Initial Intake Form

Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How did you hear about us:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (Mobile):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Home):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please* ***circle*** *the phone numbers above where it is okay to leave messages.*

Preferred method of contact: ❑ Call ❑ Text ❑ Email

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_# of hours worked/week:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (Mobile):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance:** Please provide a copy of your insurance card(s)

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_\_\_\_

Relationship to patient (if other than self):

**Policy/Member ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pharmacy:**

Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT HEALTH CARE**

Are you currently receiving healthcare? ❑Yes ❑No

If **yes**, where/from whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If **no**, when and where did you last receive healthcare?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is/was the reason?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSONAL MEDICAL HISTORY**

List any surgeries, hospitalizations, imaging (CT, MRI, EEG, EKG, etc), please include dates:

**IMMUNIZATION HISTORY**

❑Polio ❑Tetanus shot ❑Measles/Mumps/Rubella ❑Hepatitis A ❑Pertussis ❑Diphtheria ❑Chicken pox ❑Tuberculosis ❑Hepatitis B ❑ HIB ❑ Flu shot Date? \_\_\_\_\_\_\_\_\_\_ ❑Others\_\_\_\_\_\_\_\_\_\_\_\_

Childhood Illness: ❑Chicken Pox ❑Mononucleosis ❑Rubella ❑German Measles ❑ Diptheria

 ❑Strep Throat ❑Tuberculosis ❑ Scarlet Fever

**Preventative Screening Tests:**

*List the most recent date and test result if known.*

Routine Blood Tests (CBC, lipids, etc):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_

**Sex:** Female  /  Male  /  Intersex  /  FtoM Male  /  MtoF Female

**Women**:

Pap smear Date:\_\_\_\_\_\_\_\_\_\_\_\_ ❑Normal ❑Abnormal

Mammogram Date:\_\_\_\_\_\_\_\_\_\_\_\_ ❑Normal ❑Abnormal

**Men**:

❑ PSA (prostate) Date:\_\_\_\_\_\_\_\_\_\_\_\_ PSA number? \_\_\_\_\_\_\_\_\_

**Social History:**

**Exercise**

Do you exercise? ❑Yes ❑No

If **yes**, what type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_minutes/day:\_\_\_\_\_\_\_\_\_days/week:\_\_\_\_\_\_\_\_

**Diet**

Do you follow a particular diet (ie, vegan, vegetarian, gluten-free, dairy-free, Atkins, Blood Type Diet, Low fat, etc)? ❑Yes ❑No Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tobacco Use**

Smoke Cigarettes: ❑Yes, currently ❑Yes, in the past. Date quit:\_\_\_\_\_\_\_ ❑Never smoked

If you marked Yes, currently or past, please indicate: Packs per day:\_\_\_\_\_\_ Years of use:\_\_\_\_\_\_

Other tobacco use: ❑Pipe/Cigar/Chew/Snuff Years of Use:\_\_\_\_\_\_\_\_\_

Tobacco exposure: ❑Second-hand smoke. Years of exposure:\_\_\_\_\_\_\_\_\_

**Alcohol use**

Do you drink alcohol? ❑Never ❑Past # drinks/wk:\_\_\_\_\_\_\_ ❑Currently # drinks/wk:\_\_\_\_\_\_\_

Have you been treated for alcoholism? ❑Yes ❑No

**Drug use**

Do you use recreational drugs? ❑Yes ❑No ❑Yes, in the past only

If **yes**, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Caffeine Intake**

Do you drink caffeinated versions of the following (please **circle**): coffee tea soda cocoa

How much of the previously circled beverages do you drink in one day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much plain water do you drink in one day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mental Health**

Have you had any times of major psychological trauma? ❑Yes ❑No

Age:\_\_\_\_\_\_\_\_ Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age:\_\_\_\_\_\_\_\_ Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age:\_\_\_\_\_\_\_\_ Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received mental health counseling? ❑Yes ❑No

**Toxic Exposure**

Have you had exposure to toxic chemicals/metals, pesticides/herbicides or paints?

If **yes**, what type and when:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL**

What time of day is your energy: Best:\_\_\_\_\_\_\_\_\_\_Worst:\_\_\_\_\_\_\_\_\_\_Is this a change? Y/N

**Sleep**

How many hours of sleep do you get in a typical night? \_\_\_\_\_\_ Do you wake refreshed? [ ]Yes [ ] No

**Family History**

***Answer or check those applicable:***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Father** | **Mother** | **Brothers** | **Sisters** | **Spouse** | **Children** |
| Age (if living) |  |  |  |  |  |  |
| Health G= good P= poor |  |  |  |  |  |  |
| Cancer |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |
| Epilepsy |  |  |  |  |  |  |
| Mental Illness |  |  |  |  |  |  |
| Asthma, Hay fever, Hives |  |  |  |  |  |  |
| Anemia |  |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |  |
| Glaucoma |  |  |  |  |  |  |
| Tuberculosis |  |  |  |  |  |  |
| Age (at death) |  |  |  |  |  |  |
| Cause of death |  |  |  |  |  |  |

**REVIEW OF SYSTEMS**

**For the following please circle: Y = Yes/Current issue N = No/Never had P = Past problem**

**MENTAL/EMOTIONAL**

Depression Y N P

Mood Swings Y N P

Anxiety/Nervousness Y N P

Tension Y N P Memory Problems Y N P

Poor Concentration Y N P

Considered suicide Y N P

Attempted suicide Y N P

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SKIN**

Rashes Y N P

Itching Y N P

Changes in skin color Y N P

Acne/boils Y N P

Eczema Y N P

Lumps/bumps Y N P

Hair Loss Y N P

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEAD**

Headaches Y N P

Head Injury Y N P

Jaw issues or TMJ Y N P

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NECK**

Lumps in neck Y N P

Swollen Glands Y N P

Goiter Y N P

Pain or Stiffness in neck Y N P

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EYES**

Impaired Vision Y N P

Glasses or Contacts Y N P

Eye Pain or strain Y N P

Tearing or dryness Y N P

Double Vision Y N P

Glaucoma Y N P

Cataracts Y N P

Color blindness Y N P

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EARS**

Impaired hearing Y N P

Ringing in ears Y N P

Earaches Y N P

History of ear infections Y N P

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOSE, THROAT, MOUTH**

Stuffy nose Y N P

Frequent Colds Y N P

Frequent sore throats Y N P

Sinusitis Y N P

Hoarseness Y N P

Sore Tongue or lips Y N P

Gum Problems Y N P

Tooth Problems Y N P

Teeth grinding Y N P

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESPIRATORY**

Cough Y N P

Excess Sputum Y N P

Coughing up Blood Y N P

Wheezing Y N P

Asthma Y N P

Bronchitis Y N P

Pneumonia Y N P

Pleurisy Y N P

Emphysema Y N P

Pain with Breathing Y N P

Shortness of Breath Y N P

 -Lying down? Y N P

Tuberculosis Y N P

**CARDIOVASCULAR**

High Blood Pressure Y N P

Heart Disease Y N P

Angina Y N P

Chest Pain Y N P

Murmurs Y N P

Rheumatic Fever Y N P

Swelling in ankles Y N P

Palpitations, Fluttering Y N P

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERIPHERAL VASCULAR**

Deep Leg Pain Y N P

Cold Hands and Feet Y N P

Varicose Veins Y N P

Thrombophlebitis Y N P

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BLOOD**

Anemia Y N P

Easy Bleeding or Bruising Y N P

Previous Blood Transfusion Y N P

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GASTROINTESTINAL**

Trouble Swallowing? Y N P

Change in Thirst Y N P

Change in Appetite Y N P

Nausea Y N P

Vomiting Y N P

Vomiting Blood Y N P

Bowel Movements: Frequency? \_\_\_\_\_

Is this a change? Y N P

Blood in Stool Y N P

Black stools Y N P

Diarrhea Y N P

Constipation Y N P

Abdominal pain or cramps Y N P

Heartburn Y N P

Belching or passing gas Y N P

Jaundice (yellow skin) Y N P

Liver Disease Y N P

Gall Bladder Disease Y N P

Ulcer Y N P

Hemorrhoids Y N P

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NEUROLOGIC**

Fainting Y N P

Vertigo or Dizziness Y N P

Seizures Y N P

Paralysis Y N P

Muscle Weakness Y N P

Numbness/Tingling Y N P

Loss of Memory Y N P

Loss of Balance Y N P

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ENDOCRINE**

Hypothyroid Y N P

Heat/Cold Intolerance Y N P

Excessive Thirst Y N P

Excessive Hunger Y N P

Fatigue Y N P

Hyperthyroid Y N P

Diabetes Y N P

-Type 1 or 2? \_\_\_\_\_\_\_

Seasonal depression Y N P

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MUSCULOSKELETAL**

Joint Pain or Stiffness Y N P

Arthritis Y N P

Broken Bones Y N P

Muscle Spasms Y N P

Weakness Y N P

Sciatica Y N P

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMMUNE**

Reactions to vaccines Y N P

Persistent swollen glands Y N P

Slow wound healing Y N P

Chronic fatigue Y N P

Chronic infections Y N P

Night sweats Y N P

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BREASTS**

Do you perform self-exams? Y N P

Breast Lumps Y N P

Pain or Tenderness? Y N P

Nipple discharge? Y N P

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FEMALE REPRODUCTIVE**

Are you sexually active? Y N P

Sexual orientation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth control? Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age of first Menses \_\_\_\_\_\_\_\_\_\_\_

Age of Last Menses if

menopausal:\_\_\_\_\_\_\_\_\_\_\_\_

Date of last Pap smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abnormal Pap smear? Y N

If yes, date:\_\_\_\_\_\_\_\_\_

Duration of Menses: \_\_\_\_\_\_\_\_\_ days

Length of Cycle: \_\_\_\_\_\_\_\_\_ days

Regular Cycles Y N

Bleeding Between Periods Y N P

Painful Menses Y N P

Excessive/Heavy Flow Y N P

PMS? Y N P

If so, what symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Menopausal Symptoms Y N P

Vaginal odor Y N P

Vaginal Discharge Y N P

Endometriosis Y N P

Ovarian Cysts Y N P

Gonorrhea Y N P

Chlamydia Y N P

Genital Warts Y N P

Herpes Y N P

Syphilis Y N P

Pain with Intercourse Y N P

Sexual Difficulties Y N P

Difficulty Conceiving Y N P

Number of Pregnancies: \_\_\_\_\_\_\_\_\_\_

Number of Live Births: \_\_\_\_\_\_\_\_\_\_\_

Number of Miscarriages:\_\_\_\_\_\_\_\_\_\_

Number of Abortions: \_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MALE REPRODUCTIVE**

Are you sexually active? Y N

Sexual orientation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth control? Type: \_\_\_\_\_\_\_\_\_\_\_\_\_

Hernias Y N P

Testicular Masses Y N P

Testicular Pain Y N P

Penile Discharge or Sores Y N P

Gonorrhea Y N P

Chlamydia Y N P

Genital Warts Y N P

Herpes Y N P

Syphilis Y N P

Prostate Disease Y N P

-What Type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Impotence Y N P

Premature Ejaculation Y N P

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List all Allergies (Medication, Food, Animals, ect.)**

|  |  |
| --- | --- |
| Allergic to:  | Describe Reaction |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**MEDICATION LIST**

List all medications you are currently taking.

|  |  |  |  |
| --- | --- | --- | --- |
| Date Started | Name of Medication & Strength (ex. Mg, units) | How to take (ex: take 1 tablet by mouth 2 times daily) | Why are you taking this medicine |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**SUPPLEMENT LIST**

List all supplements you are currently taking.

|  |  |  |  |
| --- | --- | --- | --- |
| Date Started | Name of Medication & Strength (ex. Mg, units) | How to take (ex: take 1 tablet by mouth 2 times daily) | Why are you taking this medicine |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have reviewed the Notice of Privacy Practices

(Please initial one of the following options and sign below.)

\_\_\_\_\_\_\_\_\_\_ I wish to receive a paper copy of Privacy Notice.

\_\_\_\_\_\_\_\_\_\_ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can

request a copy at any time and the Privacy Notice is posted in the office.

**PATIENT CONSENT TO TREATMENT**

Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

The patient to see a provider gives his/her permission and authority for care by them in accordance with appropriate test, diagnosis, and analysis. The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I hereby consent to the provision of diagnosis, care, and/or treatment by **Dr. Jaqueline Brockert ND.** I hereby acknowledge and confirm that I am mentally capable of giving informed consent to theprovision of the diagnosis, care and/or treatment and am not subject to duress or undue influence.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Patient or Person Date

**PLEASE READ THIS DOCUMENT CAREFULLY. BY EXECUTING THIS CONTRACT, YOU AGREE TO ALL RIGHTS, DUTIES, AND RESPONSIBILITIES STATED HEREIN.**

1. **If You Do Not Have Insurance.** All payments are to be paid at the time of services.

2. **If You Have an Accepted Insurance.** All deductibles and co-payments are to be paid at the time of service.

3. **Cash Patient.** All payments are to be paid at the time of services. You are a cash patient until you submit insurance cards, and we qualify and accepts your insurance coverage.

4. **Reasonable Fees.** Fees are usual, customary, and reasonable according to professional industry standard, and, therefore, are covered up to the maximum allowance determined by each carrier.

5**. Patient Financial Responsibilities:**

A. **Patient Responsibility for Uncovered Claims/Services.** If your carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance. If services are not covered by your insurance, patient is responsible for the non-covered services. It is your responsibility to know what your insurance does and does not cover.

B. **Patient Responsible for Cost of Recovery**. If your account is delinquent for more than three months and no payments are established, we will take legal action to recovery the full amount owed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Responsible Party or Guardian Date:

**CANCELLATIONPOLICY/NO SHOW POLICY**

1. **Cancellation/No Show Policy for Doctor Appointment**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment within 48 hours, you may be preventing another patient from getting much needed treatment.

**If any appointment is not cancelled at least 48 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature Patient/Guardian Date**