal Data

Date________________________ Date of Birth_________________________
Name____
Address____
City _______________________________ State __________ZIP___________
Phone/Home____________ Work ____________ Cell___________________
Fax_____________________ Email__________________________________
Spouse or Parent (if minor) ____
Children (Names/Ages)
____
Occupation____
Emergency Contact________________________ Phone_________________
Referred by____

Healthcare History

Physician______________________Chiropractor_______________________
Other healthcare practitioners you have seen for your main health concern:
____
Brief Medical History/Diagnosis___________________________________
____
____Do you take any prescription or recreational drugs? Yes / No
Please list: ____
Do you have any body piercings or wear toe rings, and if so, where?
____
Do you currently wear orthotics for spinal/structural support? Yes / No
Are you are a vegetarian? Yes / No

Healthcare Concerns

Please list your five main healthcare concerns in order of importance:
1____
2____
3____
4____
5____

Holistic Nutrition & Wellness Center
MARY JANE MACK, LLC
725 4th Ave NW | PO Box 1126 | Issaquah, WA 98027 | 425-392-0659 | 1-888-777-4232

info@maryjanemack.com

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability ACT (HIPAA) Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you, and that relates to your past, present or future physical/mental health, conditions and related healthcare services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as Required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration Requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates

Required Uses and Disclosures

Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your physician amend your protected health information.

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before April 14, 2003. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

3/16/09

Signature______________________________________Date_____________

Credit Card Authorization

The practice accepts both VISA and MASTERCARD credit cards for payment. Credit card payment over the phone requires completion of this form. By completing this form you thereby authorize Mary Jane Mack, LLC to keep your credit card number on file for payment of future office visit(s) and/or purchase and shipment of product(s).

Cardholder's Billing Address

Full Name

Address

City/State/Zip

Phone

Cardholder's Shipping Address

(Please complete if the shipping address is different than the billing address.)

Full Name

Address

City/State/Zip

Phone

Credit Card Information

Card Type (Please circle one) VISA / MASTERCARD

Card Number _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ (_ _ _)

(Please include the additional three digits shown on the back of card in signature strip.)

Expiration Date _ _ / _ _

Cardholder's Agreement

I authorize Mary Jane Mack, LLC to charge my office visit(s) and/or product(s) with the above credit card account number. I am fully aware that my credit card is being charged for any such purchase(s).

Signature ________________________________ Date____________

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Policies and Procedures

Prior to your appointment with Mary Jane, a new client packet will be either e-mailed or sent to you via mail. Please take the time to accurately fill out the health questionnaire and read the enclosed material. Mary Jane requires the following:

- Products recommended **must** be purchased through Mary Jane Mack directly in order to remain a client.

Payment for consultation and product is due at the time of your visit. As per above, you will be required to purchase product from our office. Please respect other clients time by arriving on time for your appointment. If you must reschedule your appointment, please provide 24 hours notice. Missed appointments are subject to billing consistent with our fee schedule. We accept cash, VISA, MasterCard.

Cancellations:

If you are unable to keep your appointment, kindly give 24 hours notice to cancel. If not, you may be billed for the time you reserved.

Return Policy:

If a product is to be returned for any reason it must be returned within 30 days, with proof of purchase, unopened in the original packaging (bottle and carton, if applicable). All returns are subject to a 15% restocking fee.

I have read and understand the Policies and Procedures .

Signature____ Date________________