Consent for Treatment

I understand that the orthomolecular modality used by Mensah Medical, LLC, utilizes nutrient protocols for treatment.

By signing this form, I agree to participate in this modality with the understanding that even with the highest level of compliance, desired outcomes are not guaranteed and that levels of response may vary.

Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Print Patient's Name — Date

_____

Print Legal Guardian's Name, if applicable

For Office Use Only

Date received by Mensah Medical: _____Received by: _____

Health History Form

Date:_____

Name:_____ DOB_____ Sex: M or F

1. Education: (Last grade completed) _____

2. Significant birth events or traumas: _____

_____

3. Injuries / Head traumas: _____

_____

4. Surgeries: _____

_____

5. Number of Pregnancies: _____

6. Seasonal Allergies: _____ _____

_____ _____

7. Food or Chemical Sensitivities: _____ _____

_____ _____

8. Do you drink alcohol? _____ How frequently? _____

9. Do you / Have you used marijuana / cannabis? _____ How frequently? _____

9. Do you / Have you used other recreational drugs? _____ How frequently? _____

10. Primary Diagnosis: _____ _____

11. Other Diagnosis: _____ _____

_____ _____

12. Present Supplements / Medication: Past Supplements / Medications:

_____ _____

_____ _____

_____ _____

Name:_____

Present Supplements / Medication:	Past Supplements / Medications:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

	Check all that apply to you:	Check all that apply to your relatives:
White spots on fingernails	_____	_____
Under-achiever	_____	_____
Sensitivity to texture (i.e. fabrics)	_____	_____
Tantrums	_____	_____
Strong willed	_____	_____
Stretch marks	_____	_____
Sensitive to sound	_____	_____
Social isolation	_____	_____
Skips breakfast	_____	_____
Sensitive to loud noise	_____	_____
Ringing in the ears	_____	_____
Reading disorder	_____	_____
Psoriasis or eczema	_____	_____
Pre-mature gray	_____	_____
Poor wound healing	_____	_____
Poor short-term memory	_____	_____
Poor muscle tone	_____	_____

Name:_____

	Check all that apply to you:	Check all that apply to relatives:
Phobias and fears	_____	_____
Perfectionist	_____	_____
Panic	_____	_____
Pale skin / poor tanning	_____	_____
Sensitive to smell	_____	_____
Obsessions	_____	_____
Negative perspective	_____	_____
Mood swings	_____	_____
Menstrual irregularity	_____	_____
Sensitivity to bright lights	_____	_____
Highly creative	_____	_____
Heart murmur	_____	_____
Hallucinations	_____	_____
Fruity breath odor	_____	_____
Frequent nausea	_____	_____
Frequent infections	_____	_____
Dry mouth	_____	_____
Depression / sadness	_____	_____
Delusions	_____	_____
Delayed puberty	_____	_____
Dark urine	_____	_____
Chronic joint pains	_____	_____
Anxiety	_____	_____
"Stitch in the side" pain	_____	_____

Name:_____

	Check all that apply to you:	Check all that apply to relatives:
"Night owl"	_____	_____
ADD / ADHD	_____	_____
Ulcers	_____	_____
Kidney disorder	_____	_____
Diabetes	_____	_____
Heart disease	_____	_____
Arthritis	_____	_____
Cancer	_____	_____
Dementia	_____	_____
Stroke	_____	_____
Autism	_____	_____
Schizophrenia	_____	_____
Bipolar disorder	_____	_____
Asthma	_____	_____

Additional Comments / Explanations:

_____

_____

_____

_____

_____

_____

HIPAA Authorization Form

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). By signing this authorization, I permit **Mensah Medical, LLC** (the "Practice") to use and/or disclose individually identifiable health information (PHI) about my medical history, lab results and outcomes of any therapies provided only under the following conditions:

- with my permission or at my (the patient's) request.
- the purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.
- the Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing information without my consent or participation.

VOICE MAIL MESSAGES: Please initial in the space provided next to each of the following permissions **if you are in agreement:**

I give the Practice permission to leave a medical message on my:

_____ Home voice mail Phone: _____

_____ Work voice mail Phone: _____

_____ Cell phone voice mail Phone:_____

If I cannot be reached directly or by voice mail, the Practice may leave a message with my:

_____ Spouse Name: _____ Phone: _____

_____ Parent Name _____ Phone: _____

_____ Other: _____ Phone: _____

Please read and sign here if you agree to the following statement: **If I cannot be reached directly or by voice mail, please do not leave a medical message.**

_____

EMAIL COMMUNICATION: The Practice cannot send private medical information by email due to privacy concerns. However, the Practice does utilize email communication for appointment reminders and general announcements of new or updated services, programs, research, clinic locations, seminars, and research.

_____ I do not want to receive email communication.

_____ I consent to receive email communication as described above.

Email address (if the patient is a minor, please list the email address of the parent or legal guardian):

_____@ _____

Email address is ☐ Self ☐ Parent or Legal Guardian

I do not have to sign this authorization in order to receive treatment from Mensah Medical. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subjected to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to written revocation must be submitted to the Privacy Officer at:

Mensah Medical, LLC
4355 Weaver Parkway, Suite 110
Warrenville, IL 60555

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Date

_____
Print Legal Guardian's Name, if applicable

For Office Use Only
Date received by Mensah Medical: _____Received by: _____

Mensah Medical, LLC

Date: _____

PATIENT NAME: Last _____ **First** _____ **Middle Initial**_____

DOB: _____/_____/_____ **Sex**: M or F **Social Security #** (last 4 digits): _____

Home Phone: (_____)_____

Address: **Cell Phone**: (_____)_____

_____

_____

Zip Code: _____

Email: _____

Occupation: _____ Disabled Retired Student

Employer Phone: (_____)_____

If Patient is a minor: Mother's Name: _____

Father's Name: _____

Legal Guardian: _____

Emergency Contact: _____ Phone: (_____)_____

Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Other: _____

GUARANTOR: **Last**_____ **First** _____ **Middle Initial**_____

DOB: ____/____/____ **Sex**: M or F **Social Security #** (last 4 digits): _____

Address: **Home Phone**: (_____)_____

_____ **Cell Phone**: (_____)_____

_____

Zip Code: _____

Email: _____

Occupation: _____ Disabled Retired Student

Employer Phone: (_____)_____

Mensah Medical, LLC

Permission for Disclosure

PATIENT NAME:

Last _____ **First** _____ **Middle Initial**_____

DOB: _____/_____/_____ **Sex**: **M or F**

I, _____, give permission to:
(Printed Name of Patient)

_____	_____	_____
(Printed Name of Person)	(Relationship)	(Telephone)
_____	_____	_____
(Printed Name of Person)	(Relationship)	(Telephone)
_____	_____	_____
(Printed Name of Person)	(Relationship)	(Telephone)

to communicate with the staff of Mensah Medical, LLC on my behalf.

Signed by: _____ _____
Signature of Patient or Legal Guardian Date

_____
Print Legal Guardian's Name, if applicable

For Office Use Only
Date received by Mensah Medical: _____Received by: _____