

LABBE HEALTH CENTER

Dr. Labbe D.C., CCN, DCCN

Office Number (877) 600-5222

Fax Number (858) 272-2677

Enclosed is your Patient Information forms and Patient Symptom Survey that must be completed prior to your appointment or Phone Consultation. Please email or fax these forms to our office **prior** to your consultation (our fax number is listed above). Your punctuality on this day will ensure that you have the full time allotted for you to spend with Dr. Labbe.

For some patients, we may suggest some specific tests be done. One of these tests is a “Toxic Element Screening.” This requires taking hair samples. Prior to taking this sample, you may not perm or color your hair for 8 weeks. If you have an appointment scheduled for a perm or coloring, you may consider waiting until after your consultation.

We may also suggest a blood test for you. This requires a 12-hour fasting. You can only have water for the 12 hours prior to the test.

Please note: Lab hours are usually between 8:00AM to 5:00PM. Call our office for a location near you. If you are Diabetic or have another medical condition that makes fasting difficult please do not fast, we will take your condition into account with your testing.

Our office is located at 4747 Morena Blvd., Ste. 310 San Diego, CA 92117. We are freeway close to Interstate 5, just south of La Jolla. Please call if you need further directions.

Please give 24 hour notice if you will be unable to keep your appointment.

We look forward to meeting with you! If you have any questions, please feel free to call our office.

Yours in good health,

Dr. Joni Labbe

(877) 600-5222

LABBE HEALTH CENTER

Dr. Labbe D.C., CCN, DCCN

Office Number (877) 600-5222

Fax Number (858) 272-2677

Please fill out and sign the following forms for your consultation. This is needed for the complimentary Phone Consultation also. Please fax complete forms to (858) 272-2677.

We will provide a receipt for you to submit to your insurance. You are responsible for payment in full at the time of service.

****I clearly understand that all services rendered me are my responsibility and payment is expected at the time of service.**

Patient's Signature _____ Date _____

If under 18 years of age, parent or guardian's signature _____

Nutritional Informed Consent

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: *"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."*

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biochemical processes of the human body.

Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

I have read and understood the above:

Signature _____ Date _____



LABBE HEALTH CENTER

Dr. Joni Labbe
4747 Morena Blvd. Suite 310
San Diego, CA 92117
(858) 483-4770

First Time Evaluation Form

Today's Date: _____ Referred By: _____

Name: _____ M__ F__

Birth-date: __/__/__ Age: ____ Email: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Cell: (____) _____ Work: (____) _____

Fax: (____) _____ Height: _____ Weight: _____

Occupation: _____ Number Of Children: _____

Marital Status: S__ M__ D__ W__ Spouse's Name: _____

LABBE HEALTH CENTER

PATIENT SYMPTOM SURVEY

DATE _____

PATIENT'S NAME _____ AGE _____

WEIGHT _____ HEIGHT _____ BLOOD PRESSURE _____ PULSE _____ O₂ _____

This is a confidential patient symptom survey. Please check each condition which is true for you. If the condition does not apply to you or you do not understand a term or if you are not sure if a condition applies to you, then do not check the box. Use common sense. For example, Insomnia once in the last month probably isn't that important and would not be marked. However, Insomnia occurring 1-2 times per week is notable and would be marked. Please take your time...If you have any questions call us at (877) 600-5222 and fax completed survey to (858) 272-2677.

Primary Complaints

- | | | |
|---|---|---|
| <p>090 <input type="checkbox"/> General Good Health</p> <p>091 <input type="checkbox"/> Desires Nutritional & Metabolic Analysis</p> <p>001 <input type="checkbox"/> Skin Disorder 692.9</p> <p>002 <input type="checkbox"/> Acne 706.1</p> <p>003 <input type="checkbox"/> Psoriasis 696.1</p> <p>004 <input type="checkbox"/> Urticaria (Hives) 708.9</p> <p>005 <input type="checkbox"/> ADD/ADHD 314.00/314.01</p> <p>006 <input type="checkbox"/> Allergies, Unspecified 477.9</p> <p>007 <input type="checkbox"/> Allergic Rhinitis from food 477.1</p> <p>008 <input type="checkbox"/> Sinusitis 461.9</p> <p>009 <input type="checkbox"/> Alzheimer's 331.0</p> <p>010 <input type="checkbox"/> Poor Concentration/ Memory 310.1</p> <p>011 <input type="checkbox"/> Parkinson's Disease 332.0</p> <p>012 <input type="checkbox"/> Anemia 285.9</p> <p>013 <input type="checkbox"/> Arthritic Disorder 716.90</p> <p>014 <input type="checkbox"/> Osteoporosis 733.00</p> <p>015 <input type="checkbox"/> Asthma 493.90</p> <p>016 <input type="checkbox"/> Emphysema 492.8</p> <p>017 <input type="checkbox"/> Cancer</p> <p>018 <input type="checkbox"/> Breast 174.9female 175.9male</p> <p>019 <input type="checkbox"/> Prostate 185</p> <p>020 <input type="checkbox"/> Lung 162.9</p> <p>021 <input type="checkbox"/> Colon and Rectal 153.9</p> <p>022 <input type="checkbox"/> Skin 173.9</p> <p>023 <input type="checkbox"/> Leukemia w/o remission 208.90
Leukemia w/ remission 208.91</p> <p>024 <input type="checkbox"/> Lymphoma, malignant 202.8</p> <p>025 <input type="checkbox"/> Brain Tumor, malignant 191.9</p> <p>027 <input type="checkbox"/> Anxiety Disorder 300.00</p> <p>028 <input type="checkbox"/> Autism 299.00</p> <p>033 <input type="checkbox"/> Edema 782.3</p> | <p>034 <input type="checkbox"/> Eczema 692.9</p> <p>035 <input type="checkbox"/> Chronic Fatigue 780.71</p> <p>036 <input type="checkbox"/> Circulatory Disorder 459.9</p> <p>037 <input type="checkbox"/> Heart Disease 429.9</p> <p>038 <input type="checkbox"/> High Cholesterol 272.0</p> <p>039 <input type="checkbox"/> High Blood Pressure 401.9</p> <p>040 <input type="checkbox"/> Low Blood Pressure 458.9</p> <p>041 <input type="checkbox"/> Tachycardia
(High Heart Rate) 785.00</p> <p>042 <input type="checkbox"/> Numbness 782.0</p> <p>043 <input type="checkbox"/> Constipation 564.0</p> <p>044 <input type="checkbox"/> Indigestion 536.8</p> <p>045 <input type="checkbox"/> Ulcerative Colitis 556.9</p> <p>046 <input type="checkbox"/> Depression 311</p> <p>047 <input type="checkbox"/> Diabetes Mellitus 250.0</p> <p>030 <input type="checkbox"/> Diabetes Type I 250.01</p> <p>031 <input type="checkbox"/> Diabetes Type II 250.02</p> <p>029 <input type="checkbox"/> Hyperglycemia
[high blood sugar] 790.29</p> <p>048 <input type="checkbox"/> Hypoglycemia
[low blood sugar] 251.2</p> <p>049 <input type="checkbox"/> Dizziness/Balance Problem
780.4</p> <p>050 <input type="checkbox"/> Ear Infection 381.4</p> <p>051 <input type="checkbox"/> Epstein Barr 075</p> <p>052 <input type="checkbox"/> Eye Problems 379.91</p> <p>053 <input type="checkbox"/> Cataracts 366.9</p> <p>054 <input type="checkbox"/> Glaucoma 365.9</p> <p>055 <input type="checkbox"/> Macular Degeneration
362.50</p> <p>056 <input type="checkbox"/> Fever 780.6</p> <p>057 <input type="checkbox"/> Fibromyalgia 729.1</p> <p>058 <input type="checkbox"/> Gallbladder Disorder 575.9</p> | <p>059 <input type="checkbox"/> Gout 274.9</p> <p>060 <input type="checkbox"/> Headaches 784.0</p> <p>061 <input type="checkbox"/> Hearing Loss 389.9</p> <p>062 <input type="checkbox"/> Infertility, male 606.9</p> <p>064 <input type="checkbox"/> Liver Disease 571.9</p> <p>065 <input type="checkbox"/> Hepatitis 573.3</p> <p>066 <input type="checkbox"/> Hepatitis B 070.30</p> <p>067 <input type="checkbox"/> Hepatitis C 070.51</p> <p>068 <input type="checkbox"/> Kidney Disorder 593.9 or
Bladder Disorder 596.9</p> <p>063 <input type="checkbox"/> Prostate Disorder 602.9</p> <p>069 <input type="checkbox"/> Hyperthyroidism 242.90</p> <p>070 <input type="checkbox"/> Hypothyroidism 244.9</p> <p>071 <input type="checkbox"/> Systemic Lupus 710.0</p> <p>072 <input type="checkbox"/> Infertility, female 628.9</p> <p>073 <input type="checkbox"/> Interstitial Cystitis 595.1</p> <p>074 <input type="checkbox"/> Irregular Menstrual Cycle
626.4</p> <p>075 <input type="checkbox"/> Menopausal Symptoms 627.2</p> <p>076 <input type="checkbox"/> Hot Flashes 627.2</p> <p>077 <input type="checkbox"/> Mental Disorder 300.9</p> <p>078 <input type="checkbox"/> Insomnia 780.52</p> <p>079 <input type="checkbox"/> Mouth/Throat/Tongue</p> <p>080 <input type="checkbox"/> Canker Sores 528.2</p> <p>081 <input type="checkbox"/> Overweight 278.02</p> <p>082 <input type="checkbox"/> Underweight 783.22</p> <p>083 <input type="checkbox"/> Sexual Disorder 302.89</p> <p>084 <input type="checkbox"/> Spinal Problems 724.9</p> <p>085 <input type="checkbox"/> Obesity 278.00</p> <p>086 <input type="checkbox"/> GERD 530.81</p> <p>087 <input type="checkbox"/> HIV 042</p> <p>088 <input type="checkbox"/> Crohn's Disease 555.9</p> <p>089 <input type="checkbox"/> Irritable Bowel Syndrome
564.1</p> |
|---|---|---|

- | | | |
|---|---|---|
| 092 <input type="checkbox"/> Normal Pregnancy v22.2
**only applicable if <i>currently</i> pregnant | 142 <input type="checkbox"/> Non-Systemic Lupus 695.4 | 146 <input type="checkbox"/> Scleroderma 710.1 |
| 093 <input type="checkbox"/> Shingles 053.9 | 143 <input type="checkbox"/> Multiple Sclerosis 340 | 171 <input type="checkbox"/> Goiter 240.9 |
| 140 <input type="checkbox"/> Migraines 346.90 | 144 <input type="checkbox"/> ALS Lou Gerigs disease
335.20 | 178 <input type="checkbox"/> Raynaud's Syndrome 433.8 |
| 141 <input type="checkbox"/> Rheumatoid Arthritis 714.0 | 145 <input type="checkbox"/> Polymyalgia Rheumatica
725 | 179 <input type="checkbox"/> Hemochomatosis 275.0 |
| | | 180 <input type="checkbox"/> Thalassemia 282.49 |
| | | 181 <input type="checkbox"/> Brain aneurysm 431 |

If necessary, please state your most significant concern...

General Health

- | | |
|--|---|
| 100 <input type="checkbox"/> Fingernail base is pink | 124 <input type="checkbox"/> Unexplained weight loss of over 20lbs within the last 4 months |
| 101 <input type="checkbox"/> Fingernail base is purple | 125 <input type="checkbox"/> Energy level is worse than it was 5 years ago |
| 102 <input type="checkbox"/> Fingernails have ridges or white spots | 127 <input type="checkbox"/> Sleeps less than 6 hours per night |
| 103 <input type="checkbox"/> Fingernails are soft | 128 <input type="checkbox"/> Unable to recall dreams the next day |
| 104 <input type="checkbox"/> Fingernails are splitting | 129 <input type="checkbox"/> Sensitive to chemicals, paint, fumes, cologne |
| 105 <input type="checkbox"/> Fingernails peel | 130 <input type="checkbox"/> Had blood transfusion in the past |
| 106 <input type="checkbox"/> Pale fingernail beds | 131 <input type="checkbox"/> Had transplant in the past |
| 107 <input type="checkbox"/> Blacks out easily | 138 <input type="checkbox"/> Takes anti-rejection drugs |
| 108 <input type="checkbox"/> Balance problems | 132 <input type="checkbox"/> Had a major accident or injury |
| 109 <input type="checkbox"/> Difficulty walking | 137 <input type="checkbox"/> Sleep Apnea |
| 110 <input type="checkbox"/> Has tattoos | 139 <input type="checkbox"/> Toxic chemical exposure |
| 111 <input type="checkbox"/> Brittle hair | 175 <input type="checkbox"/> Has been out of the country recently |
| 112 <input type="checkbox"/> Dry hair | 176 <input type="checkbox"/> Had childhood vaccines |
| 113 <input type="checkbox"/> Thin hair | 177 <input type="checkbox"/> Had a vaccine in the last 12 months |
| 114 <input type="checkbox"/> Hair loss | 147 <input type="checkbox"/> Had a flu shot last year |
| 115 <input type="checkbox"/> Drinks alcoholic beverages daily | 182 <input type="checkbox"/> Had a pneumonia vaccine last year |
| 116 <input type="checkbox"/> Drinks less than 8 glasses of water per day | 183 <input type="checkbox"/> Had a Hepatitis B vaccine in the last 2 years. |
| 117 <input type="checkbox"/> Currently on Chemotherapy | Has a family history of: |
| 118 <input type="checkbox"/> Currently on radiation treatment | 184 <input type="checkbox"/> Cancer |
| 148 <input type="checkbox"/> Had radiation therapy in the last year | 185 <input type="checkbox"/> Heart Disease |
| 149 <input type="checkbox"/> Had chemotherapy in the last year | 186 <input type="checkbox"/> Diabetes |
| 119 <input type="checkbox"/> Had chemotherapy in the past | 187 <input type="checkbox"/> Alcoholism |
| 120 <input type="checkbox"/> Has had radiation treatments in the past | 188 <input type="checkbox"/> Depression |
| 121 <input type="checkbox"/> Gained over 20 lbs in the last 12 months | 189 <input type="checkbox"/> Obesity |
| 122 <input type="checkbox"/> Somewhat Overweight | |
| 123 <input type="checkbox"/> Somewhat Underweight | |

Lifestyle Habits

- | | | |
|--|--|--|
| 380 <input type="checkbox"/> Drinks beverages from a can | 373 <input type="checkbox"/> Drinks caffeinated tea | 376 <input type="checkbox"/> Drinks decaffeinated tea |
| 370 <input type="checkbox"/> Drinks alcohol | 374 <input type="checkbox"/> Drinks decaffeinated coffee | 377 <input type="checkbox"/> Drinks more than 3 cups of coffee per day |
| 371 <input type="checkbox"/> Drinks caffeinated coffee | 375 <input type="checkbox"/> Drinks decaffeinated pop/soda drinks per week | 378 <input type="checkbox"/> Drinks more than 3 cups of tea per day |
| 372 <input type="checkbox"/> Drinks caffeinated pop/soda | | |

- 388 Drinks diet pop/soda
 379 Drinks 1 or more pop/sodas per day
 I had 4 alcoholic drinks in one day:
 172 never
 173 more than 3 months ago
 174 less than 3 months ago
 389 Anorexia

- 381 Has more than 5 alcoholic
 391 Craves sugar / starches
 382 Currently smokes
 383 Quit smoking in the last 5 years
 384 Smoked for more than 5 years
 385 Smokes more than 1 pack per day

- 126 Rarely exercises
 133 Regularly exercises
 386 Takes Vitamins
 134 Vegetarian
 135 Eats no red meat
 136 Eats no meat, no dairy
 387 Frequent use of artificial sweeteners
 389 Anorexia
 390 Bulimic

Surgeries

- 700 Tonsillectomy and/or Adenoids
 701 Appendix
 702 Gallbladder
 703 Thyroid
 715 Radiated thyroid
 708 Cancer

- 704 Hysterectomy, complete
 705 Hysterectomy, partial
 706 Tubal ligation
 707 Breast implants
 709 Coronary by-pass
 710 Spinal surgery

- 711 Extremity surgery
 712 Hip replacement
 713 Knee replacement
 714 Splenectomy
 716 Cataract surgery
 717 Hemorrhoidectomy

Gastrointestinal

- 265 4-5 bowel movements per week
 266 3 or less bowel movements per week
 267 6 or more bowel movements per week
 268 Black tarry stools
 269 Pale or yellow colored stool
 270 Blood stools
 271 Constipation
 272 Hemorrhoids
 273 Loose bowel movements
 274 Frequent diarrhea
 275 Frequent nausea
 276 Frequent vomiting
 277 Abdominal gas
 278 Belching and burping after eating
 279 Bloating after eating
 280 Severe abdominal pains
 281 Stomach ulcers
 282 Uses digestive aids
 283 Uses laxatives

- 284 Immediate indigestion upon eating
 285 Indigestion in 2 hours or more after meals
 286 Indigestion within 1 hour after meals
 287 Difficulty swallowing
 288 Eating relieves fatigue
 289 Eats when nervous
 290 Excessive hunger
 291 Poor appetite
 292 Experiences fainting spells when hungry
 293 Feels shaky when hungry
 294 Frequently drowsy after eating a meal
 295 Gall bladder disease
 296 Has had intestinal worms
 297 Reflux/Hiatal hernia
 298 Liver disease
 299 Irritable Bowel Syndrome
 300 Diverticulitis
 301 Diverticulosis

Respiratory

- 485 Catches severe colds
 486 Chronic chest condition
 487 Chronic cough

- 488 Constant runny nose
 489 COPD
 490 Difficulty breathing

- 491 Frequent colds
 492 Frequent nose bleeds
 493 Frequent sinus infections

- 494 Frequent stuffy nose
- 495 Hay fever
- 498 Post nasal drip

- 496 Nasal polyps
- 497 Night sweats
- 501 Spits up phlegm

- 499 Sneezing spells
- 500 Spits up blood
- 502 Wheeze

Mouth and Throat

- 400 Bad breath
- 401 Bitter taste in the mouth in the morning
- 402 Dry mouth
- 403 Excessive saliva
- 404 Sores or cracks in the corners of the mouth
- 405 Glands often swell
- 406 Frequent canker sores

- 407 Frequent fever blisters
- 408 Frequent sore throats
- 409 Frequently has a sore tongue
- 410 Sore gums
- 411 Swollen gums
- 412 Swollen tongue
- 413 Tongue burns

- 414 Tongue has grooves or fissures
- 415 Tongue is coated
- 416 Gums bleed when brushing teeth
- 417 Toothaches
- 418 Amalgam dental fillings
- 420 Other dental fillings (gold, composite, etc)
- 419 Has had root canal(s)

Endocrine

- 245 Coarse hair
- 246 Coarse skin
- 247 Diabetic
- 248 Excessive thirst
- 249 Frequently feels cold
- 250 Frequently feels hot
- 251 Gets lightheaded when standing quickly
- 252 Heals slowly

- 253 Unusually jumpy or nervous
- 254 Unusually tired most of the time

Cardiovascular

- 190 Cold feet
- 191 Cold hands
- 192 Experiences shortness of breath while sitting still
- 193 Heart skips beats
- 194 Tendency of High blood pressure
- 195 Leg cramps during bedtime
- 196 Leg cramps during daytime
- 197 Low blood pressure at times

- 198 Pain in leg/hips when walking
- 199 Frequent swollen ankles
- 200 Pains in the heart or chest
- 201 Spells of rapid heart rate
- 202 Troubled with blood clots
- 203 Unusually slow pulse rate
- 204 Varicose veins
- 205 Heart palpitations

Skin

- 520 Bruises easily
- 521 Excessive perspiration
- 522 Frequent goose bumps
- 523 Has acne
- 524 Has Psoriasis
- 525 Hives
- 526 Itchy skin
- 527 Problems with Eczema
- 528 Has moles which are changing in size and/or color
- 530 Skin is rough, especially on the back of the arms

- 529 Skin eruptions
- 531 Skin is tender
- 532 Sores that heal slowly
- 533 Troubled with boils
- 534 Dry skin

Ears

- 220 Discharge from ears
- 221 Hard of hearing
- 222 Punctured ear drum
- 223 Recurrent ear infection

- 224 Ringing or noises in the ears
- 225 Tinnitus

Eyes

- 320 Bloodshot eyes
- 321 Blurred vision
- 322 Cross eyes
- 323 Eye pain

- 324 Eyes feel gritty
- 325 Eyes watery

- 326 Mild Glaucoma
327 Far sighted

- 328 Developing cataracts
330 Itchy eyes
331 Near sighted

- 329 Mild Macular degeneration
332 Dry Eyes

Feet

- 350 Corns
351 Frequent foot cramps
352 Heel spurs

- 353 Painful feet
354 Plantar warts

- 355 Swelling in the feet and/or ankles
356 Plantar fasciitis
357 Fungal Infection

Neuromuscular

- 440 Bites nails
441 Frequent muscle soreness
442 Muscle spasms
443 Muscle weakness
444 Tremors
445 Frequent headaches
446 Often dizzy
447 Frequently feels faint
448 Has Epilepsy

- 449 Has motion sickness
450 Has Osteoarthritis
451 Has Rheumatism
452 Rheumatoid Arthritis
453 Joint stiffness in the morning
454 Swollen joints
455 Leg pain at rest
456 Spinal curvature

- 457 Low back pain
458 Neck pain
459 Pain between the shoulders
460 Shoulder/arm pain
461 Numbness/tingling in the body
462 Sleep walks
463 Stutters or stammers
464 Nerve pain

Behavior Patterns

- 150 Afraid to eat anywhere except home
151 Always needs someone to advise
152 Cries often
153 Difficulty concentrating
154 Difficulty falling asleep
155 Difficulty staying asleep
156 Easily angered
157 Feelings are easily hurt
158 Frequently becomes scared for no reason
159 Frequently miserable or blue
160 Has to be on guard even with friends

- 161 Often annoyed by people
162 Recurrent bad dreams
163 Sometimes wishes to be dead or away from it all
164 Upset by criticism
165 Poor memory
166 Scared to be alone
167 Strange people or places cause fear
168 Under considerable emotional stress
169 Unhappy when other are happy
170 Brain fog

Urinary

- 555 Urinates more than 2 times per night
556 Bed wetting
557 Blood in the urine
558 Difficulty starting urination
559 Painful urination
560 Frequent urination

- 561 Troubled by urgent urination
562 Incontinence when sneezing or laughing
563 Loses bladder control
564 Frequent bladder infections
565 Frequent kidney infections
566 Kidney stones

Men Only

- 585 Difficulty completing intercourse
586 Difficulty getting or keeping an erection
587 Discharge from the urethra
588 Had a vasectomy
589 Had difficulty fathering children
590 Lumps in the testicles

- 591 Painful genitals
592 Prostate troubles
593 Sores on external genitalia
594 Herpes
595 Sexual diseases

Please list all drugs taken within the last five years including over the counter drugs, antibiotics, aspirin, inhalers, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.

<u>DRUG</u>	<u>PRESCRIBED FOR:</u>	<u>HOW LONG</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all vitamins/herbs/supplements you are currently taking. Also, list how much of each supplement you are taking.

VITAMIN/HOW MUCH/BRAND

Please list your health goals in order of importance.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

On a scale of 0-10 (10 being the most motivation possible, 0 being no motivation at all) Please rate your motivation to achieve the above health goals by circling the appropriate number below.

0 1 2 3 4 5 6 7 8 9 10

HIPAA PRIVACY RULE

The department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for health care providers to obtain their patient’s consent for uses and disclosures of health information about the patient in order to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records, and will do all we can to secure and protect your privacy. We strive to take all necessary precautions to protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information only to those we feel are in need of your health care information, information about your treatment, payment, or health care operations.

We also want you to know that we grant your full access to your own personal medical records. We may have indirect treatment relationships with facilities (such as laboratories that only interact with physicians and not patients). We may have to disclose personal health information for purposes of treatment, payment, or health care operations to these facilities. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Signature: _____ Date: _____

Print Name: _____

LABBE HEALTH CENTER

Dr. Labbe D.C., CCN, DCCN

Office Number (877) 600-5222

Fax Number (858) 272-2677

Informed Consent for Nutritional Consultation

Advanced Nutritional Programs

I acknowledge that Dr. Labbe and staff members of Labbe Health Center are not medical doctors. I understand that Dr. Labbe and staff members provide nutritional and other health-related information to help me attain and maintain my best health. Dr. Labbe will determine which nutrients my body needs bolstered. All recommendations are designed to help me move towards my best state of health through habits and advanced nutrition. I understand that Dr. Labbe and staff members do NOT diagnose, treat or claim to cure cancer or any other disease.

Missed Appointments or Late Cancellations

Are costly to Dr. Labbe and deny other individuals the opportunity to use that time. **Unless a true emergency exists, we require that all cancellations be made at least 24 hours in advance.** If you miss an appointment, or cancellations are not made in advance, **you will be charged for that appointment time.**

Office Fees

The office visit fee for Dr. Joni Labbe is \$250.00 per hour (based on 55 minutes per hour), prorated for the actual time spent with the client. The initial visit is typically 60 to 90 minutes which includes a thorough review of present nutritional concerns and an advanced, comprehensive nutritional program including recommended state-of-the-art nutritional supplements. Nutritional testing will be performed to pinpoint-target special body needs. Follow-up appointments are recommended at 3 week intervals and average 60 minutes or less per session, depending on the extent of each client's needs and concerns. Please note: If paying by check, an additional \$30.00 processing fee will be assessed for each returned check or "stop payment" check.

"Essentials Only" Program

You may wish to have an "Essentials Only" Nutritional Program with an abbreviated consultation time, such as 30 minutes. This program will provide essential nutritional recommendations, including recommended nutritional supplements. The fee for this program is the same as above (\$250.00 per hour), but prorated for the actual time spent with the client. If you wish to have an "Essentials Only" program, please indicate this when you schedule your appointment.

Time Allotment

It is your responsibility to observe the length of time your consultation is taking. Although Dr. Labbe is glad to answer your questions as your consultation proceeds, it naturally extends the length of your consultation time. If you do not wish to go beyond a certain time limit, please inform Dr. Labbe before consultation begins.

Interruptions

Due to the busy nature of our office, occasionally there may be interruptions during your consultation time. If this happens, the number of minutes of the interruption will be deducted from your total time. We apologize for any inconvenience.

Follow-Up Questions

After your consultation, if you have a brief question about your program, you may fax your question to Dr. Labbe at our office at (858) 272-2677. Please write or print clearly in dark ink and include your full name, your brief question, the date and your fax number. Address the fax to Dr. Labbe. Dr. Labbe's staff will then fax back to you a brief answer. The fax return will be attempted only twice, so be sure your fax is hooked up and has sufficient paper. There is not a charge for this brief question-answer fax procedure. If you have more than a brief question, please see "Telephone Consultations."

Telephone Consultations

If you have many questions and/or would like to speak personally with Dr. Labbe, please call to schedule a 15-minute consultation time (or longer). Dr. Labbe will then answer your questions during the scheduled consultation time. Consultation fees are calculated at \$65.00 per 15 minutes.

I have read this informed consent and understand it. I am not a minor (under the age of 18). Additionally, I am here on this day and any subsequent visit, solely on my own behalf and not as an agent for any federal, state, or local agencies on a mission of entrapment or investigation.

Signature _____

Date _____

Printed Name _____

Please note: This form must be signed and dated.

LABBE HEALTH CENTER

Dr. Labbe D.C., CCN, DCCN

Office Number (877) 600-5222

Fax Number (858) 272-2677

Patient Authorization for Use and Disclosure of Protected Health Information

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a). a postcard mailed to me at the address provided by me; and b). telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative
(e.g., Attorney, Guardian, Parent if a minor):

Relationship

Date Signed: _____

LABBE HEALTH CENTER

Dr. Labbe D.C., CCN, DCCN

Office Number (877) 600-5222

Fax Number (858) 272-2677

Nutritional Informed Consent

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g)(1), the term “DRUG” is defined to mean: “Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.”

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient’s diet in order to supply good nutrition supporting the physiological and biochemical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

I have read and understand the above:

Signature: _____

Date: _____

LABBE HEALTH CENTER

Dr. Labbe D.C., CCN, DCCN

Office Number (877) 600-5222

Fax Number (858) 272-2677

4747 Morena Blvd Suite 310

San Diego, CA 92117

Our Nutrition Return Policy:

All returns must be within 30 days of date of purchase. All items must have the original plastic seal over them, unopened. We will credit your account or reimburse your credit card with a \$25.00 re-inventory fee deducted from the balance.

We cannot accept opened supplement containers. No exceptions.
Thank you.

Customer _____ Date _____

Shipping Fees:

All Apex orders over \$250.00 have no shipping charge. We ship throughout the U.S. and use standard carrier fees from UPS. Fees are determined by weight, but cannot be pre-determined. Please note that shipping charges will be added to your order.

Customer _____ Date _____