

# Patient Information and Consent

# The Good News Doctor

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The following patient information and consent will take approximately 30 minutes to complete. This paperwork requests a detailed personal and family medical history, as well as a detailed current medical profile. This detailed summary will allow The Good News Doctor to best serve you in your health goals. Please be as detailed as possible. This paperwork must be completed prior to any appointments, analysis, or care plan recommendations. If you have any questions in completing this paperwork, please contact The Good News Dr @ 678-758-4700 or thegoodnewsdr@gmail.com.

Patient Information					
Name (First, Middle, Last)		Birthdate	Age	Social Security #	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address		Apt. #	City	State	Zip
Email Address					
Cell Phone		Home Phone			
Employer (or Parent's Employer if minor)			Occupation		
Parent/Guardian Name (if minor)			Parent/Guardian Phone		
<b>Marital Status</b> <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		<b>Race</b> <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander			
Name of Spouse/Partner					

Emergency Contact					
Name (First, Middle, Last)		Relationship	Cell Phone	Home Phone	
Address	City	State	Zip	Email Address	

By signing below, I affirm the information provided above is correct.

Print Patient Name: \_\_\_\_\_

Print Parent/Guardian Name (if applicable): \_\_\_\_\_

Patient (Parent/Guardian Signature): \_\_\_\_\_ Date: \_\_\_\_\_

Newsletter Communications
<p>At The Good News Doctor, we believe in educating our patients on a variety of subjects relating to a health and wellness lifestyle. To help achieve this goal, we send out electronic newsletters and communications to our patients via e-mail. These e-newsletters are intended strictly as informational and are not meant to intrude upon your privacy or to create e-mail spam. Please be assured that your e-mail address will be kept strictly confidential. If you would like to receive these e-newsletters, please indicate so below.</p> <p><input type="checkbox"/> Yes, I would like to receive the OSHC e-newsletters. <input type="checkbox"/> No, please do not send these e-newsletters.</p>

## Past and Current Medical History

**MAKE AN (X) BY ANY OF THESE CONDITIONS YOU MAY HAVE HAD OR CURRENTLY HAVE.**

*Include onset date (MM/YY).*

- |   |  |
|---|--|
| <input type="checkbox"/> Heart Disease: _____                             | <input type="checkbox"/> Seizures: _____                   |
| <input type="checkbox"/> High Cholesterol: _____                          | <input type="checkbox"/> Nerve Impairment: _____           |
| <input type="checkbox"/> Heart Attack: _____                              | <input type="checkbox"/> Cervical Spine Disorder: _____    |
| <input type="checkbox"/> Kidney, Bladder, Prostate Disease: _____         | <input type="checkbox"/> Lumbar Spine Disorder: _____      |
| <input type="checkbox"/> High Blood Pressure: _____                       | <input type="checkbox"/> Severe Headaches: _____           |
| <input type="checkbox"/> Blood Clots: _____                               | <input type="checkbox"/> Tuberculosis/Tb: _____            |
| <input type="checkbox"/> Bleeding Tendency: _____                         | <input type="checkbox"/> Muscle Disease: _____             |
| <input type="checkbox"/> Liver Disease: _____                             | <input type="checkbox"/> Depression: _____                 |
| <input type="checkbox"/> Lung Disease: _____                              | <input type="checkbox"/> Anxiety: _____                    |
| <input type="checkbox"/> Bowel Disease: _____                             | <input type="checkbox"/> Traumatic Brain Injury: _____     |
| <input type="checkbox"/> Diabetes: _____                                  | <input type="checkbox"/> Concussion: _____                 |
| <input type="checkbox"/> Hypoglycemia (Low Glucose): _____                | <input type="checkbox"/> Insomnia: _____                   |
| <input type="checkbox"/> Thyroid Disease: _____                           | <input type="checkbox"/> Asthma: _____                     |
| <input type="checkbox"/> Stomach Disease: _____                           | <input type="checkbox"/> Joint Replacement: _____          |
| <input type="checkbox"/> Anemia Or Other Blood Disease: _____             | <input type="checkbox"/> Arthritis: _____                  |
| <input type="checkbox"/> Stroke: _____                                    | <input type="checkbox"/> Restless Legs: _____              |
| <input type="checkbox"/> Cancer (Past Or Present): _____ What Type: _____ | <input type="checkbox"/> Sexual Transmitted Disease: _____ |

## Past and Current Medical History

Please provide a detailed medical history including current and past diagnoses and any minor or major traumas, diseases, surgeries that you did not indicate above. Include approximate dates and length of health condition.

## Previous Solutions/Therapies

Please provide a detailed summary of the previous therapies and solutions you have tried in the past to target your health concerns and conditions.

## Family History

Please list family medical history for each family member and reason for death (if applicable).

**Mother:** Date of Birth: \_\_\_\_\_ Year of Death (if applicable): \_\_\_\_\_

Reason for Death (if applicable):

**Father:** Date of Birth: \_\_\_\_\_ Year of Death (if applicable): \_\_\_\_\_

Reason for Death (if applicable):

**Sibling 1:** Date of Birth: \_\_\_\_\_ Year of Death (if applicable): \_\_\_\_\_

Reason for Death (if applicable):

**Sibling 2:** Date of Birth: \_\_\_\_\_ Year of Death (if applicable): \_\_\_\_\_

Reason for Death (if applicable):

**Grandmother (Maternal):** Date of Birth: \_\_\_\_\_ Year of Death (if applicable): \_\_\_\_\_

Reason for Death (if applicable):

**Grandfather (Maternal):** Date of Birth: \_\_\_\_\_ Year of Death (if applicable): \_\_\_\_\_

Reason for Death (if applicable):

**Grandmother (Paternal):** Date of Birth: \_\_\_\_\_ Year of Death (if applicable): \_\_\_\_\_

Reason for Death (if applicable):

**Grandfather (Paternal):** Date of Birth: \_\_\_\_\_ Year of Death (if applicable): \_\_\_\_\_

Reason for Death (if applicable):

## Prescriptions/Supplements/Therapies

Please list all current medications, supplements, or other therapies you are currently using for your health.

## Personal Habits

Do you **currently** drink alcoholic beverages?  Yes  No If yes, \_\_\_\_\_ drinks per  Day  Week  Month  
If you do not currently, but previously drank alcoholic beverages, when did you stop (MM/YY)? \_\_\_\_\_

Do you **currently** smoke or chew tobacco?  Yes  No If yes, \_\_\_\_\_ times per day, \_\_\_\_\_ years of use  
If you do not currently, but previously used tobacco, when did you stop (MM/YY)? \_\_\_\_\_

Do you **currently** use an e-cigarette?  Yes  No If yes, \_\_\_\_\_ times per day, \_\_\_\_\_ years of use  
If you do not currently, but previously used e-cigarettes, when did you stop (MM/YY)? \_\_\_\_\_

Do you **currently** use recreational or medical marijuana?  Yes  No If yes, \_\_\_\_\_ times per day, \_\_\_\_\_ years of use  
If you do not currently, but previously used marijuana, when did you stop (MM/YY)? \_\_\_\_\_

Do you **currently** use any other recreational drugs?  Yes  No If yes, \_\_\_\_\_ times per day, \_\_\_\_\_ years of use  
If you do not currently, but previously used recreational drugs, when did you stop (MM/YY)? \_\_\_\_\_

Have you ever been addicted to prescription, non-prescription or recreational drugs?  Yes  No  
If yes, which drugs and how long? \_\_\_\_\_

Do you physically work out for fitness?  Yes  No

If yes,  
How many times per week do you work out at a moderate level? \_\_\_\_\_ How long is each session? \_\_\_\_\_  
What type of activities do you prefer? \_\_\_\_\_

On average, how many hours per week do you spend watching TV, Movies, Video Games, etc.? \_\_\_\_\_

On average, how many hours per week do you spend working at a computer/laptop? \_\_\_\_\_

On average, how many hours of restful sleep do you receive each night? \_\_\_\_\_

What time do you normally wake up each morning? \_\_\_\_\_ What time do you normally go to bed each night? \_\_\_\_\_

Are you currently following any type of diet or meal plan?  Yes  No

If yes, what type of diet or meal plan are you following?

## Health Goals/Objectives

Please indicate what your specific health goals are now and how committed you are to achieving those goals.

## ***Terms Of Acceptance***

When a patient seeks health care/treatment or health recommendations from The Good News Doctor and accept a patient for such care, it is essential for both to be working towards the same objective.

We have one goal: To support the patient or client in restoring the body to optimal health using an inclusive approach of natural therapies and solutions.

The Good News Doctor may recommend health products, treatment or care beyond what the patient has initially requested because it may support the patient's body in reaching optimal health.

The patient may decline any recommendation made by The Good News Doctor. The Good News Doctor may share product websites for the patient to learn more about a certain natural solution or therapy.

The Good News Doctor will not solicit business opportunities. For more information on the solutions and therapies The Good News Doctor may recommend, visit [www.thegoodnewsdr.com](http://www.thegoodnewsdr.com).

## ***Financial Arrangements***

The Good News Doctor offers conservative fees. We want to make sure that our patients are able to receive the needed care in an affordable manner.

The Good News Doctor does not accept insurance or Medicaid. Payment must be made in the form of cash, check or credit card. In some cases, payment may be required prior to treatment or care.

If your bill remains unpaid after 120 days and no satisfactory payment arrangements have been made towards reconciling it, then the debt on your account may be assigned to a collection agency.

I have read and understand the Terms of Acceptance and Financial Arrangements above and give the doctor permission to evaluate me.

I further agree to the fee schedule set forth by The Good News Doctor and will ultimately be the party that is financially responsible for this account.

Print Patient Name: \_\_\_\_\_

Patient Signature (or Parent/Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

## ***Privacy Notice***

We recognize and respect the privacy expectations of today's consumers and the requirements of applicable federal and state privacy laws. We believe that making you aware of how we use your non-public Personal Information, and to whom it is disclosed, will form the basis for a relationship of trust between us and the public that we serve. This Privacy Statement provides that explanation. We reserve the right to change this Privacy Statement from time to time consistent with applicable privacy laws.

In the course of our business, we may collect Personal Information about you from the following sources:

- From applications or other forms we receive from you or your authorized representative;
- From your transactions with or from the services being performed by us, our affiliates or others;
- From our internet websites;
- From the public records maintained by governmental entities that we either obtain directly from those entities or from our affiliates or others; and
- From consumer or other reporting agencies.

### **OUR POLICIES REGARDING THE PROTECTION OF THE CONFIDENTIALITY AND SECURITY OF YOUR PERSONAL INFORMATION**

We maintain physical, electronic and procedural safeguards to protect your Personal Information from unauthorized intrusion. We limit access to the Personal Information only to those employees who need such access in connection with providing products or services to you or for other legitimate business purposes.

### **OUR POLICIES AND PRACTICES REGARDING THE SHARING OF YOUR PERSONAL INFORMATION**

We may share your Personal Information with our affiliates, such as medical doctors, radiologists and/or other chiropractors for the purpose of rendering patient care. We may also disclose your Personal Information as applicable to:

- Your employer as related to Workers' Compensation injuries, and
- Attorneys as related to personal injury/automobile accident cases.

In addition, we will disclose your Personal Information when you direct or give us permission, when we are required by law to do so, or when we suspect fraudulent or criminal activities. We also may disclose your Personal Information when otherwise permitted by applicable privacy laws, for example, when disclosure is needed to enforce our rights arising out of any agreement, transaction or relationship with you.

### **RIGHT TO ACCESS YOUR PERSONAL INFORMATION AND ABILITY TO CORRECT ERRORS OR REQUEST CHANGES OR DELETION**

You are afforded the right to access your Personal Information and, under certain circumstances, to find out to whom your Personal Information has been disclosed. Also, you are afforded the right to request correction, amendment or deletion of your Personal Information. We reserve the right, where permitted by law, to charge a reasonable fee to cover the costs incurred in responding to such requests. Anyone wishing to obtain a copy of their records must sign a release form. All requests must be made in writing via mail, fax or in person.

Print Patient Name: \_\_\_\_\_

Patient Signature (or Parent/Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

## ***Patient Consent Form***

### **FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT ANALYSIS, TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.**

I, \_\_\_\_\_ hereby state that by signing this consent and initialing each item, I acknowledge and agree as follows:

\_\_\_\_ 1. The practice's Privacy Notice has been provided to me and I have carefully read it prior to my signing this consent.

\_\_\_\_ 2. The practice reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.

\_\_\_\_ 3. I understand that, and consent to, the following appointment communications and reminders that will be used by the practice:

- Postcards mailed to the addressee(s) I have provided.
- Telephoning me at the number(s) I have provided and leaving messages for me on my answering machine or with the individual answering the phone.
- Text messages at the number(s) I have provided.
- E-mail at the email address(s) I have provided.

\_\_\_\_ 4. The practice may use and/or disclose my Personal Health Information (PHI) (which includes information about my health or condition, analysis, and the treatment provided to me) in order for the practice to make analyses about my condition(s), treat me, obtain payment for that treatment/care, and as necessary for the practice to conduct its specific health care operations.

\_\_\_\_ 5. I understand that I have the right to request that the practice restrict how my PHI is used and/or disclosed except to obtain payment for treatment provided. However, the practice is not required to agree to any restrictions that I have requested, and I have the right to refuse treatment.

\_\_\_\_ 6. I understand that this consent is valid as long as I am a patient in this office. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent. If I revoke this consent at any time, the practice has the right to refuse to treat me.

\_\_\_\_ 7. I give The Good News Doctor permission to treat me in a private room while leaving the door ajar. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a private room for these conversations.

\_\_\_\_ 8. The doctor recommends that a spouse/partner (if applicable) be present at my report of findings visit; therefore I hereby give permission for my protected health information to be disclosed at that time and at any time my spouse/partner contacts the office to check on my status.

I have read and understand the above statements. I understand that I have the right to refuse to sign this authorization. If I choose to decline signing this consent form, this practice will not treat me.

Print Patient Name: \_\_\_\_\_

Patient Signature (or Parent/Guardian): \_\_\_\_\_ Date: \_\_\_\_\_