



Patient Privacy: *Patient information will never be disclosed or sold to an individual or company.* The information you provide herein is used solely by Young Again Wellness & Weight Loss Clinic for administrative, diagnostic and/or treatment purposes, and will be treated in the strictest confidence.

Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (Home): _____ (Cell) _____

E-mail address: _____

Age: _____ Date of Birth: ___/___/___ Gender: Female _____ Male _____

Married _____ Separated _____ Divorced _____ Widowed _____ Single _____ Partnership _____

Live with: Spouse _____ Partner _____ Parents _____ Children _____ Friends _____ Alone _____

Occupation: _____ Hours per week _____ Retired _____

Employer: _____

Do you have any family members that are patients at Young Again Wellness? _____

Name of next of kin or other to contact in an emergency: _____

Relationship to you: _____ Phone # _____

Address: _____

How did you first hear of us?

From a Patient

NextDoor

Yelp

Facebook/Instagram

Postcard

Google

Other: _____



Do you take or use?

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping Pills	Y N
Steroids	Y N	Laxatives	Y N	Antihistamines	Y N

Please list any prescription and OTC medications, vitamins or other supplements you are taking:

GENERAL

Height: _____ Weight: _____ lbs. Weight 1 year ago: _____ lbs.

Maximum Weight: _____ When: _____

Go on diets often? Y N Eat out often? Y N Drink/ eat refined sugar? Y N

When during the day is your energy the best? _____ When is it worst? _____

Do you exercise? Y N If yes, what kind? _____ How often? _____

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

SLEEP

How long per night? _____ If you wake frequently, why? _____

Nightmares: Y N P Wakes refreshed: Y N P Must nap during the day: Y N P

Sleep walk: Y N P Grind teeth: Y N P Snore: Y N P



Is there anything else you would like to add or comment on?

Cancellation Policy:

We will call, text, or email to confirm 24-48 hours prior to your scheduled appointment and will require a return confirmation from you.

Appointments cancelled with less than 24 hours notice may be charged \$50.00. Missed appointments will be charged the full appointment fee.

I understand and agree:

Signature _____ **Date:** _____

Printed Name: _____

**Thank you for your time and effort.
We at Young Again Wellness & Weight Loss Clinic look
forward to providing you with the best possible care!**



PAYMENT AGREEMENT

Dear New Patient,

Welcome to Young Again Wellness & Weight Loss Clinic. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care. Please read and initial the following statements:

_____ Payment for all services and medicinal items is due at the time of the visit. We accept cash, checks, Visa and MasterCard. Returned checks will be subject to a \$35 NSF fee.

_____ Phone calls and emails regarding an existing health issue that require more than 10 minutes of attention from your physical will incur a fee. Phone calls and emails regarding a new health issue, regardless of the time of attention required, will also incur a fee. Your physician will notify you of the need for a charge, so that you can determine whether you would like to address the issue and pay the fee, or schedule an appointment. Phone and email charges are not billable to insurance.

_____ You will be charged a Missed Appointment Fee of \$50.00 for any missed appointments or late cancellations (less than 24 hours notice).

Your health care provider may prescribe medication, which may be purchased at Young Again Wellness & Weight Loss Clinic or elsewhere. Most insurance companies do not cover the pharmacy items that we prescribe and dispense.

I have read and understand the above-stated policies of Young Again Wellness & Weight Loss Clinic and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ / ____ / ____
Patient Signature (Parent/guardian signature if minor) Date



E-MAIL AGREEMENT

E-Mail Authorization and Consent Agreement Between Young Again Wellness & Weight Loss Clinic and Patient

I have been advised that:

- E-mail is never, ever appropriate for urgent or emergency problems.
- E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose; system operators for most e-mail systems have access to all e-mail that passes through their systems.
- E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee.
- There is not a way to assure the privacy of e-mail on a shared computer or e-mail account.
- All e-mail correspondence will become a part of my medical record at Young Again Wellness & Weight Loss Clinic. It is extremely important to include my name on each and every e-mail sent to Young Again Wellness & Weight Loss Clinic and/or Dr. Christian.
- Since e-mail may not be monitored while my clinician is away on business or on vacation, I will follow-up by telephone or in person if I do not receive a response within a week.

I have been provided with information about the use of Internet e-mail to communicate matters pertaining to my health and healthcare, and I understand the issues and concerns inherent in this use.

I have been provided with information about the use of Internet e-mail communications between my health provider, including information concerning my healthcare and personal medical information. I understand that I may revoke this agreement at any time by contacting my clinician.

I designate that all e-mail correspondence coming from me or to me should be sent to the following Internet e-mail address:

Please print clearly: _____

Internet e-mail address (sample format: jdoe@aol.com)

Signature: _____ Date: _____

Name: _____ DOB: _____

Name of Physician (print): _____

Signature of Physician: _____



NOTICE OF PRIVACY POLICY

To our patients at Young Again Wellness & Weight Loss Clinic:

This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your health information. **We are required by law to maintain the confidentiality of your health information.** We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. 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. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health information to only certain individuals involved in your care or the payment for your care, such as family members and friends; We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.



3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Young Again Wellness & Weight Loss Clinic, 1405 N. Dobson Road, Suite 20, Chandler, AZ 85224. Note: *We must respond to this request in 30 days.*
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Young Again Wellness & Weight Loss Clinic, 1405 N Dobson Road, Suite 20, Chandler, AZ 85224. You must provide us with a reason that supports your request for amendment. Note: *We must respond within 60 days. The Privacy Officer of the patient's physician will usually do this. If the physician believes the information is complete and accurate, the physician can refuse to make any changes.*
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice any time. To obtain a copy of this notice, contact Young Again Wellness & Weight Loss Clinic.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Young Again Wellness & Weight Loss Clinic. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information policies, please contact the office of Young Again Wellness & Weight Loss Clinic at (480)-361-5108.



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Young Again Wellness & Weight Loss Clinic's Notice of Privacy Practices.

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ / ____ / ____

Patient Signature (Parent/guardian signature if minor)

Date

I authorize and agree that Young Again Wellness & Weight Loss Clinic may disclose my protected health information to the following persons each of whom is directly involved in my care:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

I acknowledge and agree that Young Again Wellness & Weight Loss Clinic may disclose my protected health information to the persons set forth in this form and until I object to such disclosures, which must be provided in writing to Young Again Wellness & Weight Loss Clinic.

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ / ____ / ____

Patient Signature (Parent/guardian signature if minor)

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because (please specific): _____.