Telehealth History Form

Patient Information: Date: ______________________

Name: ____ Date of Birth: _______________

Address: ____

City: ________________________________ State: ________________ Zip Code: ___________________

Cell Phone: _____________________________ Sex: ☐M /☐ F Height:_________ Weight: _________

Occupation: _____________________________ Email address: ________________________________

In case of emergency, contact: Name: ___________________________ Phone: __________________

How did you hear about us? ☐ Website ☐ Facebook ☐ Google ☐ Friend: ______________________

What are your main complaints? (Please describe why you are needing a Telehealth call today)

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____

What are your current symptoms? ____

____

____

Date Current Symptoms Started: _________________________________

Are you pregnant or breastfeeding? ☐Yes / ☐No Date of last chemistry screen/other lab testing ________________

Have you ever been told that you have an electrolyte imbalance or other abnormal labs? (Please check all that apply)

- ☐ Hypermagnesemia (High magnesium levels)
- ☐ Hypercalcemia (High calcium levels)
- ☐ Hypokalemia (Low potassium levels)
- ☐ Hemochromatosis (High iron levels)
- ☐ Other ________________________

Are you a diabetic? ☐Yes / ☐No Have you been told you are 'prediabetic'? ☐ Yes / ☐No

Are you a smoker? ☐Yes / ☐No If Yes, how much do you smoke?____________________________

How many alcoholic drinks do you consume in a week?____

Do you use any recreational drugs? ☐Yes / ☐No If Yes, which ones and how often? _________________________

Please list everything you are currently taking:

Prescription Medications – Strength – Frequency – Condition being treated

____

____

Over the Counter Drugs – Strength – Frequency – Condition being treated

____

____

Vitamins and Other Supplements – Strength – Frequency – Condition being treated

____

Do you take Digoxin (Lanoxin) for a heart problem? ☐Yes / ☐No

Do you take any diuretics or water pills? ☐Yes / ☐No If Yes, please list: ____

Do you take any steroids, i.e. Prednisone? ☐Yes / ☐No If Yes, please list: ______________________________________

Do you have any allergies? ☐Yes / ☐No If Yes, please list: ____

____

____

Do you have any of the following conditions? (Please check all that apply)

- ☐ Blood pressure problems (High or low)
- ☐ Heart Problems
- ☐ Stroke or "mini-stroke"
- ☐ Kidney Problems
- ☐ Kidney Stones
- ☐ Asthma
- ☐ Optic Nerve Atrophy or Leber's Disease
- ☐ Sickle Cell Anemia
- ☐ G6PD Deficiency
- ☐ Sarcoidosis
- ☐ Thyroid/Parathyroid problems (High levels)
- ☐ Pre/Post Menopause
- ☐ Hormonal Inbalances
- ☐ Liver Disease
- ☐ HIV – CD4
- ☐ Hepatitis B
- ☐ High Cholesterol or Lipids
- ☐ Cancer
- ☐ Ulcers
- ☐ Depression
- ☐ Osteoporosis
- ☐ Lung Disease (Asthma, COPD)
- ☐ Arthritis or Joint Problems
- ☐ Headaches/Migraines

List any other medical conditions you have (not mentioned above):____

____

List of all surgical procedures you've had with approximate dates: _______________________________________

____

Is there anything else you'd like the providers to know?____

____

Treatment Consent Form

This document is intended to serve as informed consent for your Telehealth Visit by the provider at ReNew Medical Center.

(Initials)_________ I have informed the nurse and of any known allergies to medications or other substances and of all current medications and supplements. I have fully informed the nurse and/or physician of my medical history.

(Initials)_________ I understand that a Telehealth Visit with a provider is a limited assessment due to the lack of an in-person physical exam.

(Initials)_________ I understand that I have the right to consent to or refuse any proposed treatment at any time.

My signature below confirms that:
1. I understand the information provided on this form and agree to all statements made above.
2. I have received all the information and explanation I desire concerning this visit.

Patient's Name & Date of Birth (Please Print) ________________________________ DOB________________

Patient's Signature ____ Date____________

ReNew Medical Center
Integrative & Regenerative Medicine

HIPAA NOTICE OF PRIVACY PRACTICES

ReNew Medical Center, LLC and their medical staff understand that health information about you is very personal and we are mandated by the Health Insurance Portability and Accountability Act (HIPAA) to protecting your health information. We create a record of the care and services you receive from us, and this record helps to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by us, and informs you about the ways in which we may use and disclose information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this Notice of our legal duties & privacy practices with respect to health information about you
- Follow the terms of the Notice that is currently in effect

How we may use and disclose health information about you:

- For Treatment
- For Payment
- For Healthcare operations
- For appointment reminders
- As required by law
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Services for the President and others
- Security Officials for Inmates
- For any services provided by ReNew Medical Center

Your rights regarding Health Information about you:

- Right to inspect and copy
- Right to Amend
- Right to Accounting of Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communication

Your Medical Records: The original copy of your and/or electronic medical record is the property of ReNew Medical Center. You may request a copy of your records to be transferred by completing a medical records release form. As allowed by AZ state law, there will be a fee for providing you with this service. We require 14 business days from the date of your request to prepare and send your records unless the records are for urgent of life-threatening health issues.
Changes to this Notice: We reserve the right to change this Notice. We will post a copy of the current notice in our facility with the current effective date.
Complaints: If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint. For complete, detailed information regarding privacy laws, visit www.cms.gov/hipaa
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Permission to Share your Health Information: We are required to follow certain federal guidelines and laws regarding the confidentiality of your personal health information. One of these prevents us from discussing anything in your medical file with anyone other than yourself or other medical personnel involved in your care. If you would like us to discuss lab results or other personal information with your significant other, family members, or any other individuals, please fill in their name and relationship to you in the section listed below.

Acknowledgement of Receipt of the ReNew Medical Center HIPAA NOTICE OF PRIVACY PRACTICES:
We request that you sign this form acknowledging you have received, read, and reviewed the ReNew Medical Center HIPAA Notice of Privacy Practices. If the patient is a minor, the legal guardian is automatically appointed by law to provide/receive protected information on behalf of the patient. I will notify the staff of ReNew Medical Center of any changes or updates to this record. This acknowledgement will become part of your records.

Printed Name of Patient ____ Date ______________________
Signature of Patient ____