CONFIDENTIAL PATIENT DEMOGRAPHIC FORM

PATIENT CONTACT INFORMATION

Today's Date: ____/____/_______

Name: ____ __________ ______/______/______
(First) (Last) (Sex) (Date of birth)

Preferred name (if different than above): ____

Permanent Address: ____

City: __________________ State: ______________ Zip: ____________

Temporary Address: ____

City: __________________ State: ______________ Zip: ____________

Home Phone: (_____) _____________________ Cell Phone: (_____) ___________________

Email Address: ____

Would you like our specials and promotions sent to your email? Yes / No

ADDITIONAL INFORMATION

Occupation: _____________________________ Employer: ____________________________

Marital Status (circle): Single Married Separated Divorced With Partner Widow(er)

Whom may we contact in case of an emergency? ___________________________________

Relationship to you: ____________________ Emergency Contact #: (_____)______________

How did you hear about us? ____

Who is your referring/primary physician?____

Referring/primary physician's contact information: Phone #: (_____)____________________

Address: ____

CONFIDENTIALITY AGREEMENT

I understand that all information shared with the Doctor is confidential, and no information will be released without my consent. During the course of treatment, it may be necessary to communicate with other health care providers; in this case, consent to release information will be given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following: (1) When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger. (2) When there is suspicion that a minor or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the individual and to inform the proper authorities. (3) When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

You will have access to your medical records in accordance to the Health Insurance Portability and Accountability Act of 1996.

If I have any questions regarding this consent form or about the services offered by Naturally Well AZ, I may discuss them with the Doctor or Staff. I have read and understand the above information.

Patient Printed Name: ____________________________

Patient or Legal Guardian Signature (if under age 18): ____________________________

Date: _____________

FINANCIAL RESPONSIBILITY AND CANCELLATION POLICY

Naturally Well AZ does not participate in any insurance plans. I understand and agree that payment is required in full at each visit unless an alternative is agreed upon in advance. I am responsible for charges incurred for all treatment rendered, and agree that I am responsible for payments for services my insurance carrier may determine non-covered, excluded, or not medically necessary. I understand my responsibility to pay includes fees for laboratory or other clinical services requested by my treating practitioner(s). I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Naturally Well AZ to take action to secure payment of an outstanding balance owed.

I understand that I will be financially responsible for any service rendered by Naturally Well AZ.

INITIAL: ______

Notice regarding insurance reimbursement for non-participating providers: I also understand that, if my plan provides reimbursement for services provided by nonparticipating providers, I may submit a claim myself to request reimbursement. I understand that it is my responsibility to know my personal plan benefits and that Naturally Well AZ staff will not be responsible for determining or assisting me with collecting insurance benefits.

INITIAL: ______

Cancellation/No-Show policy: you will be charged a $50 fee for appointments missed or canceled with notice of less than 24 hours. Consideration may be made for emergencies or circumstances beyond reasonable control.

INITIAL: ______

Patient printed name: ___________________________________

Patient signature: ______________________________________ **Date:** _______________

Parent/Guardian signature (if under age 18): ______________________________________

CONSENT FOR TREATMENT

I consent to being treated at Naturally Well AZ LLC. I understand that my care as a patient is directed by naturopathic physicians Dr. Kristina Greengard, and/or Dr. YiQiu Hu, and/or Dr. Sarah Shell, and/or Dr. Chelsea Karbon, and/or Dr. Katharine Schneller, and/or Dr. Erin Fitzgerald. I consent to services rendered and provided to me by the attending physician and licensed professionals participating or consulting about my care. I consent to treatment that may include but is not limited to:

Naturopathic principles and tenants, acupuncture and traditional Chinese medicine, botanical medicine, homeopathic medicine, mind-body medicine, hydrotherapy, physical manipulation, energy work, nutritional/diet counseling, vitamin/mineral/nutrient supplementation, venipuncture, PRP procedures, prolotherapies, injectable therapies, aesthetics procedures, minor surgical procedures, intramuscular and intravenous nutrient injection therapies, workshops, and trainings.

I state that Naturally Well AZ LLC has explained this treatment/procedure. I fully understand this information regarding treatment/procedures being performed by Naturally Well AZ LLC and all of my questions regarding treatment have been answered to my satisfaction. I agree to fill out all necessary disclosures, intakes, and forms for Naturally Well AZ to provide said treatment and naturopathic care. I understand that results are not guaranteed, and I recognize that I am responsible for my own health. My health is a direct reflection of my commitment to myself and my well-being. I understand that I may voluntarily discontinue treatment at any time. I also understand that at any time, if the physicians at Naturally Well AZ LLC feel as though I am not committed or compliant with their treatment plans, they have the right to refer me to another physician in an attempt to support my compliance and motivation for health. I cannot and will not hold Naturally Well AZ liable for said referral and discontinuation of treatment.

____
Patient full printed name

______________________________________ ______________
Patient / Guardian signature Date