Confidential Client Information (please print clearly)

Aromatic Remedies
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Full Name_______________________________________ ☐ M ☐ F Date_____/_____/_____
Street Address____________________________________City/State__________________Zip__________
Main Phone(_____)______________________☐cell☐work e-mail_____________________________
DOB_____/_____/_____ Age__________ Occupation:______________________________________
Do you consider your job stressful? ☐yes☐no Marital Status ☐S☐M☐D☐W
Emergency Contact Name____Phone(_____)_______________
Date of last physical exam_____/_____/_____ PCM/PCP Name__________________________________
Overall diet and health ☐Very good☐Good☐Average☐Not good☐Poor
Skin: ☐Oily☐Normal☐Dry Female clients Do you suffer from difficult periods? ☐yes☐no
Is there a possibility of pregnancy at this time? ☐yes ☐no
Main reason for appointment____
What diagnosis, if any, have you received from your doctor?____________________________________
When did this problem begin?________________________________
What are the causes of this problem? ____
To what extent does this problem interfere with you daily activities (work, sleep, sex, etc...)?
____
Treatment provided?____
What makes this problem worse?______________________Better?___________________________________
Is there anybody in your family with the same/similar problems?_____________________________________
Remarks and additional information:____
____
Surgeries______________________________________Hospitalization_______________________________
Significant trauma: (auto accidents, sports injuries, etc) _______________________________________
Allergies: (medicines and/or plants)____
Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc... and their dosages):
____

MEDICAL HISTORY

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer			Respiratory problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			STD			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or anxiety			Other		

Name___________________________

Date_____/_____/_____

Exercise ☐Never ☐Occasional ☐3-5x/wk ☐Daily

Tobacco ☐Never ☐Occasional ☐Light ☐Medium ☐Heavy

Alcohol ☐Never ☐Occasional ☐2-5x/wk ☐Daily

Caffeine ☐Never ☐Occasional ☐2-5x/wk ☐Daily

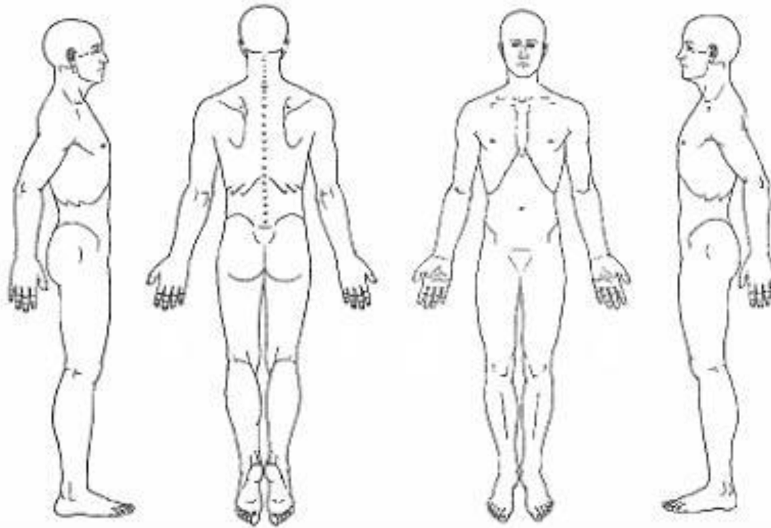
What is your expectation from therapeutic Aromatherapy Treatment? ___________________________________

____

Complete this diagram by putting a letter or letters on the figures below to indicate your symptoms.

A= Ache B= Burning N= Numbness P= Pins & Needles R= Rash S= Stabbing

O= Other



PAYMENT IS EXPECTED AT TIME OF VISIT

I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment at time of service.

Patient's Signature:____

Date:_____/______/_____

This notice describes how your health information may be used and how you can gain access to this information. Please review it carefully.

Our Promise to You, Our Valued Patient

We want to assure you that we take the Federal HIPAA (Health Insurance Portability and Accountability Act) laws seriously. These laws were written to protect the confidentiality of your health information. We trust you will never delay treatment in our office because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

Why A Privacy Policy Now ?

The most significant variable that has motivated the Federal government to legally enforce the privacy of health information is the rapid evolution of electronic technology in the health care business. The government has appropriately sought to standardize and protect the electronic exchange of your health information. This has challenged us to review how your information is used within our computers, internet, phones, fax machines, and any device used to copy or transfer that data. We want to advise you that we have developed policies and procedures for our practice to assure that your personal health information will be shared only as required for the purpose of administering your care. Our office is subject to State and Federal laws regarding the confidentiality of your health information and we promise our adherence to those laws. We also want you to understand our procedures and your rights as a valued patient. Your health information will be communicated only for the purpose of conducting health care business and obtaining payment for services. Be assured that without your written permission, your health information will not be used for any other purpose.

How Your Health Information May Be Used To Provide Treatment

Within our office, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories, or other health professionals providing you treatment.

To Obtain Payment

Your health information may be included with an invoice in order to collect payment for the services provided to you in this office. We will make every effort to work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations to our staff. Some of the best teaching opportunities use clinical situations experienced by patients receiving care in our office. As a result, your health information may be included in the training programs for students, interns, and associates, as well as business and clinical employees. It is also possible that your health information will be disclosed during audits by government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing or credentialing activities.

In Patient Reminders
Because we believe regular care is very important to your general health, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you and your family. These communications are an important part of our philosophy, which is to partner with our patients to see they receive the best care we can provide. This may include postcards, newsletters, flyers, and telephone or electronic reminders such as e-mail (unless you tell us that you prefer not to receive reminders).
Public Health and National Security
We may be required to disclose necessary health information to Federal officials or military authorities in order to complete investigations related to public health and or national security.
For Law Enforcement
As permitted or required by State and Federal law, we may disclose your health information under certain circumstances to proper authorities for the purpose of law enforcement. This may take place if you are a victim of a crime, or in order to report a suspected crime.
Family, Friends and Care Givers
We may share your health information with those that assist you with your home hygiene, care, treatment, or payment. We will be certain to obtain your permission prior to sharing your information. In the event of an emergency, if you are unable communicate your wishes; we will use our very best judgment when sharing your health information with anyone participating in your care.
Medical Research
Advancing health care knowledge often involves learning from the careful study of health histories of prior patients. Formal review and study of health histories will transpire only under the ethical guidance, requirements and approval of an Institution Review Board.
Authorization to Use or Disclose Heath Information
Other than the information stated above, or information that Federal, State and Local laws require, we will not disclose your health information without your written authorization. You may revoke that authorization in writing at any time.
Patient Rights
This law is careful to describe that you have rights related to your health Information. Be assured that our office will make every effort to honor reasonable restriction preferences from our patients.
Confidential Communications
You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information privately, with or without other family members present, or through sealed mail communications. We will make all reasonable efforts to honor your request.
Inspect and Copy Your Health Information
You have the right to read, review and copy your health information. This includes your complete chart and billing records. If you would like a copy of your health information, please

let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe as completely as possible your reason for the request. Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information have been requested, sealed and or delivered to any authority for review.

Documentation of Health Information

You have the right to request a description of how our office used your health information for reasons other than treatment, payment, or health care operations. Our documentation procedure will enable us to provide information on your health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. We greatly appreciate your limited request for no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of This Notice

You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time. We are required by law to maintain privacy of our health information and provide to you or your representative this Notice of Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our notice. Patients will be notified of any such changes. You have the right to express concerns or complaints to any staff member or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing any concerns you may have regarding the privacy of your health information.

Patient Acknowledgement

Patient Name (Print)______________________________________Date _____/_____/_____

Patient Signature____

Informed Consent

Please read this entire document prior to signing. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the Aromatherapy treatment

The focus of Aromatherapy is a holistic restoration of physical, mental, emotional, and spiritual health through the application of essential oils. Aromatherapy has not been evaluated by the FDA. Any information provided is not intended to diagnose, treat, cure, or prevent any disease. This information is not intended to take the place of diagnosis and treatment by a qualified licensed medical provider. Any recommendations are for educational purposes only and are believed to be effective. However, no expressed or implied guarantee as to the effectiveness of this information can be given nor liability taken.

Analysis/Examination/Treatment

A thorough intake process will be conducted to include a detailed health history. It is advantageous for you, the client, to be as honest as possible so that a personalized treatment plan may be developed.

The material risks inherent with Aromatherapy treatment

As with any complementary Alternative Medicine (CAM), there are certain risks that may arise during treatment. These complications include, but are not limited to: sensitivity to a particular essential oil, photosensitivity associated with certain essential oils, skin irritation, mucosal irritation, allergic reactions, or dermatitis. All precautions will be taken to diminish the risks associated with the application of essential oils. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring

Due to the thorough nature of the examination process, the probability of an interaction is rare. However, you will be sent home with detailed instructions on how and when to apply/use your personalized blend and are expected to follow those instructions to the best of your ability to avoid contraindications.

The availability and nature of other treatment options

If you choose to use one of these other treatment options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. Other treatment options for your condition may include:

- Self-administered, over-the-counter medications
- Medical care and prescription drugs
- Hospitalization
- Surgery

The risks and dangers attendant to remaining untreated

If you choose to remain untreated, your condition may continue to grow worse over time. However, the choice of all medical care for you and your family always lies with you.

I have read the above explanation of Aromatherapy. I have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing therapeutic aromatherapy and have decided that it is in my best interest to undergo the recommended protocol. Having been informed of the risks, I hereby give my consent.

Signature____Date_____/_____/_____