

Integrative Health, Inc.
PRP and INJECTION INTAKE

CONFIDENTIAL

5191 S. Yosemite, Suite B Greenwood Village, CO 80111 Phone: (303) 577-9977 www.integrativehealthinc.com

Important: Complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Date ____/____/____		First Name		Last Name		Preferred Name	
Gender M T F	Date of Birth ____/____/____	Age	Marital Status Single Married Separated Divorced				
Street Address				City		State	Zip
Phone (Daytime) – Home Work Mobile <i>Circle One</i> () ()				Alternate Phone # – Home Work Mobile <i>Circle One</i> () ()			
Place of Employment		Occupation		Phone Numbers of Emergency Contact Primary () Alternate ()			
Circle Insurance Coverage (Please circle one) None Workers' Comp Auto Injury Health Insurance Company _____							
E-Mail:							
How did you hear about us? <i>Please circle one and write the name</i> Current Patient's name: _____ Doctor: _____ Advertisement: _____ Friend: _____ Insurance: _____ Other: _____							

Chief complaint: _____
 How long? _____ How often: _____
 What caused this (accident, lifestyle, drug, etc.)? _____
 Describe the worst it can be: _____
 What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other? _____
 Get temporary relief? _____ Fixes problem? _____ Causes side effects? _____
 How does this affect your life? _____
 Affect your family? _____ Affect your sleep? _____
 Affect your work? _____ Affect your hobbies? _____
 What is your goal/plan if the problem continues 5/10/20 years? _____

Complaint #2: _____
 How long? _____ How often: _____
 What caused this (accident, lifestyle, drug, etc.)? _____
 Describe the worst it can be: _____
 What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other? _____
 Get temporary relief? _____ Fixes problem? _____ Causes side effects? _____
 How does this affect your life? _____
 Affect your family? _____ Affect your sleep? _____
 Affect your work? _____ Affect your hobbies? _____
 What is your goal/plan if the problem continues 5/10/20 years? _____

Other Complaints:

3) _____ 4) _____

MEDICAL CONDITIONS, MEDICATIONS & ALLERGIES – Please list all conditions, surgeries, prescription medications you use and known allergies.					
Name (condition, surgery, medication or allergy)	Description/ Purpose	Date/ Start Date	Dose (if applicable)	Frequency	Additional Info

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a “C” under the appropriate person’s column. “P” should be used to indicate a past problem. Leave blank those that do not apply. If you require more space, use the reverse side of this form.

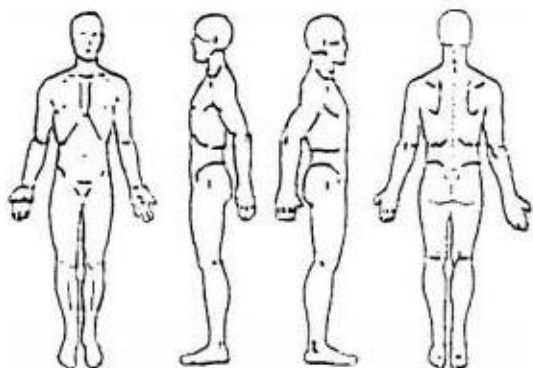
Age	You	Father	Mother	Spouse	Brother(s)		Sister(s)		Children	
AIDS / HIV										
Alcohol										
Anxiety										
Arthritis										
Asthma / Hay Fever / Allergy										
Back Trouble										
Bursitis										
Cancer										
Constipation										
Depression										
Diabetes										
Digestive Trouble										
Headaches										
Heart Trouble										
Hepatitis										
High Blood Pressure										
Immune Disorder										
Insomnia										
Kidney Trouble										
Liver Trouble										
Migraine										
Neck Pain										
Thyroid Disorder										
Tobacco										
Weight Problem										
Other Emotional Problems: _____										
Other: _____										

If any of the above family members are deceased, please list their age at death and cause.

MUSCULOSKELETAL

- Muscle Cramps – Where? Muscle Pain / Rheumatism – Where? Arthritis – Where?
- Joint Swelling – Where? Tendonitis – Where? Bursitis – Where?

Please mark problem areas on diagram:



Describe Pain and Location

- Sharp Burning Aching
- Fixed Other: _____

- Sharp Burning Aching
- Fixed Other: _____

- Sharp Burning Aching
- Fixed Other: _____

INJECTION CONSENT

1. In conjunction with the procedure *Trigger Point Injections*, I understand the following:

a. Nature and purpose of procedure (describe in laymen’s terms)

Injection of small muscles, spasms on _____
 _____with local anesthetic (1% OR 2% Lidocaine) Kenalog , Marcaïn, Sarapin or Traumeel (a natural anti-inflammatory medicine).

b. Material risks of procedure: ALLERGIC REACTION, BRUISING, INFECTION, SCARS, BLEEDING, DIZZINESS AND IN RARE CIRCUMSTANCES, POSSIBLE COLLAPSE OF LUNG, CARDIOVASCULAR AND/OR CEREBRAL PROBLEMS. Other risks of procedure are: _____

c. Likelihood of success: Good Fair Poor Unknown because: _____

d. Practical alternatives to procedure: None Meds Modalities Therapy

e. Prognosis if procedure rejected: Good Fair Unknown because: _____

2. CONSENT: The procedure identified above has been explained to me and all of my questions have been answered. I acknowledge that no guarantees have been made concerning the outcome of the procedure. I hereby consent to the performance of this procedure as ordered by: _____

3. To the best of my knowledge, I have no known allergies to:
- I have allergies to Lidocaine, or similar numbing medications.
 - I DO NOT have allergies to Lidocaine, or similar numbing medications
 - I am currently taking a blood thinning medication (such as Coumadin)
 - I AM NOT currently taking a blood thinning medication (such as Coumadin)

Patient’s Printed Name

Patient’s Signature

Date

Signature of Physician

Date



Request and Informed Consent for Intramuscular Joint Injections

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ AND FULLY UNDERSTAND ITS CONTENTS.

Patient's Name: _____

Date: _____

The following procedure has been explained to me in general terms, and I understand that:

1. The **DIAGNOSIS REQUIRING THIS PROCEDURE** is: _____
2. The **NATURE OF THIS PROCEDURE** is: An injection of _____ and local anesthetic into the Shoulder Subacromial Bursa Other _____
3. The **PURPOSE OF THIS PROCEDURE** is to reduce inflammation, relieve pain and cushion joint.
4. **MATERIAL RISK OF THIS PROCEDURE:** As a result of this procedure being performed, there may be a risk of infection, allergic reaction, scars, bleeding, pain at the site of injection, vasovagal reaction, collapsed lung, and in rare circumstances brain damage, cardiac arrest or death.
5. In addition to these material risks, there may be other possible risks, such as: pain at the site of injection, seizure, collapsed lung.
6. The **LIKELIHOOD OF SUCCESS** with the above procedure is: OOD AIR OOR
7. **PRACTICAL ALTERNATIVES TO THIS PROCEDURE** include: Modalities and Therapy
8. If I choose not to have this procedure performed, my prognosis is UNKNOWN.

I understand that the physician and medical personnel will rely on statements about my medical history and other corresponding records pertaining to my condition to determine whether to perform the above procedure which has been explained to me and is recommended as a course of treatment for my condition.

I understand that the practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES** have been made to me concerning the results of this procedure.

I understand that during the course of the procedure described above, it may be necessary to perform other procedures which are unforeseen, or not known to be needed at the time of this signed consent/authorize the physician herein to make the decision concerning such procedure, if additional procedures are deemed necessary or appropriate.

I also consent to the diagnostic studies, test, local anesthesia and/or general anesthesia, x-ray examinations and any other course of treatment related to the diagnosis or procedure explained herein. Too, I consent to the taking of photographs or the use of video recording equipment during the procedure for the purpose of medical education.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND/OR THE FORM HAS BEEN EXPLAINED TO ME. I FULLY UNDERSTAND ITS CONTENTS AND WAS GIVEN AMPLE OPPORTUNITY TO ASK ADDITIONAL QUESTIONS WHICH WERE ANSWERED TO MY SATISFACTION.

I voluntarily consent to allow any Physician or Nurse Practitioner designated ABC Medical and all medical personnel under the provider's direct supervision to be involved in performing such procedures described or otherwise referred to herein.

Signature of patient or responsible person

Physician Signature



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Deep Tissue Heat Laser (pre and post PRP Injection)

Are you a candidate for laser therapy?

Laser therapy is an FDA cleared modality for the treatment of pain and inflammation and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. If you answer yes to any of the questions below, you will need to discuss details of your condition with your clinician.

Please check YES or NO to the questions below:

YES NO Do you have a pacemaker or any other implanted devices?

YES NO Are you pregnant?

YES NO Do you have cancer?

YES NO Are you taking medication that may increase your sensitivity to light?

YES NO Have you had a steroid injection in the last 7 days?

Laser therapy utilizes visible and invisible laser radiation; therefore, appropriate eye protection is required at all times during treatment.

Effects of your treatment will continue for up to 18 hours. Individuals respond uniquely to treatment; you may see immediate results after the first treatment or depending on the severity of your condition you may require several treatments before you begin to feel results.

Increased soreness may occur after your first laser session. This is a normal healing phenomenon known as retracing. Mild bruising may occur from the soft tissue manual therapy element of your treatment program.

By signing below, you understand the information provided above and consent to treatment. By signing below you are stating you also understand that failing to complete any part of my treatment program will reduce my chances of success.

Patient Signature

Date

Printed Patient Name



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_____(initial) I, hereby understand Integrative Health Wellness Center is a wellness building that houses a variety of health professional businesses. As a patient, I realize I am not being treated by Integrative Health Inc., but the specific provider’s business seen by. Integrative Health is not your health care provider and cannot be held responsible to any harm or damages to your person. I, hereby release Integrative Health Inc. from any damages that could occur to my person.

Consent For Care

_____(initial) I, hereby authorize and request the provider(s) in which I scheduled with at 5191 S Yosemite St, Ste B, to perform such examinations and therapeutic treatments as in the judgement of the provider(s). I understand I am not forced to accept medical treatment.

Authorization To Release Information

_____(initial) I AUTHORIZE the provider(s) seen at 5191 S Yosemite Street, Ste B, to release any information required to process this claim to any insurance company or attorney involved in my case. I also authorize any insurance company or medical provider to release my medical records to the provider(s) at 5191 S Yosemite St, Ste B. The information is to be used for the purpose of preceding my claim for benefits due.

_____(initial) I understand that my record will be kept confidential and will not be released to others unless they are involved in my care plan. I understand that I may request a copy of my records at any time and a fee may apply.

Payment Agreement

_____(initial) I assume full responsibility for and agree to pay all costs, charges and expenses for goods and services furnished by provider(s) seen at 5191 S Yosemite St, Ste B, at time of service.

_____(initial) I hereby authorize my insurance benefits to be paid directly to the provider(s) seen at 5191 S Yosemite St, Ste B. I must pay charges and services not covered by any insurer third-party and/or paid to the providers(s) seen at 5191 S Yosemite St, Ste B, for any reason within a time period deemed reasonable by the provider(s). The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator or third party responsible for payment of the charges.

Cancellation Notice

_____(initial) Kindly give 24 HOURS NOTICE for cancellations. Late cancellations are subject to 50% CANCELLATION FEE, no shows or cancellation with less than 2 hours before scheduled appointment are subject to a 100% CANCELLATION FEE. Cancellation fee is based on the cash rate of service. Call-backs or email reminders are a courtesy and I understand that I am responsible for my appointment and providing 24 hour notice for cancellations or reschedules.

Your Printed Name

Signature

Date



INTEGRATIVE HEALTH, INC.
WELLNESS CENTER
 EXPERTS PROVIDING NATURAL HEALTHCARE

5191 S Yosemite St, Suite B, Greenwood Village, CO 80111
 Phone: 303-577-9977 Fax: 303-694-4341
 www.IntegrativeHealthInc.com

Consent for Purpose of Treatment and Healthcare Operations
In this document, "I" and "my" refer to the patient/client

I consent to the use or disclosure of my protected health information by the provider(s) seen at Integrative Health Inc, 5191 S Yosemite St, Ste B., for the purpose of analyzing, diagnosing and providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that analysis, diagnosis or my treatment may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice, the provider(s) seen are not required to agree to the restrictions that I may request. However, if the provider(s) agrees to a restriction that I request, the restriction is binding on the provider(s). I have the right to revoke this consent, in writing at any time, except to the extent that the provider(s) has taken action in the reliance on the consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I may review the Notice of Privacy Practices online on the link provided below and understand that I have the right to read the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Integrative Health, as well as my rights and duties of the provider(s) seen at 5191 S Yosemite St, Ste B, with respect to my protected health information.

The Notice of Privacy Practices is available online at: <https://www.hhs.gov/hipaa/for-individuals/index.html>

 Your Printed Name

 Signature

 Date

