Abundant Health
Wellness Center

OFFICE OF
Dana West, RD, LD, DIPACLM
Registered & Licensed Dietitian;
Lifestyle Medicine Certified

Thank you for choosing Abundant Health Wellness Center, Inc. (AHWC) for your nutrition and wellness coaching. AHWC is a non-profit corporation. Our mission: We are committed to applying Biblical principles for the well-being of the whole person, to cooperate with the Creator in His compassionate work in the restoration of your health. Our goal: To help you achieve your best health by helping you to put knowledge into action, embrace health and conquer disease.

At Abundant Health Wellness Center, you will have opportunities to learn how to take charge of your health and develop skills to meet your individual health goals through one-on-one individualized counseling, motivational lectures and discussions, positive-thinking and healthy mind promotion, cognitive behavior therapy, and online classes.

You will find attached all the new patient forms to complete. When filling in this digital copy, make sure to complete all the items in red. You may return them via fax, email or bring them with you to your in-person appointment. We do offer video and phone consultations as well, for your convenience.

New Patient Checklist:

- Consent to Treat
- Personal & Contact Information (includes approval to text, email and leave messages)
- Policy Agreement
- Medical Questionnaire

Please include a copy of a photo ID with your paperwork.

Please bring medical documentation or lab results from your doctor(s) that may be pertinent to your health status, evaluation, and treatment.

Please sign each section which requires your signature on the new patient forms. Should you have any questions or concerns, please feel free to contact our office, 479-363-6585.

If for any reason you are not able to keep your appointment, please give the office a 24-hour notice.

Sincerely,

Eden Mesa

Administrative Assistant, AHWC

14558 US-412
Huntsville, AR 72632
[O] 479-363-6585
[F] 870-455-2201
Email: Info@abundanthealthwellnesscenter.org
Website: http://abundanthealthwellnesscenter.org

General Consent for Care and Treatment Consent

Name: **DOB:** **Date:**

TO THE PATIENT and/or PARENT: You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

Abundant Health Wellness Center, Inc. (AHWC) requires your consent to use and disclose your protected health information to carry out treatment and healthcare operations. If you would like a more detailed description of such uses and disclosures, please refer to our Notice of Privacy Practices. You have the right to review our Notice of Privacy Practices before signing this consent. The terms of our Notice of Privacy Practices of AHWC may change from time to time. You can get a copy of our revised Notice of Privacy Practices by contacting our office at 479-363-6585. This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at Abundant Health Wellness Center or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your provider about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request the health care provider, Dana West, RD, LD, or the designees as deemed necessary, to perform reasonable and necessary medical evaluation, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing or procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Medical Information:

Primary Care Physician: Phone:

Fax: Date of Last Visit:

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. If signing virtually, the virtual signature is accepted as my signature.

Signature of Patient: Date:

Name:

DOB:

Date:

How did you learn about this office?

CONTACT INFORMATION

Home phone:

Cell phone:

Work phone:

Where do you prefer to receive phone calls (i.e.. Home, cell, or work phone)?

Email:

My signature on this page gives my approval for sending me texts, emails, or voicemails regarding my appointments and medical information.

EMERGENCY CONTACT

Name:

Home phone:

Cell phone:

If signing virtually, the virtual signature is accepted as my signature.

Signature of Patient Date

POLICY AGREEMENT

Name: DOB: Date:

Your understanding of the following policies will help facilitate a positive working relationship.

Please read the following policies and place your signature on page 5 indicating you have read all the policies listed on pages 4-5.

Policies to Know:

Insurance: We do not bill insurance. If you would like a copy of a superbill, we will be happy to provide it upon request after the consultation/treatment.

1. I understand that I can submit the visits to my insurance company for personal reimbursement, but that my insurance company may not reimburse me at all.
2. I understand if I submit a claim that reimbursement should be sent to me. If my insurance company reimburses AHWC for the visits, the check will be voided and sent back with an explanatory letter.
3. I understand that my insurance company may not reimburse me in full for the consultation/treatment; AHWC will not reimburse the difference.

Privacy Law/HIPAA:

A***. Permitted Uses and Disclosures***. A covered entity is permitted, but not required, to use and disclose protected health information, without an individual's authorization, for the following purposes or situations: (1) To the Individual (unless required for access or accounting of disclosures); (2) Treatment, Payment, and Health Care Operations; (3) Opportunity to Agree or Object; (4) Incident to an otherwise permitted use and disclosure; (5) Public Interest and Benefit Activities; and (6) Limited Data Set for the purposes of research, public health or health care operations. Covered entities may rely on professional ethics and best judgments in deciding which of these permissive uses and disclosures to make.

(1) To the Individual. A covered entity may disclose protected health information to the individual who is the subject of the information.

(2) Treatment, Payment, Health Care Operations. A covered entity may use and disclose protected health information for its own treatment, payment, and health care operations activities. A covered entity also may disclose protected health information for the treatment activities of any health care provider, the payment activities of another covered entity and of any health care provider, or the health care operations of another covered entity involving either quality or competency assurance activities or fraud and abuse detection and compliance activities, if both covered entities have or had a relationship with the individual and the protected health information pertains to the relationship.

Treatment is the provision, coordination, or management of health care and related services for an individual by one or more health care providers, including consultation between providers regarding a patient and referral of a patient by one provider to another.

It is my responsibility to obtain a proper referral prior to my visit and bring it with me. If a referral is faxed, I will call to verify that it was received.

B. ***Health care operations*** are any of the following activities: (a) quality assessment and improvement activities, including case management and care coordination; (b) competency assurance activities, including provider or health plan performance evaluation, credentialing, and accreditation; (c) conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs; (d) specified insurance functions, such as underwriting, risk rating, and re insuring risk; (e) business planning, development, management, and administration; and (f) business management and general administrative activities of the entity, including but not limited to: de-identifying protected health information, creating a limited data set, and certain fundraising for the benefit of the covered entity.

Policy for cancellations and No Call/No Show*:* I understand I am required to give a 24-hour advanced notice if I need to cancel or reschedule my appointment. Because our time is valuable cancellations made less than 24-hour notice and/or No SHOWS are subject to a $25 before the next appointment can be scheduled.

I will be billed a $35 fee for any returned check. All payments for a returned check and further payments will be due in cash, credit/debit card, or money orders only.

Fees for Service	
Initial Consultation	$ 99 each
Follow-up Consultation	$ 75 each

I have read, understand, received a copy (if requested), and agree to the insurance, self-pay, and missed appointment policies. If signing virtually, the virtual signature is accepted as my signature.

Signature of Patient Date

MEDICAL QUESTIONNAIRE

Providing the following information will allow our medical staff a better understanding of your condition and will enable us to help you in more a timely fashion. Explain as fully as possible. Attach additional paperwork as needed. Thank You!

PLEASE PRINT

Name:

Date of Birth:

Today's Date:

Height:

Weight:

Weight one year ago:

Do you consider yourself underweight, overweight, just right?

Weight history (if applicable):

GOAL AND ACHIEVEMENT ASSESSMENT

How can we help you? What are you looking to achieve?

Tell us about your experience in the past with trying to achieve the above items?

Medical History:

Please give names and dates of past and present ailments, operations, abnormal lab/test results (anything you feel significant, including past complaints. Please give complete and detailed information and attach any medical forms (labs, reports) that would give us a better understanding).

List any family medical history that we should be aware of:

What are you currently being treated for (Please give dates of diagnosis)?

List all your drug, food, and environmental allergies:

List all medicine, pills, or drugs you are taking now and why:

Medication	Dosage	# times/day	Start Date

List mineral and/or vitamin, or other supplements you are taking:

Supplement	Dosage	# times/day	Start Date

Do you have or have you had any of the following? Enter the appropriate number in the appropriate box.

0 = Never, 1 = Rarely, 2 = Occasionally, 3 = Sometimes, 4 = Most of the time, 5 = Always

Past	*Present*		*Past*	*Present*		*Past*	*Present*	
		Absent Minded			Excessive Hunger			Light-headedness
		Acne			Excessive Worry			Low Blood Pressure
		Attention Deficit Disorder			Faint When Hungry			Lumbago (rheumatic pain in the lower back and loins)
		Alcoholism			Fatigue			Lupus
		Allergies			Feels Shaky if Hungry			Mental Disorder
		Anemia			Fibromyalgia			Migraine Headaches
		Appendicitis			Food Allergies			Motion Sickness
		Arthritis			Foul Smelling BM/Urine			Nausea
		Asthma			Frequent Colds			Nervous Disorder/Anxiety
		Bad Breath			Frequent Kidney Infections			Night Blindness
		Cancer			Frequent Lower Bowel Gas			Pain w/bowel movement
		Celiac Disease			Frequent Urination			PCOS
		Chest Pains			Gallstones			Poliomyelitis
		Chills/Cold Skin			Gastroesophageal Reflux (GERD)			Prostate Trouble
		Cold Hands/Feet			Hay fever			Respiratory Problems
		Constipation			Headaches			Rheumatic Fever
		Crave sweets/coffee			Heart Disease			Sexual Disorders/Infertility
		Crohn's Disease			Heart Pounds Hard			Sinusitis
		Depression			Hemorrhoids			Skin Problems
		Diabetes			High Blood Pressure			Sleep Apnea

Diarrhea	High Cholesterol/ Triglycerides		Sluggish in the A.M.
Difficulty Breathing	Hot Most of the Time		Swollen Glands
Digestive Disorders	Hypoglycemia		Too Fast Digestion
Dizziness	IBS		Tuberculosis
Eat When Depressed	Indigestion/Heartburn		Ulcers/Colitis
Eat When Nervous	Insomnia		Venereal Infection
Eating relieves fatigue	Irritable before Meals		Wake Up Tired
Eczema	Itching of the Nose		Weight Problem
Emphysema	Itching of the Rectum	Other:	
Epilepsy	Kidney Stones		
Excessive Fear	Lactose Intolerance		

Explain fully the past or present ailments marked 4-5 or any of the other you consider significant for us to have more information. Use a separate piece of paper if needed.

TEMPERANCE

Do you use Tobacco?

Indicate type: Amount/Frequency:

Start Date:

Quit Date:

Do you use alcohol?

Type/Amount/Frequency:

Start Date:

Quit Date:

Do you use illicit drugs?

Start Date:

Quit Date:

Do you use caffeine?

How many of the following do you drink a day?

DRINK	AMOUNT	DRINK	AMOUNT
Regular Coffee		Decaffeinated Coffee	
Energy Drink		Tea Sweet or Unsweet	
Caffeinated Soda		Other types of caffeine use:	

VISION:

Do you have any difficulty with vision?

Please explain:

GI ASSESSMENT

Do you have indigestion?

Gas?

Bloating?

If "yes", How Often?

What foods/medications tend to cause indigestion, bloating or gas?

How often do you have a bowel evacuation/movement?

What is the color & texture of your bowl movement?

Do you have Diarrhea?

Constipation?

Nausea?

What color is your urine usually?

Do you have trouble chewing or swallowing?

If yes, please explain

Do you wear dentures, partials or removal plates, or other devices?

OUTDOOR LIFE AND PHYSICAL ACTIVITY

How many minutes/hours do you spend out of doors in the fresh air/sunlight daily?

Recreational activities enjoyed:

How often do you exercise?

Describe the exercise:

What is the usual time you exercise?

How do you feel before exercising?

How do you feel after exercising?

Do you have a fitness tracker?

HYDRATION

What is your favorite beverage?

How often do you drink it?

How much water do you drink daily?

How many of the following do you drink a day?

Caffeine-free Soda

Sports Drink

Herb Tea (Caffeine free)

Fruit Juice

Punch/Kool-aid

Milk (What type?)

Other:

What types of liquids, if any, do you drink with your meals?

REST AND STRESS

What time do you go to bed?

What time do you get up?

Do you sleep through the night?

Explain:

What time is your last meal before retiring?

Do you eat a snack before bedtime?

Do you wake up during the night and snack?

If so, what do you eat?

Hours per week watching TV?

Types of shows watched (comedy, detective, horror, religious, etc.):

On a scale of 1 to 10 rate your stress level (1= very little stress and 10=an extreme amount of stress):

What are your main stressors?

How do you handle your stress?

What sets you off?

ATTITUDE

Describe your attitude toward life:

Do you feel you are in control of your life, or do you feel someone else is controlling you and making decisions that you feel you should be making?

NUTRITION

Have you ever worked with a Dietitian/Nutritionist?

Do you have set mealtimes?

If yes, what are they?

Who does the cooking in your home?

Who does the shopping in your home?

How long does it take you to eat a meal?

How many times PER WEEK do you eat the following meals out of the home? (fast food, take out, restaurants)

Breakfast

Lunch

Supper

Which restaurants do you choose to patronize?

Please explain what kind of environment is around you while you eat? (Examples: peaceful, relaxed, hurried, stressed, etc.)

How often do you feel stuffed after your meals?

How often do you feel tired after eating?

Do you eat snacks?

If yes, type and time of snacks:

Do you eat when you're stressed?

Do you multi-task while eating?

What are your favorite foods?

What are your least favorite foods?

How would you describe your eating habits (Carbaholic, Meat and Potatoes, Grazer, etc.)?

Are you following any special diet?
Explain diet:

Has your doctor prescribed any specific type of diet for you now or in the past?
If yes, please explain:

Other information you feel is necessary for us to know: