MEDICAL HISTORY

Date: _____ Patient Name: _____ Date of Birth: ___/___/___

If you are a returning patient within the past 2 years:
Have there been any changes in your medical history or medications since your last visit? Yes_____ No_____
If yes, please note changes below.

New or returning patients that have not been seen within the past 2 years please complete the following:
Have you ever had or have you now (please check each item below)

Yes	No	Problem	When	Explain
		Arthritis		
		Tendency to bleed or anemic		
		Asthma/ COPD/ lung disease		
		Convulsions/ Seizures		
		Diabetes		
		Fainting spells		
		Migraines/ frequent headaches		
		Pace maker/ heart murmur		
		High blood pressure		
		Hepatitis/ other blood disease		
		Thyroid trouble		
		Tuberculosis		
		Cancer		
		Other disorders		

Past surgeries or injuries (broken bones, head, neck, and joint injuries):_____
_____

Allergic to drugs, foods, plants, other:_____
_____

Medications:_____
_____

CORNERSTONE FITNESS & WELLNESS, LLC

POLICY 2

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

By signing below, you hereby consent for this Practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form.

You should read the Notice of Privacy Practices for PHI attached to this form before signing the Consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer for this Practice.

You have the right to request that the Practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to requested restrictions, however; if the Practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

You may communicate with the following individuals regarding my condition or course of treatment:_____

You may communicate confidential information to me, including invoices for services, to the following address and/or phone numbers:_____

X _____ _____

Individual Signature Date

As a personal representative, I have authority to act for the individual because I am the individual's

_____

Cornerstone Fitness & Wellness

ACKNOWLEDGEMENT OF RECIPT OF NOTICE OF PRIVACY PRACTICE

◁ You May Refuse To Sign This Acknowledgement ▷

I, _____, have received a copy of this office's Notice of Privacy Practice.

_____

Please Print Name

X _____

Signature

_____

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledge could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

P.O. Drawer 1200 • Clanton, AL 35046 • Phone 205-280-6450 • Fax 205-280-6451