HEALTH UTAH PATIENT POLICIES

801-785-9517

The staff and doctors at Health Utah are dedicated to making your experience in our clinic a very positive and rewarding one. In order for everyone to have such an experience each patient is asked to respect the following policies.

1. We ask that you arrive on time to all of your appointments. If you are more than ten minutes late, you may be asked to reschedule your appointment. In return, we promise to do all that is within our power to respect your time and minimize the time you must wait. Please recognize and be patient with the fact that there are some instances in health care that cause unavoidable delays.

2. (INITIAL) _____ IF YOU FAIL TO SHOW FOR AN APPOINTMENT OR SHOW UP TOO LATE TO BE SEEN, YOU WILL BE BILLED FOR THE APPOINTMENT. You may change or cancel an appointment date or time if done so within 24-hours notice. If done within the 24-hour grace period, no penalty will apply. ***Please sign your initials in the space provided above to signify your understanding of this policy.***

3. We ask that your cell phone be turned off during all treatments. Due to the nature of our treatment protocols, such interruptions can be very disruptive.

4. Children are welcome in the office. Please be sure they are properly supervised to ensure they do not disrupt treatment.

5. Due to space limitations, we ask that only one family member accompany the patient into the treatment room.

6. Be prepared to pay for services prior to seeing the doctor.

7. We ask that you ensure you are well rested and well hydrated prior to all appointments. A good rule of thumb for water intake is to cut your weight in half and drink that many ounces of water each day.

8. If there is anything you are uncomfortable with during a treatment, please bring it to the attention of the doctor or a staff member. We truly want you to feel our love for you and our dedication to making your time in our office a wonderful healing experience.

As signified by my signature below I, _____, have read, or have had read to me, Health Utah's policies and understand and agree to abide by them.

_____ _____

Patient's Signature Date

_____ _____

Guardian's Signature Date

NMT Treatment and Consent Form

Neuromodulation Technique ("NMT") is intended to determine the patient's perception of conditions contributing to illness. I desire to be screened with NMT, and hereby consent to participate in this type of screening and treatment. The procedure has been explained to me, and I understand certain adverse effects may result from the treatment. These could include, but are not limited to, a temporary soreness in muscles of the arms tested, or a temporary flare-up of my symptoms. Other possible side effects include symptoms of heightened immune function or detoxification such as fever, chills, headache or body aches.

I understand NMT is not a medical diagnostic procedure, and therefore does not diagnose disease. Diagnosis requires particular types of clinical examination procedures by a physician trained in diagnosis. By contrast, NMT is intended to determine the patient's perception of conditions contributing to illness. I understand Muscle Response Testing ("MRT") employed in NMT, like any medical procedure, is not 100% accurate.

I understand alternative methods of treatment are available. These have been described to me. If I am suffering from severe allergic reactions to substances, I will consult an appropriate physician and, if so advised, take medication (to prevent itching, tissue swelling, fever, cough, pains, etc.) to keep my symptoms under control while I am being treated with NMT.

I understand determination of the existence and identification of particular infectious agents in the body requires specific laboratory testing. NMT does not diagnose any infectious agent, nor is it a substitute for appropriate laboratory testing. Rather, NMT evaluates the perceptions of the autonomic control system and immune system with regard to such issues, and attempts to optimize autonomic function with respect to immune system control. NMT is not a method of diagnosing or treating cancer. Medical oncologists are the only heath care personnel appropriately trained to manage the treatment of cancer. NMT is not a substitute for appropriate medical care of cancer.

I agree to cooperate and take an active role in my treatment by maintaining a positive attitude regarding treatment, continuing contact with and treatment from medical practitioners, and communicating progress and side effects to the health care provider administering NMT. I understand I am to continue all medications and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them.

I understand there is no guarantee concerning the effect of the treatment. I understand I am free to discontinue treatment at any time, but acknowledge I am responsible for full payment of the normal and necessary fees associated with my screening and treatment.

I understand clinical data is presently being collected that requires the gathering of certain information in accordance with research protocols. I understand the result of this study may be published in a medical or scientific journal, and a number or letter designation of my case, but not my name, may be used in reports of this study.

I have read, or have had read to me, the above statements, and have been provided with the opportunity to ask any pertinent questions I have regarding this screening and treatment program. I have been informed I am to contact the doctor if any problems are encountered during my treatment. I understand the conditions stated above, and hereby consent to participate in this type of screening and treatment. By signing below I agree to the terms and procedures set forth above.

IN WITNESS WHEREOF, I have executed the forgoing this _____day of_____, _____.

_____	_____
Patient's Signature	Patient's Printed Name
_____	_____
Guardian's Signature	Guardian's Printed Name

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are committed to protecting your privacy. While the law requires us to give you this disclosure, please understand we respect and always will respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health information.

- We may have to disclose your health information to another health provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment for our services.
- We may have to use your health information within our practice for quality control or other operational purposes.
- We may need to use your personal information to remind you of your appointments, or to send you a welcome to our office, an office newsletter, or promotional information.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form.

We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices we will notify you in writing by mail or when you come in for a treatment. Please feel free to call us at any time for a copy of our privacy practices.

We will not provide your health information to any individual, company, or organization without your signed authorization except as noted above.

The Right to Revoke Your Authorization

You may revoke your consent at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information prior to receiving your request. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

As indicated by my signature below, I have read your consent policy and agree to its terms. I am also acknowledging I have received a copy of this notice.

_____	_____
Patient's Printed Name	Authorized Provider Representative
_____	_____
Patient's Signature	Date

New Patient Weight Loss Intake Form

Basic Patient Information

Name:				Date:
Street Address:				
City:		State:		Zip:
Home Phone:			Cell Phone:	
Email Address:				
Sex: ◯ M ◉ F	Age:	Birth date:	Height:	Weight:
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced				
Occupation:			Hobby:	
How did you hear about us?				

Health and Wellness History

Are you currently under the care of a physician?
List all medications you are taking:
List surgeries or medical procedures you have undergone:
List all dietary restrictions/allergies/sensitivities you have:
Check ALL that apply to you: ☐ Heart Condition ☐ Epilepsy/Seizures ☐ Pregnant ☐ Might Be Pregnant ☐ Taking Heart Medication/Blood Thinners ☐ Currently Undergoing Chemotherap ☐ Breast Feeding ☐ Known Adverse Reactions to Niacin or B Vitamins ☐ Headaches ☐ Yeast Infections ☐ Frequent Illness

On a scale of 1 to 10, 10 being maximum energy, how would your rate your energy level?
Is is hard to fall or stay asleep?
How often do you wake up at night to urinate?
How often do you have a bowel movement?
Are your bowel movements ever too soft or too hard?
Do you have to take something to help you have regular bowel movements? ☐ Yes ☐ No
Do you ever have heartburn or GERD? ☐ Yes ☐ No
Do feel bloated after meals? ☐ Yes ☐ No
Do you ever have stomach pain or cramps? ☐ Yes ☐ No
Do you ever feel nauseated? ☐ Yes ☐ No

Please answer the following questions honestly so we can do our best to help you reach your goals.

Check ALL areas of treatment that interest you:

☐ Weight Loss ☐ Cleansing and Detoxification ☐ General Wellness ☐ Body Wraps
☐ More Energy ☐ Stress Reduction ☐ Other
What is your current weight?
What do you consider to be your ideal weight?
When was the last time you were at your goal weight?
How many times a year do you diet?
What is stopping you from losing weight on your own?
What have you tried in the past that has failed?
Do you exercise ☐ Yes ☐ No What is your preferred exercise?
Does your weight problem make you physically uncomfortable? ☐ Yes ☐ No
Please describe:

Does your weight problem cause physical pain? ☐ Yes ☐ No
Please describe:
Does being overweight and unhealthy limit your activities? ☐ Yes ☐ No
Do you binge eat? ☐ Yes ☐ No
Do you suffer from uncontrollable cravings? ☐ Yes ☐ No
Do you feel that food controls you? ☐ Yes ☐ No
Do you eat because of your emotions? ☐ Yes ☐ No
Do you eat between meals? ☐ Yes ☐ No
What do you crave?
What do you choose to eat between meals?
Name all beverages you drink from most to least:
Is successful weight loss a top priority? ☐ Yes ☐ No
How fast do you want to be slim, trim, and fit?
What's more important to you: fast or permanent?
Does your family support your weight loss efforts? ☐ Yes ☐ No
Can you remember being at your ideal weight? ☐ Yes ☐ No
What do you remember most about it?

What is the most important element in deciding to use our services?

Circle only ONE of the four answers:

EFFECTIVENESS: "My results are my top priority."
TIME: "I want results quickly."
SERVICE: "I need extra support along the way."
AFFORDABILITY: "I need this to be affordable."

I understand that my entire patient history will remain completely confidential and will not be released without express written consent from me.

Signature: _____ Date: _____