INFINITY
ALIGNMENT
NATURAL HEALTH

NUTRITION INFORMATION FORM

Please print clearly:

Name_____ Date _____
US Shipping Address _____ Apt.# _____

City _____ State _____ ZIP _____

International Shipping Address _____

_____

Mobile Phone (_____) _____-_____Work Phone (_____) _____-_____
E-mail address: _____
REFERRED BY: _____
Occupation _____ Employer _____
Date of Birth _____ Age _____ Sex: ◯ M/◯ F Height _____ Weight _____
Emergency Contact:_____ Phone: _____
Overall health (circle one): ◯Excellent / ◯ Good / ◯ Fair /◯ Poor ◯ Other: _

_____

Chief complaint (what can we help you with): (use separate sheet if more room needed) _____
Previous treatments for this complaint _____

_____

Other complaints or problems: (use separate sheet if needed)_____

_____

Dental History: cavities, fillings, crowns, bridges, caps, and/or root canals?

_____

_____

Current medications/drugs being taken: (use separate sheet if needed) _____

_____

Are you currently under the care of a physician or other health care professionals?
(If yes, please give name and date of last visit):

_____

Nutritional supplements you are taking: _____
Do you smoke, drink coffee or alcohol? (if yes indicate how much)
Cigarettes / Cigars / Vaping _____ Coffee / Caffeine _____ Alcohol _____

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Name: _____ **Date** _____

HISTORY:

List any major illnesses (with approx. dates): _____

_____

List any surgery or operations with approx. date: _____

_____

Past Accidents or injuries: _____

_____

Environmental Exposures: (circle all that apply)

◯ Mold ◯ Asbestos ◯ Pesticides ◯ Radiation ◯ Other: _____

FAMILY HISTORY:

Mom age: _____ Deceased Y ☐

Health Problems:

Dad age: _____ Deceased? Y ☐

Health Problems: _____

Paternal Mom age: _____ Deceased Y ☐ N ☐

Health Problems: _____

Paternal Dad age: _____ Deceased Y ☐ N ☐

~~Health Problems:~~ _____

Maternal Mom age: _____ Deceased Y ☐ N ☐

Health Problems: _____

Maternal Dad age: _____ Deceased Y ☐ N ☐

Health Problems: _____

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Marital Status: S ☐ M ☐ D ☐ W ☐ Name of Spouse _____

Describe health of spouse: _____ Number of children if any

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Pregnancy History: Delivery Method: _____

Any Complications? Yes ☐

Explain: _____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	_____	M ☐/F ☐	
_____	_____	M ☐/F ☐	
_____	_____	M ☐/F ☐	

Any family history of serious illnesses (circle those which apply): Cancer ☐/ Diabetes ☐ / Heart ☐ Other

Any household pets or other animals you or family members are in close contact with:

_____

What can we do to make you happier?_____

_____

SIGNED: _____ DATE _____

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Cancellation Policy

Your appointment is reserved especially for you. Kindly give at least 24 hours' notice if you cannot keep your scheduled appointment. Patients who do not give at least 24 hours' notice will be automatically charged a $25 missed appointment fee to the card on file.

I have read and understand the Cancellation Policy and the automatic charge.

(Print full name.)

Signature

Date

Acknowledgement of Receipt
Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Name (please print) Date

Parent, Guardian or Patient's legal representative

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release Personal Health Information.

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PERMISSION & AUTHORIZATION FORM
REGARDING THE USE OF
QUANTUM NUTRITION TESTING

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at Infinity Alignment Natural Health to perform a Quantum Nutrition Testing health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, **and not for the treatment, or "cure" of any disease.**

I understand that **Quantum Nutrition Testing is a safe, non-invasive, natural method** of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that **Quantum Nutrition Testing** is not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, Infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of **Quantum Nutrition Testing** or any natural health, nutritional or dietary programs recommended, but rather I understand that **Quantum Nutrition Testing** is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health..

I understand that my Practitioner may only be licensed in the State of California and any consulting given is done so under religious advisement as a practicing minister.

I have read and understand the foregoing. This permission applies to subsequent visits and consultations.

Date: _____ Print Name: _____

Address:_____ City _____ State_____ Zip _____

Phone: (_____) _____ - _____

Signed: _____

Witness:_____ (If minor, signature of parent or guardian required)

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice, while it is in effect. This Notice takes effect: **04-15-03,** and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by the applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician/dentist or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide for you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization. We may from time to time contact you by mail or phone to update you on information that may be pertinent to your dental health unless you state in writing otherwise.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities, if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

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Correspondence: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, post cards, or letters), birthday cards, or recall cards and missed appointment notification.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. **(You must make a request in writing to obtain access to your health information).** You may obtain a form to request access by using the contact information listed at the end of the Notice. We will charge a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you for duplication of your records and x-rays.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing).** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. **(Your request must be in writing, and it must explain why the information should be amended).** We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), your are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS:
If you want more information about our privacy practices or have questions or concerns, please contact us

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file you complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services

☐ **I agree with this Notice of Privacy Practices and all that is held within.**

☐ **Individual Refused to Sign**

☐ **Communication barriers prohibited obtaining acknowledgment**

☐ **An emergency situation prevented us from obtaining acknowledgment**

☐ **Other: Please specify:**_____

_____ _____

Patient Signature **Date**

_____ **OP 5021 3/2/03**

Print Name

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Patient Messaging Consent

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balance due, lab results, or other communications.

I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events.

I consent to the receiving multiple messages per day from the automated outreach and messaging system, when necessary.

Patient Name **Date**

Patient Signature

Best Email

Best Phone Number

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ASSIGNMENT OF BENEFITS / PAYMENT

I hereby assign from any and all Group and individual insurance policies which provide medical benefits or, all benefits, rights, title and interest to **Infinity Alignment Natural Health** as Assignee, for services rendered unto me both by reason of accident or illness. This is to act as a limited assignment of my rights and benefits to the extent of the Assignee's services provided and in no way should be construed as a delegation of any duties under said insurance policy by the Assignor to Assignee, or a delegation of any conditions precedent under the above referenced insurance policies.

ASSIGNMENT OF CAUSE OF ACTION

In the event my insurance company fails to pay Assignee the full amount due and owing to Assignee after notice is given, I hereby assign and transfer to Assignee any and all causes of action in tort or contract and proceeds from such causes of action, that I might have or that might exist in my favor against such insurance company and authorize Assignee to prosecute said cause of action either in my name or Assignee's name and further I authorize Assignee, in his, her or its full and unreviewable discretion, to compromise, settle or otherwise resolve said claim or cause of action as Assignee shall see fit.

DIRECTION OF PAYMENT

I hereby authorize said insurance company to pay directly to Assignee the amount of this and/or any future bills for services rendered to me. I also agree to pay in a timely manner any difference between the total charges and the amount paid by the insurance company directly to Assignee. I further agree to pay any applicable deductible, co-payment or any other amount not covered by my insurance. In the event that I do not have insurance coverage, I hereby further give an irrevocable lien to said Assignee against any and all insurance benefits named herein and any and all proceeds of any lawsuit, proceeding, award, adjustment, settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the Assignee.

CASH PAYMENT I understand that I am not utilizing insurance for payment and that payment in full is due at the time that services are rendered to me by Infinity Alignment Natural Health. Any balances not paid within thirty (30) days of the date of service shall accrue interest at the rate of 18% per annum. I remain personally responsible for payment of services rendered. If and when insurance is presented, I will follow the guidelines as outlined in this Assignment pertaining to insurance.

RELEASE OF INFORMATION

I hereby authorize Assignee and his, her or its office to disclose and release any information concerning my illness or injuries otherwise protected by the Federal HIPPA to a requesting party with a properly executed medical records release.

If any term of this Assignment or the application thereof to any person or circumstances shall be determined invalid or unenforceable the remainder of this Assignment shall not be affected thereby, and each term and provision of this Assignment shall be valid and enforced to the fullest extent of the law.

Any action to construe, declare or enforce this Assignment shall only be brought in a court of competent jurisdiction with venue lying solely and exclusively in Seminole County, Florida. The prevailing party in any action brought to construe, declare or enforce this Assignment including, but not limited to, any action brought by Assignee to collect unpaid amounts from the undersigned, shall be entitled to recover its actual attorney's fees, attorney's travel time charges and expenses, paralegal fees, computer access and utilization charges, expert witness fees and expenses, costs, expenses and expenses of investigation, discovery, and litigation. The parties to this Assignment expressly waive the right to trial by jury of any cause of action or defense pertaining to this Assignment.

Patient Signature:_____ Date: _____

Print Name: _____

Witness: _____ Date: _____

Print Name: _____