Platelet-Rich Plasma (PRP) Injections

PRP Injections might also be augmented with Trigger Point Injections (TPI) to help with functional improvement of surrounding muscles.

Useful Patient Information

It is helpful for the patients to provide radiology reports for any studies that have been performed (X-rays, MRI, CT, etc.), along with any notes regarding prior therapies or treatments (such as steroid injections, physical/occupational therapy, etc.).

Precautions Prior to Treatment

1. Stop aspirin and blood-thinning supplements (fish oil, turmeric, ginger, etc.) **10 days prior to injections.**
    - If on prescription blood thinners (coumadin, warfarin, Plavix, etc.), patients should consult with their prescribing physicians as to the safety and timing of stopping these medications prior to injections.

Possible Indications for Treatment

- Tendon injury / tendinitis (shoulder rotator cuff, tennis/golfer's elbow, Achilles tendon injury, etc.)
- Ligament injury (medial & lateral collateral ligaments of knee, ankle, etc.)
- Joint pathology (meniscal injury of knee, degenerative disease/arthritis of knee, shoulder, wrist, etc.)
- Fascial pathology (plantar fasciitis, IT band injury, etc.)
- Muscle/Cartilage injury
- NOT indicated for spine/vertebral/nerve issues

Post Treatment

- No smoking, caffeine, or alcohol for 3 days
- No strenuous exercise for 3 days (light exercise ok)
- May experience bruising or tenderness.

Keep a positive attitude! Plan for success and keep your spirits high!
Stress can impede the healing process, so keep that smile going ☺

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	Date of Birth	Age	Marital Status
M T F	_____/ _____/ _____		**Single Married Separated Divorced**

Street Address	City	State	Zip

Phone (Daytime) – **Home Work Mobile** *Circle One*	Alternate Phone # – **Home Work Mobile** *Circle One*
( )	( )

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? *Please circle one and write the name*

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.

	You	Father	Mother	Spouse	Brother(s)		Sister(s)		Children		
Age											
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.

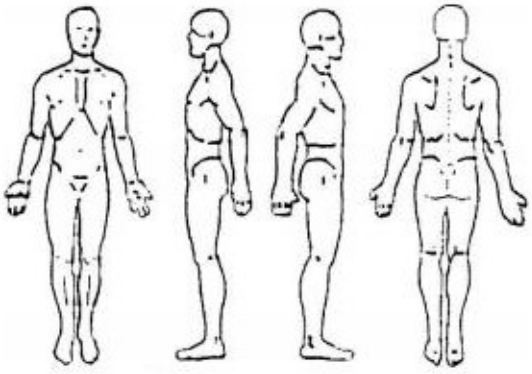
_____

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:_____

Please read the statements below and check the boxes next to those with which you agree:

□ I have been offered to view a copy of Integrative Health's HIPPA guidelines and privacy policies.
□ I certify that the information provided to this office is up to date and correct to the best of my knowledge.
□ I am the authorized parent or guardian of this child (if applicable) and authorize this office to treat my child.

Signature: _____ Date: _____

Signature of Parent: _____ Date: _____

Thank you for taking the time to provide us with this vital information. We are here to serve you!

Integrative Health Inc
Experts Providing Healthcare

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

Platelet-Rich Plasma (PRP) Treatment Consent Form

Patient Name: _____ **DOB:** _____ **Date of Service:**_____

Purpose of Treatment:

Platelet-Rich Plasma (PRP) therapy involves using your own blood components to promote healing and tissue regeneration. Blood will be drawn from you, processed to concentrate platelets, and then reintroduced into targeted areas of your body.

Potential Benefits:
- Reduced pain and inflammation
- Enhanced tissue regeneration and healing
- Improved joint function and mobility

Potential Risks and Complications:
- Temporary bruising, swelling, or soreness at injection sites
- Infection (rare)
- Bleeding or hematoma formation
- Nerve damage or tissue injury (rare)
- Allergic reaction (extremely rare)

Procedure Details:
- Your blood will be drawn using standard techniques.
- The blood sample will be processed to separate the platelets.
- Concentrated platelets (PRP) will be injected into the targeted treatment areas.

Patient Responsibilities:
- Inform your provider about your complete medical history, medications, allergies, or recent illnesses.
- Follow pre and post-treatment care instructions as provided.
- Report any unusual symptoms or complications immediately.

Consent and Authorization:
I acknowledge that I have discussed the PRP treatment with my healthcare provider, including potential risks, benefits, alternatives, and expected outcomes. I have had ample opportunity to ask questions and have received satisfactory answers. I understand that results may vary and cannot be guaranteed.

By signing below, I give my consent to Integrative Health Inc. to perform Platelet-Rich Plasma (PRP) therapy as described above.

Patient Signature: _____ Date:_____

Integrative Health Inc
Experts Providing Healthcare

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

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

Integrative Health Inc
Experts Providing Healthcare

5191 S Yosemite St, Suite B

Greenwood Village, CO 80111
Phone: 303-577-9977
www.IntegrativeHealthInc.com

_____(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, herby 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