Welcome to the Center for Living Health as a new patient of Morgan Allen, CHC.

The Center for Living Health was founded by husband and wife team Michael Allen MD and Linda Lazar Allen CAMT. Together they created a heart centered practice that consciously strives to bring balance, strength and optimal health to the whole person by integrating conventional and holistic medicine and therapies. We look forward to supporting you in a more balanced approach to health.

Enclosed is our new patient packet. This packet contains notices and agreements that need to be read and signed **before** your first appointment. It can take awhile to fill out the forms completely; and we have found that a detailed patient history is one of the most effective ways of discovering the root cause of troublesome symptoms**.**

Please be sure to complete this form ahead of time and bring it to your visit.

Please read through our cancellation policies and be aware of your commitment as a patient of our practice. Missed appointments are costly and take away valuable appointment time from others.

Our team of providers and support staff at The Center for Living Health are committed to providing you with the highest level of personalized integrative care and working together with you as partners in your health and healing.

Again, welcome to the Center for Living Health.
We look forward to seeing at your upcoming appointment.

Office Practices and Policies

Cancelling Appointments/Missed Appointments

- Appointment changes with Morgan must be at least 2 business days prior to your scheduled appointment.
- Patient agrees to pay all late cancellation and missed appointment fee's.

PPO Insurance

We are an out of Network provider, which means we do not participate with any insurance company. All patients must pay at time of service for their care.

Unpaid Balance Fees
I understand and agree to pay Overdue/Unpaid Balance Fee's as follows: 1) 10% unpaid balance fee applied to all balances 30 days past due. A second 10% fee will be applied to all balances 60 days overdue . 2) Unpaid balances past due 90 days will be sent to collections and a 50% collection fee will be applied to your account.

Our Notice of Privacy Practices
Private controlled use of your information by staff is essential to your care. Patient Understands and Agrees That By Signing the New Patient Form: .

- Patient consents to CFLH's use and disclosure of protected health information about you for treatment, payment & health care operations (TPO)
- Patient consents Center for Living Health staff to call, text, email and leave messages on voice mail that assist the practice in carrying out TPO such as appointment reminders, statements and calls pertaining to my care, using the address or numbers I provide.
- Copy of our Privacy Practices is available on our website or in our office.

Patient Consent to Use of Telemedicine

By signing this form, I understand the following:

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

I have read and understand the information provided above regarding telemedicine. I hereby authorize Center for Living Health practitioners to use telemedicine in the course of my diagnosis and treatment when I request it.

Signature of Patient (or parent if under 18):_____

Date: _____

If authorized signer, relationship to patient: _____

Patient Information

Teen Patient Form

Please write or print clearly. All of your information will remain confidential between you and the Integrative Nutrition Health Coach.

PERSONAL INFORMATION

First Name: _____

Last Name: _____

Email: _____ How often do you check email? _____

Phone: Home: _____ Mobile: _____

Age: _____ Height: _____ Date of Birth: _____ Place of Birth: _____

Current weight: _____ Weight six months ago: _____ One year ago: _____

Would you like your weight to be different? _____ If so, what? _____

Why did you come for a Nutritional Consult? _____

SOCIAL INFORMATION

What is your relationship status? _____

What grade are you in? _____

Do you enjoy school? Please explain: _____

_____

Do you have a large or small group of friends? _____

HEALTH INFORMATION

Please list your main health concerns: _____

_____

Other concerns? _____

Any serious illnesses/hospitalizations/injuries? _____

_____

How is/was the health of your mother? _____

How is/was the health of your father? _____

Where do your parents and grandparents come from? _____

How is your sleep? _____ How many hours? _____ Do you wake up at night? _____

Why? _____

Constipation/Diarrhea/Gas? Please explain: _____

Allergies or sensitivities? Please explain: _____

MEDICAL INFORMATION

Are you concerned with body image? Please explain: _____

_____

Do you have any healers, helpers, therapies, or pets? Please list: _____

_____

What role does exercise, sports, and activities play in your life? _____

_____

FOOD INFORMATION

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

What is your food like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes?

What percentage of your food is home-cooked?

Do you enjoy the food?

Where do you get the rest from?

Do you crave sugar, coffee, cigarettes, or drugs? Please explain?

The most important thing I should do to improve my health is:

ADDITIONAL INFORMATION

Anything else you would like to share?

GIRLS ONLY

Are your periods regular? _____

How many days is your flow? _____

How frequent? _____

Painful or symptomatic? Please explain: _____

What is your birth control history? _____

Do you experience yeast infections or urinary tract infections? Please explain: _____