Membership start date: _____

****(Please fill out every single line and write as clearly and concisely as possible.) ****

Full Name: _____

First *Last*

Address: _____

Street Address *Apt*

_____

City *State* *Zip*

Birth Date: _____ Primary Phone: _____

Email Address: _____ How did you hear about us? _____

Preferred Pharmacy Name/Phone Number: _____

Emergency Contact Information

Contact Name: _____

First *Last*

Relationship: _____ Primary Phone: _____

I hereby authorize the medical providers at Pro Health Wellness Clinic to examine, prescribe, and treat me (or in the case that the patient is a minor, my child) at their clinic. I certify that all information provided is complete and correct. I assume responsibility for all charges incurred and promise to follow the instructions of the medical providers regarding treatment. I recognize that I have the right to refuse any treatment, however if I do not follow the recommendations of the healthcare provider negative health events may occur including (but not limited to) worsening disease, heart attack, stroke, or death.

_____

Patient Signature Date

HIPAA Notice of Privacy Practices

Since 1996 certain laws have been enforced regarding medical record privacy (Health Insurance Portability and Accountability Act) or HIPAA, under the law, we are now required to notify you of this, so here is a short version of these regulations for your convenience.

This Notice of Privacy Practice describes the ways we are allowed by law to use your protected health information (medical records) or PHI to carry out treatment, payment, or other healthcare operations and for other purposes that are permitted or requested by law. It also describes our rights to access and control your PHI. We are required to abide by these privacy laws.

According to the privacy laws, your physician will use your PHI as he has always done for treatment, payment, or other health care operations. In addition, we may also disclose your PHI from time to time to other physicians or health care providers who become involved in taking care of you. Your PHI will be used, as needed, in order for us to obtain payment for our services. At the front desk you will be asked to fill out paperwork, we will call you by name when the provider is ready to see you. We may also use you PHI when necessary to contact you concerning your visit. We will share your PHI with business associates who perform services for us. There could include billing services or transcribing services. They are also required to maintain confidentiality.

Your PHI could be used to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. Other uses or disclosures will be made only with your written authorization, unless otherwise allowed or required by law. You may revoke this authorization at any time, in writing.

Unless you object, we may reveal (with your signed consent) to a member of your family, close friend, or other person your choice, parts of your PHI that relate to that person's involvement in your health care. If you are unable to agree or object to this, as in an emergency, your physician will try to obtain your consent as soon as possible. Your PHI may be disclosed to public health agencies or law enforcements needed to protect you or others. Your PHI may be disclosed by us in order to comply with workman's compensation laws. If you are an inmate, we may disclose necessary information to the staff of the institution.

You have the right to inspect and copy your PHI except for certain legal limitations. You may ask us not to disclose your PHI for purposes of treatment, payment or health care operations, as well as family members. This must be specific and in writing. However, your doctor is not required to agree to such restrictions if he believes it is not in your best interest. You may ask for your PHI to be amended. You also have the right to know to whom we have revealed your information if it is other than treatment, payment, or health care operations.

Print Name:
Sign Name:
Date:

Medical History Form

Check yes if you have been diagnosed with the following. Leave blank if you have not.

Chronic Medical Conditions	
Glaucoma	
Loss of Hearing	
Ear Infections	
Nosebleeds	
Allergies	
Sinus Trouble	
Pneumonia	
COPD	
Asthma	
Shortness of Breath	
Heart Murmur	
Palpitations	
Chest Pain	
Heart Disease	
Heart Failure	
High Blood Pressure	
Heart Arrhythmia	
Swollen Ankles	
Heartburn/Indigestion	
GERD	
Stomach Ulcers	
Constipation	
Diarrhea	
Gall Bladder Disease	
IBS	
Liver Disease	
Hepatitis	
Kidney Disease	
Kidney Stones	
Frequent Urination	
Diabetes	
Hypoglycemia	

Chronic Medical Conditions	
Back Pain	
Joint Pain	
Arthritis	
Osteopenia/Osteoporosis	
Gout	
Dizziness/Vertigo	
Fainting Spells	
Memory Loss	
Headaches/Migraines	
Seizures/Epilepsy	
Anxiety	
Depression	
Bipolar	
Schizophrenia	
Anorexia/ Bulimia	
Blood Clot/DVTs	
Alcohol Abuse	
Drug/Substance Abuse	
Anemia	
Hyperthyroidism	
Hypothyroidism	
Cancer (Please Specify)	
Chemo/Radiation	
Prostate Disease/BPH	
Stroke	
High Cholesterol	
HIV/AIDS	
Cold Sores/Fever Blisters	
Chronic Fatigue	
Lyme Disease	
Fibromyalgia	
Meniere's Disease	

Primary Care Physician: _____

Please list any other chronic conditions: _____

_____

_____

Family History: Please indicate family members that have been diagnosed with the following (only include siblings, parents, and grandparents)

Heart Attack	
Hypertension	
Cancer	
Stroke	
Epilepsy/Seizures	
Arthritis	
Diabetes	
Obesity	
High Cholesterol	
Other:	

Have you had any major hospitalizations or surgeries?

Year	Illness or Surgery

Please list all current medications, including herbal supplements and vitamins

_____

_____

_____

_____

_____

Please list all allergies to any foods or medications

For women Are you pregnant? _____ Are you breastfeeding? _____

Are you post-menopausal? _____

INFORMED CONSENT FOR HEALTHCARE TREATMENT

I, _____, do hereby give my consent to receive healthcare treatment and advice from the medical staff at Pro Health Clinic.

1. PURPOSE OF TREATMENT:
I understand that the purpose of the healthcare treatment and advice I will receive is to diagnose, prevent, or treat illness, injury, or disease, and to promote my overall health and wellness.

2. NATURE OF TREATMENT:
I understand that the nature of the treatment will depend on my individual health needs. This may include but is not limited to, medical examinations, laboratory tests, medications, and other treatments. I understand that medication dispensed by Pro Health Clinic or prescribed by my provider may be "off-label". Off-label prescribing is when a provider prescribes medication for a condition, age group, dosage, or form of administration that is not officially approved by the Food and Drug Administration (FDA).

3. RISKS AND BENEFITS:
I acknowledge that the potential benefits and risks associated with the healthcare treatment and advice have been explained to me. I understand that, while the aim is to improve my health, all medical treatments carry potential risks, which may include side effects, allergic reactions, or unforeseen complications.

4. ALTERNATIVE TREATMENTS:
I understand that alternative treatments or procedures are available and have been explained to me. I also understand that I have the right to refuse any treatment or procedure.

5. CONFIDENTIALITY:
I understand that all information about my health and medical treatments will be kept confidential according to the Health Insurance Portability and Accountability Act (HIPAA), unless otherwise required by law or for my care.

6. QUESTIONS, CONCERNS, and COMMUNICATION:
I have been allowed to ask questions and discuss concerns about my treatment and medical care. All my questions have been answered to my satisfaction.

Pro Health Clinic offers an SMS/Text notification of labs and reminders of service for patients to receive text messages and notifications regarding their scheduled clinical appointments. I understand that message and data rates apply. I agree to receive such notifications via SMS/Text notification.

By signing below, I acknowledge that I have read and understood the information provided in this consent form, and I agree to proceed with the healthcare treatment and advice.

Patient's Full Name: _____

Signature: _____ Date: _____

CONSENT FOR INTRAVENOUS (IV) HYDRATION THERAPY

I, _____, do hereby give my consent to receive Intravenous (IV) Hydration Therapy administered by medical staff under the direction of the provider on duty at Pro Health Clinic.

1. PURPOSE OF TREATMENT:

I understand that the purpose of IV Hydration Therapy is to replenish fluids, vitamins, and nutrients directly into my bloodstream, which may enhance my overall wellness, boost my immune system, improve physical performance, increase energy levels, and assist in managing various health conditions.

2. RISKS AND BENEFITS:

I acknowledge that the potential benefits and risks associated with IV Hydration Therapy have been explained to me. Possible benefits may include improved hydration, nutrient replenishment, and increased energy. The risks, although rare, may include infection, infiltration or swelling, inflammation of the vein (phlebitis), allergic reactions, and sudden death.

3. ALTERNATIVE TREATMENTS:

I understand that alternative treatments or procedures, such as oral hydration and nutritional supplementation, are available and have been explained to me.

4. VOLUNTARY PARTICIPATION:

I understand that my consent to receive IV Hydration Therapy is completely voluntary, and I have the right to refuse this treatment. I have been allowed to ask questions and all my questions have been answered to my satisfaction.

5. PRIVACY AND CONFIDENTIALITY:

I understand that my medical information will be kept confidential and will not be released without my written consent, except as required by law or as necessary for my care (HIPAA, 2013).

By signing below, I acknowledge that I have read and understood the information provided in this consent form, and I agree to proceed with the IV Hydration Therapy.

Patient's Full Name: _____

Signature: _____ Date: _____

Intravenous (IV) Fluid Administration Consent Form for Minors
(Ages 12 – 17 years old)

I, _____, am the parent/guardian of

_____, a minor. I understand that the provider has recommended intravenous (IV) fluid administration for my child. I hereby give my consent to this procedure.

Procedure: IV Fluid Administration
Purpose: To correct dehydration, maintain fluid balance, deliver medications, or provide nutrients.

I understand that:

1. The procedure involves inserting a needle into a vein, usually in the arm or hand, and attaching it to a tube through which fluids will be given.

2. There may be potential complications, including discomfort, bleeding, bruising, infection, inflammation of the vein (phlebitis), infiltration or swelling, allergic reaction, and even sudden death.

3. The healthcare provider will take all necessary precautions to minimize these risks.

4. I have the right to withdraw my consent at any time.

5. I have been given the opportunity to ask questions and all my questions have been answered to my satisfaction.

I hereby authorize and give my consent for the healthcare provider to administer IV fluids as prescribed to my child. I have read and understood the information provided above.

Patient Name: _____

Patient Signature: _____

Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

Provider Name: _____

Provider Signature: _____

Date: _____

CONSENT FORM FOR MOBILE IV HYDRATION THERAPY

I, _____ (Patient's Full Name), hereby consent to the administration of Mobile Intravenous (IV) Hydration Therapy by Pro Health Clinic, as explained by the medical provider.

I understand that Mobile IV Hydration Therapy involves the administration of fluids, medications, vitamins, and other supplements directly into my bloodstream via an intravenous line. I acknowledge that the medical provider has explained to me the nature of the therapy, its anticipated benefits, potential complications, and alternative treatment options, if any.

I understand that there may be potential risks and complications associated with Mobile IV Hydration Therapy, including but not limited to:

1. Local infection at the site of the IV line
2. Blood clot or inflammation of the vein (thrombophlebitis)
3. Minor bruising or bleeding at the site of the IV line
4. Allergic reactions to the substances being infused
5. Overhydration or fluid overload, which can lead to swelling, headache, high blood pressure, or heart failure
6. Electrolyte imbalance, which can affect heart rhythm or kidney function
7. Air embolism, a rare but serious complication where air enters the bloodstream
8. Infiltration or swelling
9. Sudden Death

I acknowledge that although precautions will be taken to prevent these occurrences, not all complications can be predicted or avoided.

I hereby release the medical provider, including Pro Health Clinic, its agents, and employees from any liability associated with complications from the Mobile IV Hydration Therapy, and I will not hold them responsible for any complications that may arise as a result of this treatment.

I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I confirm that I have had an opportunity to ask questions and that all my questions have been answered to my satisfaction.

I consent to the photographing or televising of the operation(s) or procedure(s) to be performed for medical, scientific, or educational purposes, provided my identity is not revealed.

I certify that I have read and fully understand this consent form, and I accept the risks involved in this treatment.

Patient's Full Name: _____

Signature: _____ Date: _____

Healthcare Provider Name: _____

Signature: _____ Date: _____