Health Profile

Consultation involves a health profile whose purpose is not to establish a diagnosis, but rather to determine a client's health status & provide guidance. A client may be advised to seek medical advice based on his or her health profile.

Date of Application_____

Patient's First Name: _____Last Name: _____

Address: _____ Apt/Unit: # _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ E-mail: _____

Date of Birth/Age: _____ Profession: _____

Sex: M F None Marital Status: S M D W

Whom may we thank for referring you? _____

Height: _____ Weight: _____lbs. Weight 1 year ago: _____ lbs. Min. Adult Weight: _____

Maximum Weight: ____ lbs. at age _____ Height: _____ Your Weight Goal: _____

Do you exercise? □ Yes □ No If yes, what kind and how often? _____

Have you been on a diet before? □ Yes □ No _____

If yes, please specify which diet and why you think it didn't work for you (e.g. too rigid, too much cooking involved, etc.): _____

Have you ever had injectable Vitamin B therapy before? □ Yes □ No

What are your primary health interests in wanting this treatment procedure?

_____

Do you have diabetes? □ Yes □ No Do you tend to be hypoglycemic? □ Yes □ No

Hypertension: □ Yes □ No **Kidney Function**: □ Yes □ No **Liver Function**: □ Yes □ No

Colon Function: □ Yes □ No **Stomach/Digestive Function**: □ Yes □ No

Ovarian/Breast Function: □ Yes □ No **Thyroid Function**: □ Yes □ No

Do any of the following apply to you? □ Depression □ Anxiety □ Panic Attacks

□ Bulimia (or history of) □ Anorexia (or history of)

Inflammatory Conditions: Do any of the following apply to you?

□ Migraines □ Fibromyalgia □ Rheumatoid Arthritis □ Lupus □ Osteoarthritis

□ Chronic Fatigue Syndrome □ Psoriasis

Do you have Parkinson's disease? □ Yes □ No Do you have Cancer? □ Yes □ No

Remission? □ Yes □ No Are you generally fatigued or have low energy? □ Yes □ No

Please provide detail to any of the above health questions in which you answered YES to:

_____

Are you currently taking Vitamins, Herbs or Supplements? □ Yes □ No
Allergies: Do you have any food or medication allergies? □ Yes □ No
If so, please list: _____

Vitamin, Herb or Supplement Name Reason
1. _____
2. _____
3. _____
4. _____
5. _____

Eating Habits: (please be as honest as possible so that we may better help you) Breakfast Do you have breakfast every morning? □ Yes □ Sometimes □ Never
Approximate Time: _____Examples: _____
_____
Do you have a snack before lunch? □ Yes □ Sometimes □ Never
Approximate Time: _____Examples: _____
_____
Lunch
Do you have lunch every day? □ Yes □ Sometimes □ Never
Approximate Time: _____Examples: _____
_____
Do you have a snack before dinner? □ Yes □ Sometimes □ Never
Approximate Time: _____Examples: _____
_____
Dinner
Do you have dinner every day? □ Yes □ Sometimes □ Never Approximate Time:
_____Examples: _____
_____
Do you eat a snack at night? □ Yes □ Sometimes □ Never
Approximate Time: _____Examples: _____
_____
Do you prefer: □ Sweet foods □ Salty foods □ Fatty foods
Are you a vegetarian? □ Yes □ No
How many glasses of water do you drink per day? _____ Glasses
How many cups of coffee do you drink per day? _____ Cups
Do you smoke? □ Yes □ No If yes, packs per day? _____ For how many yrs.? _____
Do you drink alcohol? □ Yes □ No If yes, what, how much, and how often? _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. The Health Insurance Portability and Accountability Act of 1996 (HIPAA)requires all health care records and other individually identifiable health information (PROTECTED HEALTH INFORMATION) used or disclosed to patient, significant new rights to understand and control how your health information is used. HIPAA provides prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- Treatment means providing, coordinating, managing health care and/or related services by one or more wellness coaches. Examples of treatment would include office visits and suggestions made to you regarding your overall health.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your medical plan for your medical services.
- Health care operation include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

An example would include periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including releases of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected health information when we are required to do so by federal, state or local law. We may disclose your protected health information to public health authorities that are authorized by law to collect information (i.e. The Centers for Disease Control) or to a health oversight agency for activities authorized by law included by not limited to: response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your protected health information if requested by a law enforcement official for any circumstance required by law. We may release your protected health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we may also release information in order for funeral directors to perform their jobs. We may release protected health information to organizations that handle organ, eye, or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantations if you are an organ donor. We may use and disclose your protected health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your protected health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your protected health information to federal officials for intelligence and national security activities authorized by law.

We may disclose protected health information to deferral officials in order to protect the President, other officials or foreign heads of state or to conduct investigations. We may disclose your protected health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary; (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public.
We may release your protected health information for a workers' compensation and similar programs. Any other uses and disclosures will be made only with your written request, except to the extent that we have already taken actions relying on your authorization. You have certain rights in regard to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from use by alternative means or at alternative locations.
- The right to request a copy of your protected health information (charges for the copying are subject to state requirements).
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosure of protected health information outside of treatment, payment, and health care operations.
- The right to obtain a paper copy of this notice from us upon request We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our notices of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

Ravive Health & Vitality, LLC

2907 Shelter Island Dr. Ste. 219 San Diego, CA 92106

For more information about HIPAA or to file a complaint:

THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF CIVIL RIGHTS

200 INDEPENDENCE AVE, S.W. WASHINGTON, D.C. 20201

877-696-6775 (toll free)

2907 Shelter Island Drive Ste. 219
San Diego, CA 92106
619-642-0477
info@ravivevitality.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by Federal Law to give you this notice and to prove that you received it.

You may use your mark or a stamp if you are unable to sign this form.

I, _____, have been given a copy of the HIPPA rules.

Signature of Patient/legal representative Date

I gave _____ a copy of this Privacy Notice on _____.

But he/she declined to sign for it.

Employee /Witness Signature Date

2907 Shelter Island Drive Ste. 219
San Diego, CA 92106
619-642-0477
info@ravivevitality.com

Consent for Care

I,_____, herby grant permission to all providers at 2907 Shelter Island Drive to perform such examinations, therapeutic treatments and injections. I understand that my record will be kept confidential and will not be released to others unless they are involved in my care plan. I understand that I may look at my records at any time and I can request a copy of it. I am not forced by anyone to accept medical treatment. Authorization to Release Information I AUTHORIZE all providers to release any information required to process this claim to any insurance company or attorney in this case. I also authorize any insurance company or medical provider to release my medical records to ALL providers here. This information is to be used for the purpose of preceding my claim for benefits due. I hereby agree that a photocopy of this document is valid and effective as the original copy. Payment Agreement I hereby authorize my insurance benefits to be paid directly to ALL providers. I assume full responsibility for and agree to pay all costs, charges and expenses of every kind and service furnished by ALL providers with no refund. I must pay charges and services not covered by any insurer third-party and/or paid to ALL providers for any reason within a time period ALL providers deem reasonable. The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator or third party responsible for payment of the charges. Cancellation Notice KINDLY GIVE 24 HOURS NOTICE OF CANCELLATION. LATE CANCELLATIONS ARE SUBJECT TO A 50% CANCELLATION FEE. NO SHOWS OR CANCELLATION OF LESS THAN 2 HOURS BEFORE SCHEDULED APPOINTMENT ARE SUBJECT TO A 100% CANCELLATION FEE. Call-backs or email reminders are a courtesy and you are ultimately responsible for your appointment.

_____

Your Printed Name

Signature Date