Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, “I” and “my” refer to the client, and “care provider” refers to Edmond Wellness.

I consent to the use or disclosure of my protected health information by the care provider for the purpose of analyzing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the care provider. I understand that analysis or treatment of me by the care provider may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The care provider is not required to agree to the restrictions that I may request. However, if the care provider agrees to a restriction that I request, the restriction is binding on the care provider.

I have the right to revoke this consent, in writing, at any time, except to the extent that the care provider has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of the care provider and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the care provider. The Notice of Privacy Practices for the care provider is available at Edmond Wellness. This Notice of Privacy Practices also describes my rights and duties of the the care provider with respect to my protected health information.

The care provider reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of the care provider and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Client or Representative Printed Name of Client

_____ _____

Date of Signing Description of Personal Representative’s Authority

Appointment Reminders Health Care Information Authorization

Your doctor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a voice message will be left. By signing this form, you are giving Edmond Wellness authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your treatment information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§ 164.524)

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____

Signature of Client or Personal Representative Printed Name of Client

_____ _____

Date of Signing Description of Personal Representative's Authority

Individual Health Information Sheet

Name: _____ Phone: _____

Address: _____ Birth Date: _____

City: _____ Mobile: _____

State/Zip: _____ Email: _____

List top 3 symptoms you would like relief from (see symptom sheet):

_____

Health Goals:

_____

How much sweaty activity weekly? _____ What type?: _____

How many ounces of water daily? _____ What type?: RO Tap Spring Distilled Filtered

Which meals do you eat? Breakfast Lunch Dinner Snacks How many bowel movements daily? _____

Do you take digestive enzymes? Yes No Breathing exercises? Yes No Blood Type: A B AB O

How much of the following do you consume? Example – 1D = once daily, 3M = 3 times monthly

Soda: _____ Coffee: _____ Smoking: _____ Alcohol: _____

Milk: _____ Fast Food: _____ Sugar: _____ White Flour: _____

Meat: _____ Raw Fruit: _____ Raw Veg: _____ Whole Grain: _____

What foods do you crave? Salty Chocolate Sweets Breads Other: _____

What are your favorite foods? _____

Rate your daily energy: (1 = lowest energy level; 10 = highest energy level): _____

List any surgeries you've had. Circle NONE if applicable:

_____

How many hours of TV do you watch daily/weekly? D: _____ W: _____

Amount of spiritual activity daily/weekly (Bible, prayer, church, etc)? D: _____ W: _____

How much time do you spend with family/friends? D: _____ W: _____

How much sleep do you get each night? _____ How much do you need? _____

List prescription meds you are taking:

_____

List supplements you take:

_____

Would you like to receive our natural health newsletter? YES NO

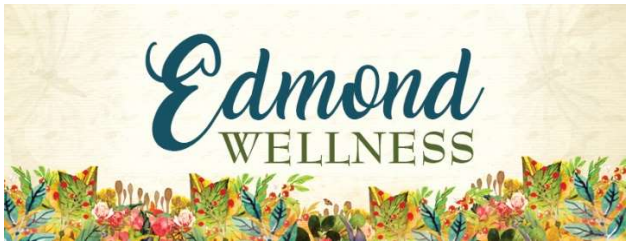
Who referred you for your appointment today? _____

I understand that I am here to learn about nutrition and better health practices and that I will be offered information about food supplements and herbs as a guide to general good health and this is a personal ministry and spiritual counseling. I fully understand that those who counsel me are not medical doctors and I am not here for medical diagnostic purposes or treatment procedures. I am not on this visit or any subsequent visit an agent for federal, state, or local agencies or on a mission of entrapment or investigation. The services performed here are at all times restricted to consultation or nutritional matters intended for the maintenance of the best possible state of natural health and do not involve the diagnosing, treatment or prescribing of remedies for disease.

Signature: _____ Date: _____/_____/_____

Symptoms and Areas of Concern

Acne
ADD/ADHD
Adrenal Glands
Allergies
Alzheimer's Disease
Anemia
Anger
Anxiety
Appetite
Arteriosclerosis
Arthritis
Asthma
Back Pain
Bad Breath
Bed Wetting
Bell's Palsy
Bites
Bladder
Blood Pressure (High)
Blood Pressure (Low)
Boils
Bones
Breathing
Bronchitis
Bruises
Burns
Cancer
Candida
Canker Sores
Carpal Tunnel
Cataracts
Chest Congestion
Chest Pain
Cholesterol
Circulation
Colds – Common
Cold – Temperature
Colic
Colon
Constipation
Cough
Cravings
Dandruff
Depression
Diabetes
Diarrhea
Digestion
Dizzy Spells
Ear Infection
Ear Ringing
Edema
Emphysema
Epilepsy
Eyesight
Fatigue
Fever
Flu
Gallstones
Gangrene
Gas
Gout
Gums
Hair Issues
Headache
Heart Issues
Heartburn
Herpes
Hemorrhoids
Hiatal Hernia
Hives
Hormones
Hyperactive
Hypertension
Hyperthyroidism
Hypoglycemia
Impotence
Incontinence
Indigestion
Insomnia
Joint Pain
Kidney Issues
Kidney Stones
Laryngitis
Leprosy
Leukemia
Liver
Lung Issues
Lupus
Lymph Glands
Menopause
Menstrual Cramps
Migraines
Mononucleosis
Mucous
Nails
Nausea
Nervousness
Nose bleeds
Parasites
Parkinson's Disease
Perspiration
PMS
Pneumonia
Polyps
Pregnancy
Prostate
Psoriasis
Rash
Reproduction
Respiratory
Rheumatism
Ring Worm
Seizure
Shingles
Sinus
Skin Issues
Snoring
Sore Throat
Stomach
Stress
Stroke
Sty
Teething
Tennis Elbow
Tonsillitis
Tumors
Ulcers
Urinary Infections
Varicose Veins
Vertigo
Weight – Over
Weight – Under
Yeast Infections
OTHER: _____



APPOINTMENT CANCELATION POLICY

Clients,

We strive to provide excellent care for you and our other clients. In order to do so effectively and efficiently, we have developed an appointment schedule that sets aside ample time for the client.

"No-shows" and cancellations inconvenience those individuals who need access to our services in a timely manner. In an effort to reduce the number of such occurrences, we have implemented an Appointment Cancelation Policy and it is effective immediately.

Our policy is as follows:

1. We request you give our office 24-hour notice in the event that you need to reschedule your appointment. Our office number is (405)285-0605 and our cell number for texting cancelations is (405)315-5710.
2. If you miss an appointment without contacting us with at least 24 hour prior notice, we will consider this a missed appointment and your session has been forfeited. If this missed appointment is for a "Try Your First Session for $35" special, that discounted price will be forfeited.
3. If you are late to your appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length.
4. Our office makes efforts to ensure your awareness of the appointment times you choose via text and email notifications. ***It is ultimately the client's responsibility to remember their scheduled appointment time.***

We thank you for trusting Dr. Holly Moulder, Naturopath and Edmond Wellness for your wellness and weight loss care.

I have read and understand the Appointment Cancelation Policy and agree to the terms of this policy.

_____ _____

Signature Date

_____ _____

Printed Name Witness Initials