Jack Hinkle, DOPC

Please print

Patient's Name:____

Date of Birth:____

Social Security:____

Street Address:____

City, State, Zip:____

Home Phone:____________________ Cell Phone:____________________

Email Address:____

Emergency Contact:____________________ Phone:________________

Place of Employment:____________________ Phone:________________

Preferred Pharmacy:____

Insurance Information

Name of Insurance Policy:____________________________________

ID Number:____________________ Group Number:________________

Secondary Insurance Information

Name of Insurance Policy:____________________________________

ID Number:____________________ Group Number:________________

I realize this office complies with the HIPPA (Health Insurance Portability and Accountability Act) regulations and that I have the Access to and /or copy of Jack T. Hinkle Notice of Privacy Policy.

Signature:______________________________ Date:________________

Basic Health Form Pharmacy ___________ Phone: _____________________

Name; ____ Phone: ____________________

Allergies: ____

____

Surgeries: ____

____

Past Medical Diagnoses: ____

____

Injuries: ____

____

Use of alcohol___ Nicotine___ Caffeine___ Drugs___ Other___
Root Canals___ Silver Fillings___ Blood Transfusions___ Candida___ Pregnancies___

Immunizations: Polio___ DPT___ Tetanus___ Hepatitis B___ Hepatitis A___
Chickenpox___ Yearly Flu___ Swine Flu___ Gardasil___ Other___

Home Supplements: ____

____

Current Medications: ____

____

DOCTOR'S SECTION below this line

Diagnoses:		Supplements:	
1.________	8.________	1.________	8.________
2.________	9.________	2.________	9.________
3.________	10.________	3.________	10.________
4.________	11.________	4.________	11.________
5.________	12.________	5.________	12.________
6.________	13.________	6.________	13.________
7.________	14.________	7.________	14.________

Colonoscopy______ SIG______ Pap/Breast_______ BMD_______ Mam_________ Chest_______

Jack T. Hinkle, D.O.P.C.
Board Certified Family Practice

Welcome to our clinic,

I hope that the services we offer will enhance the quality of your health. I will work with you to help you achieve your health care goals. This sheet contains some introductory information and requires your signature at the bottom. There are certain things required by the government and my insurance carrier that need to be noted.

1. This is part time practice and coverage is not available 24/7. Our focus is on prevention and optimizing your health. I am not on-call after hours or on weekends. I am not an attending physician at the hospital. If you need services after hours you are to go to one of several walk-in centers, or the emergency room for emergencies.
2. Prescription refills. It is your responsibility to keep tract of your refill needs and let us know a week before you are running out. If we happen to be unavailable we have made arrangements for Stapley's Pharmacy in St. George (435-673-3575) to provide you with enough until our return. Some medications cannot be refilled this way.
3. Be aware that I might not participate with any insurance companies in the future. Upcoming planned changes in health care & coverage will affect the privacy of your records, freedom of choice, treatment options and much more.

Three forms need your signature:

1. There is an arbitration form to be signed. Arbitration has been shown to be more efficient and less costly in adjudicating complaints should there be any.
2. The HIPPA form describes the principles for protection of and disclosure of your medical needs.
3. Medicare patients are required to sign the form that states there are many services that I offer that are not covered by Medicare. This may include some injections, vitamins, and supplements, certain clinic procedures, IV, etc.
4. After signing this form start on the history forms that the front desk will give you. If you have concerns about Candida (yeast) then ask for the Long Yeast Questionnaire.

We are glad that you are here. It is our pleasure to provide these services for you. If you have any questions concerning our policies, forms or procedures please ask.

Signature:______________________________ Date:_______________
(Patient or Legal Guardian)

Jack Terrell Hinkle, D.O.P.C.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give consent for Jack Terrell Hinkle, DOPC to disclose PHI (protected health information) about me to carry out TPO (treatment, payment and health care operations). The Notice of Privacy Practices provided by Jack Terrell Hinkle, DOPC describes such users and discloses more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Jack Terrell Hinkle, DOPC reserves the right to revise its Notice of Privacy Practices at any time. A Notice of Privacy Practices may be obtained by forwarding a written request to Jack Terrell Hinkle, DOPC privacy officer.

With this consent, Dr. Hinkle, may call home or other alternative location and leave a message on voice mail or a person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory tests results, among others.

With this consent, Dr. Hinkle, may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

With this consent, Dr. Hinkle, may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Hinkle, restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Dr. Hinkle, to use and disclose my PHI to carry out TPO.

I hereby authorize my insurance benefits to be paid directly to Jack Terrell Hinkle, DOPC realizing that I am responsible for payment of non-covered services and I hereby authorize the release of pertinent information to insurance carriers.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. If I do not sign this consent, or later revoke it, Jack Terrell Hinkle, DOPC may decline to provide treatment to me.

Signature:______________________________________ Date:____________________
(Patient or Legal Guardian)

Print Patient or Legal Guardian Name:____

Jack T. Hinkle, D.O. * **[you will need to "backspace" any line that you type information on]**

History. Name: ______________________________. **DOB** ____________. **Date**__________. **Sex** _____
Ht: _________. **Weight: in high school**________. **Highest** ________. **Now** _______. **Goal** _______.
Chief Complaints: ____
~ ____
~ ____
~ ____
~ ____
~ ____
~ ____

History of Chief Complaints (location, quality, severity, timing, signs, symptoms etc.)
~ ____
~ ____
~ ____
~ ____
~ ____
~ ____

History Sequence: (from birth put down any significant event and consequence, i.e. Allergies after the flu, arthritis after a vaccine or medication, headaches after a surgery, fatigue after __ etc., (it is important to find a trigger before the event)
~ ____
~ ____
~ ____
~ ____
~ ____
~ ____
~ ____

Energy level: ____/ 10. Worse after exercise? ____. Prolonged recovery after exercise?_____ Hx. Candida_____
Daily Stress Level: ___/ 10. **Chronic stress:** ______**months;** _____**years. Daily Fatigue Level** ___**/10.**
Allergies: ____
~ Seasons_____________ **All Year**___. **Worse: Indoors**__ **Outdoors**__ **Evenings** ___ **at bed**__ **if damp**___
~ Animals__________ **Raking leaves**__ **Mowing grass** __ **Wind**__ **Before fall frost** __ **in certain homes** __
~ in certain states ____ **previous allergy treatments** ______________ **Better with** ___________________
Food Allergies: ____
Chemical Sensitivities: ____**Breast fed**__ **Colic**__
Hx. of recurrent infections requiring antibiotics: __ **Parasites**__ **Food Poisoning**__ **Worms** __ **Lymes**__
Hx. of steroid/prednisone use? _______________**# Pregnancies**_______**Birth control use/years**_________
Habits/amount/freq.: nicotine___________ **beer**__________ **wine**___________ **soda** ______**drugs** _____
Chemical exposures: insecticide ___________ **pesticides**___________ **cleaning agents**______________
~ formaldehyde___ **petrochemicals**___________ **fumes**__________ **poor ventilation**__ **Other**___________
Home: Type______________**Old** __ **New** __ **Basement**__ **Crawl space**__ **Carpet**__ **Musty/damp/mold** ___
Central Air ___ **AC window units** __ **Air filter**__ **Water: filtered** __ **city** __, **well**___.

Occupation hx: ____
Diet: Type_____________. Previous wt. Loss diets: HCG__, Adkins__, Wt. Watchers__, S. Beach__, Other__
Cravings ____
Meals eaten: bk. ____ **lunch** ____ **dinner** _____ **snacks/when**________________.
Marital status: (circle) single married divorced separated widowed
Spiritual: worship regularly____ scripture study____ guilt or forgiveness issues____ atheist or agnostic____

Family Hx.: General ____
~ Father ____
~ Mother ____
~ Brother(s) ____
~ Sister(s) ____
~ Others ____
Dental Hx: Root canals x ___; Tooth # ____________ Silver Fillings __ Gold __ Implants __ Dentures __
~ Bridge __ Silver fillings removed ___, did your health improve after? ___. Had chelation? __________
Laboratory: (abnormal result) ____
____

Colonoscopy/results ____
Pap Smear/results: N __ HPV__ Cancer __ Mammogram/results ______________________
Bone Density/results________________ Prostate U/S ______________________
Stress Test __________________ Echocardiogram ______________________
X- Rays ____
MRI/CT scans ____
Other tests ____
Hospitalizations: ____
~ ____
____

Surgeries/outcome /residual effects: Do not list your surgeries again if listed previously. Use this section to describe any complications or health concerns that arose after any surgery.

1. ____
2. ____
3. ____
4. ____
5. ____

Conditions: Arthritis ___ Allergies ___ AIDS___ Autoimmune disorder___________ ADD___ Anemia_____ Anorexia___ Asthma___ Atherosclerosis___ Anxiety___Bleeding disorder___ Blood clots ___ Breast lump__ Bad breath___Bronchitis (chronic)___ Bulimia___ Bladder infections___ Bladder leakage___ Blood in urine__ Blood in stool___Cataracts ___ Cancer___ Chicken Pox___ Chemical dependency___Constipation___ Colitis___ Chrons___ Chronic Fatigue___ Chest Pain___, exertional___. Chronic cough___Diabetes___ Depression___ Diarrhea___ Erectile disorder___Glaucoma___ Goiter___ Gout___ Gonorrhea___ Graves___ Gall Bladder ___ Hashimoto's___Heart disease___ Heart murmur___ Heart Failure___ Heart irregularity___ Hepatitis___ Hernia___ Herpes___ High cholesterol___ HIV+___ Headaches___ Heart Burn___ Fainting ___ Hemorrhoids___ High blood pressure___ Hearing loss___ Kidney disease___ Kidney stones___ Lymes___ Liver disease___ Macular Degeneration___Measles___ Migraines___ Menstrual irregularities___________ Miscarriage___Mono___Malaria___ Multiple sclerosis___ Mumps___ Numbness__ Pneumonia___ Polio___ Prostate___Psychiatric care___ Pulmonary embolus___ Panic attacks___ Pancreatitis___ Stroke___ Swelling legs___Scarlet fever___ Suicide attempt___ Swallowing difficulty___Shortness of breath___ Thyroid problems___ Tingling___ Tonsilitis___ TB___Tinnitus___ Typhoid___ Ulcers___ Vaginal infections___ Venereal diseases_______ Difficult Delivery___ Physical/sexual abuse___ Other_______________

System Difficulties: [list any symptoms you have in these systems]

Eyes: ____________________
Ears: ____________________
Nose: ____________________
Throat: ____________________
Heart: ____________________
Lungs: ____________________
Stomach: ____________________
Colon: ____________________
Genital-Urinary-Kidney: ____________________
Joints: ____________________
Tendons: ____________________
Muscles: ____________________
Nervous System: ____________________
Memory: ____________________
Mental: ____________________
Skin: ____________________
Lymph: ____________________
Breast: ____________________
Extremities: ____________________
Immune: ____________________
Pregnancies: ____________________
Endocrine: ____________________
Sleep: Snore__ Apnea___ CPAP__ Falling asleep issues__ Wake up frequently__Frequent urination___
Immunizations: Flu Shots: _______Swine Flu Shots__________

Rank your health on scale of 1-10 [low/poor to high/great] and make any comments.
Physical: _____

Mental (clarity, focus, and logic)_____

Emotional: ___ (happy, optimistic, easygoing, vs., pessimistic, depressed, anxious, panicky)

Energy Level: _______

Spiritual: (relationship with higher being)____

Spiritual #2: _____ If there are issues of abuse, guilt or forgiveness it can be difficult to heal, as the body is the manifestation of the mind internally and externally.

Items that can impede recovery: Root Canals__, Mercury Fillings__, Chronic Infections__, Bad Teeth __, Allergies__, Cnadida__, Medications__, Financial Reserve__, Dedication & focus on healing__.

Family doctor _______________ Specialists ____________________

Hinkle Health Association

(A Private Medical Membership Association)
MEMBERSHIP CONTRACT

I, ______________________________, for membership fee paid in hand, do hereby apply for membership in Hinkle Health Association, a private medical membership organization. With the signing of this membership agreement I/we accept the offer made to become a member of Hinkle Health Association and have read and agree with the following Declaration of Purpose from Article I of Hinkle Health Association Articles of Association.

1. This Association of members hereby declares that our main objective is to protect our rights to freedom of choice regarding our medical information and care, through maintaining our constitutional rights.
2. As members, we believe that the First Amendment of the Constitution of the United States of America guarantees our members the rights of free speech, petition, assembly, and the right to gather together for the lawful purpose of advising and helping one another in asserting our rights under the Federal and State Constitutions and Statutes. We strive to maintain and improve the civil rights, constitutional guarantees, freedom of choice in medical care and political freedom of every member and citizen of the United States of America.
3. We declare the basic right of all of our members to select spokesmen from our number who could be expected to give wisest counsel and advice concerning the need for physical and mental health care assistance and to select from our membership those members who are the most skilled to assist and facilitate the actual performance and delivery of therapy, treatment and care.
4. We proclaim the freedom to choose and perform for ourselves the types of therapies and treatment modalities that we think best for diagnosing treating and preventing illness and disease of our minds and bodies and for achieving and maintaining optimum wellness. We proclaim and reserve the right to include medical and health options that include but are not limited to cutting edge treatment modalities and therapies practiced or used by any type of healers or therapists or practitioners the world over whether traditional or nontraditional, conventional of unconventional.
5. More specifically, the mission of our Association is to provide members with the highest level of quality care and the most effective methods of treatment. We try to treat their whole health pictures, and not merely the symptoms that are experienced or only according to conventional medical diagnoses. Our Association understands that wellness has many dimensions and strives every day to stay on the leading edge of new technology. The Association provides comprehensive, integrative care and educates each member as to the broad options open for the diagnosis and treatment of the member's condition. The neuro/endocrine/immune system, digestion, detoxification, holistic and nutritional alternatives to medication are addressed in the modalities of service and benefits to members.
6. The Association recognizes any person (irrespective of race, color, or religion) who is in accordance with these principles and policies as a member, and will provide a medium through which its individual members may associate for actuating and brining to fruition the purposes therefore declared.

MEMORANDUM OF UNDERSTANDING

I understand that the fellow members of the Association that provide diagnosis, therapy, treatment and care, etc., do so in the capacity of a fellow member and not in the capacity as a licensed health care provider. I further understand that with the association no doctor-patient relationship exists but only a contract member-member Association relationship. In addition, I have freely chosen to change my legal status as a public patient to a private member of the "Association". I further understand that it is entirely my own responsibility to consider the advice and recommendations offered to me by my fellow members and to educate myself as to the efficacy, risks, and desirability of same and the acceptance of the offered or recommended diagnosis, therapy, treatment and care, etc., is my own carefully considered decision. Any request by me to a fellow member to assist me or provide me with aforementioned diagnosis, therapy, treatment, and care, etc., is my own free decision in an exercise of my rights and made by me for my benefit and I agree to hold the Trustee(s), staff and other worker members and the Association harmless from any unintentional liability for the results of such care, etc., except for harm that results from instances of a clear and present danger of substantive evil as determined by the Association and as stated and defined by the United States Supreme Court.

The Trustee and members have chosen Dr. Jack T. Hinkle as the person best qualified to perform medical services to members of the Association and entrust him to select other members to assist him in carrying out that service.

In addition, I understand that, since that Association is protected by the First and Fourteenth Amendments to the U.S. Constitution, it is outside the jurisdiction and authority of Federal and State Agencies and Authorities concerning any and all complaints or grievances against the Association, and Trustee(s), members or other staff persons. All rights of complaints or grievances will be settled by an Association Committee and will be waived by the member for the benefit of the Association and its members. Because the privacy and security of medical membership records maintained within the Association which have been held to be inviolate by the U.S. Supreme Court, the undersigned member waives HIPAA privacy rights and complaint process. Medical records kept by the Association will be strictly protected and only released upon specific written request of the member. I agree that violation of any waivers in this membership contract will result in a no contest legal proceeding against me. In addition, the Association might not participate in any medical insurance plans or collections on behalf of the member, but will provide a suitable invoice for the member to pursue reimbursement by his/her insurance company, if applicable.

I agree to join the "Association", a private membership association under common law, whose members seek to help each other achieve better health and live longer with excellent quality of life.

I understand that the doctors, nurses, and other providers who are fellow members of the "Association" are offering me advice, services, and benefits that do not necessarily conform to conventional medical care. I do not expect these benefits to include on-call coverage, hospital care, or the usual and customary care provided by most physicians. I will receive such primary and specialist care elsewhere. I fully understand that the benefits I receive from the Association might or might not be covered by my health insurance.

As a member, I accept the goals of helping my body function better and choosing techniques that are both very safe and have a reasonably good chance to succeed, realizing that no diagnostic technique or treatment is foolproof. If I choose to forgo drugs, surgery, or radiation that has been recommended to me by others, I fully accept the risk that I might suffer serious consequences from that choice. Other aspects of informed consent will take place in my discussions with the providers and my fellow members of the Association.

My activities within the Association are a private matter that I refuse to share with the State Medical Board, the FDA, Medicare, Medicaid or my own insurance company without my expressed specific permission. All records and documents remain as property of the Association, even if I receive a copy of them. I fully agree not to file a malpractice lawsuit against a fellow member of the Association, unless that member has exposed me to a clear and present danger of substantive evil. I acknowledge that the members of the Association may not carry malpractice insurance and do not maintain a fund with which to pay malpractice judgements.

I enter into this agreement of my own free will or on behalf of my dependent without any pressure of promise of cure. I affirm that I do not represent any state or federal agency whose purpose is to regulate the practice of medicine. I have read and understood this document, and my questions have been answered fully to my satisfaction. I understand that I can withdraw from this agreement and terminate my membership in this association and any time. These pages and Article I of the articles of association of the "Association" consist of the entire agreement for my membership in the "Association" and they supersede any previous agreement.

I understand that the membership fee entitles me to receive those benefits declared by the Trustee(s) to be "general benefits" free of further charge. I agree to pay as levied those benefits that I receive that are declared by the Trustees to be "special assessments", according to the established Fee Schedule.

I enclose the sum of $1.00 as consideration for my life time membership contract, said term beginning with the date of the signing of this contract, and by these presents do hereby certify, attest and warrant that I have carefully read the above and foregoing Hinkle Health Association Contractual Application for Membership and I fully understand and agree with same.

IN WITNESS WHEREOF I set my hand this ______day of___________________,2012___.

____

Member's Name (Please Print Legibly) (and name of legal guardian if applicant under 18 years)

____

Member's Signature (and signature of legal guardian if applicant under 18 years)

Members Address and Phone #:

____

Street

____

City State Zip code

____

Home Phone #

____

Work Phone #

____

Cell phone #

HINKLE HEALTH ASSOCIATION

By____

Approved and accepted this____________________day of___________________, 2012.