Vital Life Medicine
E: drjodi@vitallifemedicine.com **Jodi Vingelen, ND, LMP** **T: (425) 268-8057**
1603 116th Avenue NE, Suite 111
Bellevue, WA 98004-3009
www.vitallifemedicine.com

Adult Intake Packet

Welcome to Vital Life Medicine, PLLC. In order to provide you with the best possible care, we ask you to complete this form in its entirety. It will be greatly appreciated if you can either mail (with sufficient time), fax, email, or drop this form off at the clinic prior to your appointment so that Dr. Jodi can review your health history ahead of time. Otherwise, just bring it with you to your appointment. Thank you!

PERSONAL INFORMATION

Name:_____Date: _____

Address: _____

Telephone: (Home): _____(Work): _____(Cell): _____

May I leave confidential voice-mail messages for you at any of the above numbers? Y / N (specify): H / W / C

E-mail Address: _____

May I leave confidential email messages for you at the above address? Y / N

Age: _____Date of Birth: _____Birth Gender: F M GN Identified Gender: F M GN

Married_____ Separated_____ Divorced_____ Widowed_____ Single_____ Partnership_____

Live with: Spouse_____ Partner_____ Parents_____ Children_____Friend/s_____ Alone_____Other_____

Occupation:_____ Hours per week:_____

Employer Name:_____

Employer Address:_____

Have you ever seen a Naturopathic Physician before? Y / N If so, who? _____

How did you hear about this clinic? _____

May we thank them for the referral? Y / N

If Internet: Google____ Website_____ Other_____

Has any other family member been seen at my practice? Y / N

Emergency Contact:_____ Relationship:_____

Phone:_____ Address:_____

INSURANCE INFORMATION

Insurance Company Name:_____ Telephone:_____

Name of Policy Holder:_____ DOB:_____

Policy ID Number:_____ Group Number:_____

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CONTEXT OF CARE REVIEW

Successful health care, wellness and preventive medicine are only possible when the doctor has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me in assisting your health needs.

Why did you choose to come to Vital Life Medicine?

What do you know about my approach?

What three expectations do you have from **this visit** to Vital Life Medicine?

What **long-term** expectations do you have from working with Dr. Jodi Vingelen, ND, LMP?

What expectations do you have of me personally as your health care provider?

Circle what is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

(0%) 0 1 2 3 4 5 6 7 8 9 10 (100%)

What behaviors or lifestyle habits do you currently engage in regularly that you believe **support** your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits?

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols, which we will be sharing with you?

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

What do you love to do?

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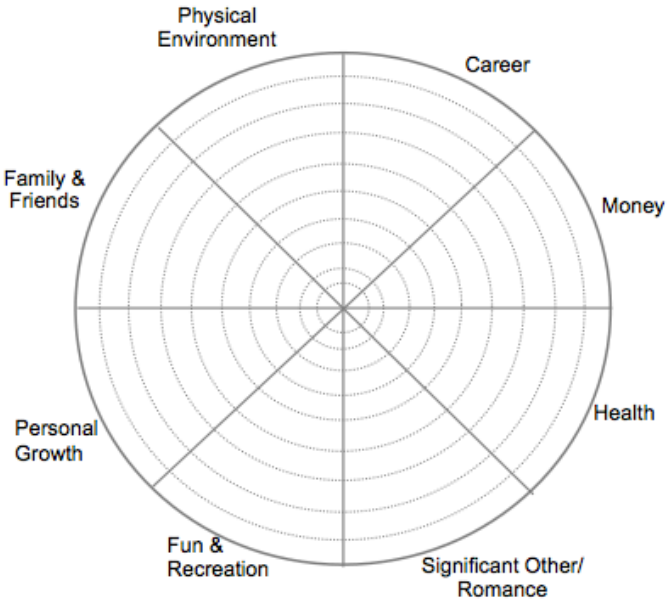
Wheel of Balance

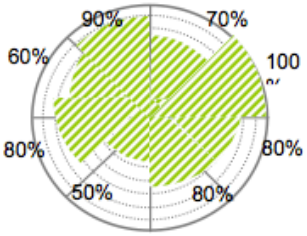
Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.



Example:



CURRENT HEALTH HISTORY

Are you currently receiving healthcare? Y / N

If **yes**, for what and from whom?_____

_____

If **no**, when and where did you last receive medical health care?_____

_____

What was the reason?_____

What are your **most important health concerns**? List as many as you can in order of importance.

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

Do you have any known contagious diseases at this time? Y / N

If yes, what?_____

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Have you ever received a blood transfusion? Y / N

FAMILY HISTORY

Do you or anyone in your family have a history of any of the following conditions? (Please circle and note who)

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney Disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma/Hay fever/Hives	Allergies	Osteoporosis	Eczema
Irritable Bowel Disorder	Alcoholism		

Any other relevant family history?_____

What is your family heritage?_____

If anyone in your immediate biological family has passed away, please indicate their age at time of death, as well as the cause of death._____

_____

CHILDHOOD ILLNESSES

Weight at Birth:_____

Please circle whether you had any of the following as a child:

Chicken pox	Diphtheria	German Measles
Measles	Mononucleosis	Mumps
Rheumatic Fever	Rubella	Scarlet Fever

IMMUNIZATIONS HISTORY

Circle all immunizations you've received and write date when you last received them.

Chickenpox/Varicella	Hepatitis A	Meningococcal
Flu (Influenza)	Hepatitis B	Measles/Mumps/Rubella (MMR)
Gardasil/HPV	Zostavax (Shingles)	Tdap (Tetanus, Diphtheria, Pertussis)
Polio	Tetanus	

HOSPITALIZATIONS, SURGERY, IMAGING

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What hospitalizations, surgeries, X-rays, CAT scans, MRI's, EEG, and/or EKG's have you had?

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

ALLERGIES

Are you hypersensitive or allergic to...

Any drugs?_____

Any foods?_____

Any environmental or chemicals?_____

EXPOSURES

Have you had daily or prolonged exposure to any toxic chemicals, paints, lead, or mercury? Y / N

If **yes**, what type and when?_____

Second hand smoke? Y / N For how long?_____

CURRENT MEDICATIONS

Do you take or use any of the following (please circle):

Antacids	Antibiotics	Appetite Suppressants	Birth Control Pills
Cortisone	Hormone Replacement	Laxatives	Pain Relievers
Sleeping Pills	Thyroid Medication	Tranquilizers	

Please list **ANY** prescription medications, over the counter medications, vitamins, or other supplements you are currently taking or use frequently. Include the dosage.

1) 2)

3) 4)

5) 6)

7) 8)

GENERAL

Height:_____ Weight:_____lbs. Weight 1 year ago:_____lbs.

Maximum Weight:_____ When:_____

Rate your energy (1-10, 10 = most energy):_____ Is this a change? Y / N

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At what time of the day is your energy at its best?_____ Worst?_____

Please rate your stress level on a scale of 1-10 (10 = most stress):_____

TYPICAL FOOD INTAKE

Do you follow a specific diet? Y / N Please explain:_____

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Beverages:_____

Do you eat 3 meals a day? Y / N

Do you cook your own meals? Y / N

Do you drink caffeinated beverages? Y / N

Do you go on diets often? Y / N

Do you eat the following?

Eggs Y / N	Red Meats Y / N	Chicken Y / N
Fish Y / N	Milk Y / N	Cheese Y / N
Bread Y / N	Yogurt Y / N	Butter Y / N
Margarine Y / N	Added Salt Y / N	Cooked Vegetables Y / N
Potato/Yam Y / N	Fruits Y / N	Salads Y / N
Sugar Y / N	Nuts & Seeds Y / N	

List any foods that you crave:_____

_____

List any foods that you react to:_____

_____

FOR THE FOLLOWING, PLEASE CIRCLE

Y = a condition you have now or yes **N = Never had or no** **P = Significant problem in the past**

HABITS

Main interests and hobbies?_____

Do you exercise? Y / N If yes, what kind and how often?_____

_____

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Average 6-8 hours of sleep?	Y N	Enjoy your work?	Y N
Sleep well?	Y N	Take vacations?	Y N
Awaken rested?	Y N	Spend time outside?	Y N
Have a supportive relationship?	Y N	Watch TV?	Y N Hrs=
Have a history of abuse?	Y N P	Read?	Y N Hrs=
Any major traumas	Y N P	Religious/spiritual practice?	Y N P What?
Use recreational drugs?	Y N P	Smoked previously?	Y N
			How many years?
			How many packs/day?
Been treated for drug dependence?	Y N P	Use alcoholic beverages?	Y N P
Do you currently use tobacco?	Y N		

MENTAL / EMOTIONAL

Treated for emotional problem/s?	Y N P	Depression? Seasonal?	Y N P
Anxiety or nervousness?	Y N P	Poor concentration?	Y N P
Mood swings?	Y N P	Considered/Attempted suicide?	Y N P
Tension?	Y N P	Memory problems?	Y N P

NEUROLOGIC

Seizures?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Vertigo or lightheadedness?	Y N P	Loss of balance?	Y N P
Loss of memory?	Y N P	Easily stressed?	Y N P

ENDOCRINE

Thyroid problem? Hypo- / Hyper-	Y N P	Heat or cold intolerance?	Y N P
Low blood sugar (hypoglycemia)?	Y N P	Diabetes?	Y N P
Excessive thirst or hunger?	Y N P	Fatigue?	Y N P
Hair loss?	Y N P	Exercise intolerance?	Y N P

IMMUNE

Reactions to immunizations?	Y N P	Chronic infections?	Y N P
Chronically swollen glands?	Y N P	Slow wound healing?	Y N P
Night sweats?	Y N P	Chronic fatigue syndrome?	Y N P
Auto-immune disease?	Y N P	Cancer?	Y N P

SKIN

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Rashes, eczema or hives?	Y N P	Itching?	Y N P
Change in skin color?	Y N P	Acne/boils?	Y N P
Lumps or bumps on skin?	Y N P	Perpetual hair loss?	Y N P
Brittle nails?	Y N P	Dry skin?	Y N P

HEAD

Headaches?	Y N P	Head injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems?	Y N P

EYES

Impaired vision?	Y N P glasses or contacts	Cataracts?	Y N P
Color blindness?	Y N P	Glaucoma?	Y N P
Tearing or dryness?	Y N P	Eye pain/strain?	Y N P
Spots in vision?	Y N P	Double vision?	Y N P

EARS

Impaired hearing?	Y N P	Ringing in ears?	Y N P
Earaches?	Y N P	Ear infections?	Y N P

NOSE & SINUSES

Frequent colds?	Y N P	Nose bleeds?	Y N P
Congestion?	Y N P	Hay fever?	Y N P
Loss of smell?	Y N P		

MOUTH & THROAT

Frequent sore throat?	Y N P	Sores in mouth?	Y N P
Teeth grinding?	Y N P	Dental cavities?	Y N P
Gum problems?	Y N P	Hoarseness?	Y N P
Sore tongue or lips?	Y N P	Jaw clicking?	Y N P

NECK

Swollen glands or lumps?	Y N P	Pain or stiffness?	Y N P
Difficulty swallowing?	Y N P	Goiter?	Y N P

RESPIRATORY

Cough?	Y N P	Sputum?	Y N P
Spitting up blood?	Y N P	Asthma or wheezing?	Y N P
Pneumonia?	Y N P	COPD?	Y N P
Pain on breathing?	Y N P	Shortness of breath?	Y N P

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Bronchitis?	Y N P	Tuberculosis?	Y N P
Emphysema?	Y N P	Shortness of breath lying down?	Y N P

CARDIOVASCULAR / BLOOD / PERIPHERAL VASCULAR

Heart disease?	Y N P	Chest pain/angina?	Y N P
High/Low Blood Pressure?	Y N P	Murmurs?	Y N P
Blood clots?	Y N P	Palpitations/Fluttering?	Y N P
Vascular disorder?	Y N P	Swelling/edema in ankles?	Y N P
Rheumatic fever?	Y N P	Fainting?	Y N P
Heart attack or stroke?	Y N P	Phlebitis/deep leg pain?	Y N P
Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Cold hands/feet?	Y N P	Varicose veins?	Y N P

Date of last routine blood work:

GASTROINTESTINAL

Trouble swallowing?	Y N P	Heartburn?	Y N P
Abdominal pain/cramps?	Y N P	Nausea/vomiting?	Y N P
Belching or passing gas?	Y N P	Constipation?	Y N P
Ulcer?	Y N P	Diarrhea?	Y N P
Jaundice (yellow skin)?	Y N P	Bowel Movements:	How often?
			Is this a change?
Gall bladder disease?	Y N P	Black stools?	Y N P
Liver disease?	Y N P	Blood in stool?	Y N P
Hemorrhoids?	Y N P	Pancreatitis?	Y N P
Change in appetite?	Y N P	Had a colonoscopy?	Y N
Change in thirst?	Y N P	Date:	Abnormal? Y / N

URINARY

Pain on urination?	Y N P	Increased frequency?	Y N P
Frequency at night?	Y N P	Inability to hold urine?	Y N P
Frequent infections?	Y N P	Kidney stones?	Y N P
Abnormal urine color/odor?	Y N P	Kidney disease?	Y N P

MALE REPRODUCTIVE

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Hernias?	Y N P	Testicular masses?	Y N P
Testicular pain?	Y N P	Prostate disease?	Y N P
Sexually transmitted infection?	Y N P	Discharge or sores?	Y N P
If yes, circle type: Chlamydia, Gonorrhea, Syphilis, Herpes			
Are you sexually active?	Y N P	Premature ejaculation?	Y N P
Impotence?	Y N P	Sexual orientation:	
Birth control? Y / N	Type?	BPH?	Y N P
Low sex drive?	Y N P	Fertility issues?	Y N P
Prostate exam?	Y N	PSA check?	Y N
Date:	Abnormal? Y N	Date:	Abnormal? Y N

FEMALE REPRODUCTIVE

Age of first menses?		Date of last annual exam/PAP?	
If menopausal, age of last menses?		Abnormal PAP?	Y N
Are cycles regular?	Y N	Bleeding between cycles?	Y N P
Length of cycle?	Days	Clotting?	Y N P
Duration of menses?	Days	Vaginal discharge, odor, pain, itching?	Y N P
Painful menses?	Y N P	Birth control?	Y N P
		What type?	
Heavy or excessive flow?	Y N P	Number of pregnancies:	
PMS?	Y N P	Number of live births:	
If yes, what are your symptoms?		Number of miscarriages:	
		Number of abortions:	
Endometriosis	Y N P	Menopausal symptoms?	Y N P
Ovarian cysts?	Y N P	Fertility concerns?	Y N P
Sexually transmitted infections? Y N P		Are you sexually active? Y N P	
If yes, circle type: Chlamydia, Gonorrhea, Syphilis, Herpes		Sexual orientation:	
History of sexual abuse? Y N P		Pain during intercourse? Y N P	
Do you do breast self-exams? Y N P		Breast lumps? Y N P	
Breast pain/tenderness? Y N P		Nipple discharge? Y N P	
Mammogram/Thermography? Y N		DEXA Scan (bone density)? Y N	
Date:	Abnormal? Y N	Date:	Abnormal? Y N
Cervical dysplasia? Y N P			

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MUSCULOSKELETAL

Joint pain/stiffness?	Y N P	Arthritis?	Y N P
Broken bones?	Y N P	Weakness?	Y N P
Muscle spasms/cramps?	Y N P	Sciatica?	Y N P

Is there anything else you would like to add or comment on? (Please use additional sheets if necessary.)

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Thank you for your time and effort.

I look forward to working with you in your healing process.

If you have any questions please ask!

~ Dr. Vingelen

CONSENT FOR TREATMENT

Vital Life Medicine, PLLC (VLM) is a Naturopathic Medicine clinic, which integrates a number of medical treatment modalities. We believe in treating people, not disease. Therefore, each individual patient will receive a treatment plan that is specifically developed for him or her. Due to the diversity of modalities offered at VLM, your treatment may include any or all of the following general modalities: Naturopathic Medicine, Physical Medicine, Therapeutic Exercise, Homeopathy, Herbal Therapy, Hydrotherapy, Psychological Counseling and Nutritional Counseling. It is understood that while our practices and procedures are safe and effective, not everyone responds the same way to different treatments, and occasionally side effects or complications may arise.

Methods, Procedures and Therapeutic Approaches
Clinicians may perform any of the following procedures as necessary to give proper assessments, determine treatment approaches, treat or otherwise address your health concerns.

- General Diagnostic Procedures: Including but not limited to venipuncture, PAP smears, radiography, blood/urine lab work, general physical exams, neurological and musculoskeletal assessments.
- Psychological and/or Lifestyle Counseling, Exercise Prescriptions
- Herbs/Natural Medicines: Prescribing of various therapeutic substance including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures – may contain alcohol; topical crèmes, pastes, plasters, washes; suppositories or other forms. Homeopathic remedies, highly dilute quantities of naturally occurring substance, may also be used.
- Dietary Advice and Therapeutic Nutrition: Use of foods, diet plans, nutritional supplements, or intramuscular vitamin injections.
- Soft Tissue and Osseous Manipulations: Use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy.
- Electromagnetic and Thermal Therapies: Includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, micro current stimulation, diathermy, and infrared and ultraviolet therapies.

Pharmaceutical Medication Your physician, at times, may prescribe prescription medication for your care.

Potential Risks: While the risk of complications or side effects from any of the above treatments is rare, it is our policy to inform our patients about them. This complications may include, but are not limited to: pain, soreness, bruising, inflammation, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; aggravation of pre-existing symptoms; and temporary worsening of symptoms. More serious complications are extremely rare.

Potential Benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant and/or Breastfeeding Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy or during breastfeeding.

Please recognize that the care you receive at VLM is voluntary. By signing this form, you are voluntarily consenting and authorizing our treatments and procedures. Please understand that you may refuse treatment and/or procedures at any time during your course of therapy and such requests will be respected.

By signing below, I acknowledge that I have read and understand the above statements regarding treatments and side effects. I understand that during my course of treatment at VLM, I will be given an opportunity to ask questions about my condition. I will also be given the opportunity to ask questions regarding the benefits, risks, and alternatives to treatments offered. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by VLM or any of its personnel regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or otherwise permitted or required by law.

I hereby consent to examination and treatment with naturopathic medicine by Dr. Jodi Vingelen at Vital Life Medicine, PLLC.

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Patient Name (PRINT) _____ Patient's Signature _____

Guardian/Personal Representative's Name (PRINT) _____ Guardian/Personal Representative's Signature _____

Relationship/Representative's Authority _____ Date _____

Vital Life Medicine Clinic Policies

In order to establish clear communication between the patient and the doctor, the following outlines the clinic policies regarding fees, policies and scheduling at Vital Life Medicine (VLM).

Fees and Payment:
You have a right to ask what these fees are prior to the visit. Payment for all services and medicinary items is due at the time of the visit that is not covered by insurance. Co-payments, if applicable, are also due at the time of service. Payment may be made by cash, check or credit card.

Returned Check Fee:
Returned checks will be subject to a $35.00 non-sufficient funds fee.

Insurance:
Dr. Vingelen is a preferred provider for multiple insurance policies. VLM is not responsible for verifying insurance coverage; it is the patient's responsibility to verify benefits and that the doctors are covered providers on your plan. The patient will be responsible for payment of any services not covered/paid for by insurance. If you have any questions about insurance coverage or preferred provider status, feel free to contact our office.

Appointment Cancellations:
When you make an appointment, we reserve that time specifically for you. If you must cancel an appointment, we ask that you give us at least 24 hours' notice. No-shows or appointments cancelled inside of 24 hours result in a charge of $50.00, emergencies excluded.

Returns on Dispensary Items:
Unopened supplements can be returned with a receipt within 30 days of purchase for a full refund with the exception of probiotics or refrigerated items, suppositories, compounded hormones, amino acids, tinctures and specialty order items.

If you have any questions regarding these guidelines, please ask.

By signing below, I acknowledge that I have read and understand the above-stated policies of Vital Life Medicine, PLLC and will comply with them in all respects.

_____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____

Patient Signature (Parent/guardian signature if minor) Date

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Authorization to Bill Third-Party Payer

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: _____

DOB: _____ SS#: _____ Daytime Phone: (_____)_____

Benefits and Billing Information

☐ **Please notify the front desk staff if your visit is related to an injury or accident** ☐

I. Does your insurance have alternative medicine benefits? Yes No

Who is your Primary Care Provider?: Dr. _____ Clinic Phone #: (_____)_____

Clinic Address: _____ City:_____ State: _____ Zip Code: _____

Does your plan require you to have a referral from you Primary Care Provider to receive coverage? Yes* No

*If yes, which licensed provider were you referred to at our clinic?:_____

II. Primary Insurance Company & Plan Name: _____

ID Number: _____ Group/Policy Number: _____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

The policy holder is my: _____ (specify relationship) Policy Holder's Gender (circle): Male Female

Is your Primary Insurance Policy a (circle): POS PPO EPO HMO Don't Know Other (specify): _____

III. Secondary Insurance Company & Plan Name: _____

ID Number: _____ Group/Policy Number:_____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

The policy holder is my: _____ (specify relationship) Policy Holder's Gender (circle): Male Female

Is your Secondary Insurance Policy a (circle): POS PPO EPO HMO Don't Know Other (specify): _____

Guarantor Information

*This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: (_____)_____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X _____ _____

Guarantor's Signature **Date**

I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that some third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Vital Life Medicine, PLLC to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

X _____ _____

Patient's Signature Date

X _____ _____

Guardian/Representative's Signature Date

_____

Relationship to Patient/Representative Authority

Vital Life Medicine
E: drjodi@vitallifemedicine.com **Jodi Vingelen, ND, LMP** **T: (425) 268-8057**
1603 116th Avenue NE, Suite 111
Bellevue, WA 98004-3009
www.vitallifemedicine.com

Adult Intake Packet

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Your Health Information Privacy Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your healthcare information. Under this law your healthcare provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care.

It is important that you understand that your information can be used and shared in the following ways:
•For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
•To assist law enforcement officials in response to criminal activities and to avert a threat to an individual or to public health safety (as in outbreaks of communicable disease).
•In response to a court or administrative order.
•To bill you or to obtain payment from third party payers.
•We may share your health information with a person(s) that you have named to be involved with your healthcare.

You have the following rights relating to your protected health information:
•To inspect your health record and receive a copy of your health record upon request.
•To request limits on the use or disclosure of your protected health information.
•To request that your physician amend information in your health record you believe is inaccurate or incomplete.
•To receive an accounting of certain disclosures we have made, if any, of your protected health information.
•To receive a paper copy of this notice upon request

You have the right to receive confidential communications from us by alternative means or at an alternative location if you choose. Please tell us how to best contact you when needed:
___Please do not phone me at home. Use this alternate phone number:_____
___Please do not phone me at work. Use this alternate phone number: _____
___Please do not leave messages on my answering machine.
___Please do not contact me by email.
___Please send mail, including my bills, to this alternate address:_____
_____
___Other request (please describe): _____

By signing below, I acknowledge that I have received and read this notice of privacy practices:

_____
Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ ___/_____/_____
Patient Signature (Parent/guardian signature if minor) Date

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E-Mail Agreement

Vital Life Medicine may use e-mail to correspond with patients as a convenience.

I have been advised that:

E-mail is never, ever appropriate for urgent or emergency problems.

E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose; system operators for most e-mail systems have access to all e-mail that passes through their systems.

E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee.

There is not a way to assure the privacy of e-mail on a shared computer or e-mail account.

All e-mail correspondence will become a part of my medical record at Vital Life Medicine.

It is extremely important to include my name on each and every e-mail sent to the clinic.

Since e-mail may not be monitored while Dr. Vingelen is away on business or on vacation, I will follow-up by telephone or in person if I do not receive a response within one week.

I have been provided with information about the use of Internet e-mail to communicate matters pertaining to my health and healthcare, and I understand the issues and concerns inherent in this use.

I have been provided with information about the use of Internet e-mail communications between myself and Vital Life Medicine, including information concerning my healthcare and personal medical information. I understand that I may revoke this agreement at anytime by contacting Vital Life Medicine.

I designate that all e-mail correspondence coming from me or to me should be sent to the following Internet e-mail address:

Please print e-mail address clearly:_____

Printed Name:_____

Signature:_____ Date:_____