GREEN LOTUS CHIROPRACTIC INTAKE FORMS

NAME: ____ TODAY'S DATE: __________________

DATE OF BIRTH: ______________________ PHONE: ______________________________

EMERGENCY CONTACT: _______________________ PHONE: _________________ RELATION: _______________

HEALTH INFORMATION

HAVE YOU EVER SEEN A CHIROPRACTOR BEFORE? ☐ YES ☐ NO CHIROPRACTOR'S NAME: ___________________

WHY ARE YOU SEEKING CHIROPRACTIC CARE AT THIS TIME? ____

WHAT MUSCULOSKELETAL PAIN OR SYMPTOMS ARE YOU EXPERIENCING AT THIS TIME? ________________________

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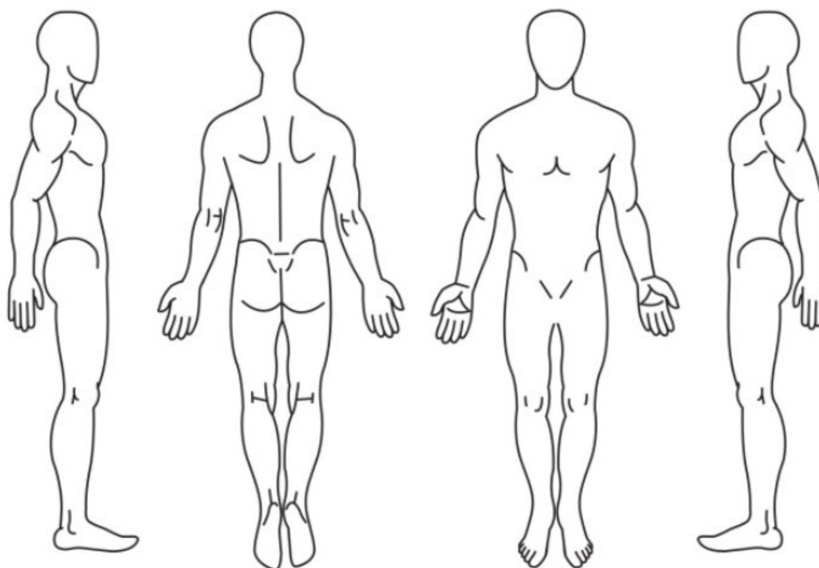
IF YOU HAVE PAIN OR PHYSICAL SYMPTOMS, PLEASE MARK THEM ON THE DIAGRAM BELOW:



LIST ANY ALLERGIES YOU HAVE: ____

LIST ANY MEDICATIONS OR SUPPLEMENTS THAT YOU TAKE: ____

____

ARE YOU CURRENTLY UNDER THE CARE OF ANY HEALTH PRACTITIONERS? (PLEASE NAME)

☐ ACUPUNCTURIST: __________________________ ☐ MASSAGE THERAPIST: _____________________________

☐ PHYSICAL THERAPIST: ______________________ ☐ MEDICAL DOCTOR: _______________________________

DO YOU, OR WOULD YOU LIKE TO, PARTICIPATE IN A YOGA, STRETCHING OR EXERCISE PROGRAM? ☐ YES ☐ NO

WHAT TYPES OF PHYSICAL ACTIVITY DO YOU ENJOY? ____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (PLEASE DESCRIBE AND LIST APPROXIMATE DATE)

☐ SURGERIES: ____________________

☐ BROKEN BONES, AND/OR JOINT DISLOCATIONS:____________________

☐ HEAD INJURIES, DISC HERNIATIONS OR SPINAL INJURIES: ____________________

☐ AUTO ACCIDENTS OR WORK INJURIES: ____________________

☐ MAJOR OR RECENT FALLS: ____________________

☐ OTHER SIGNIFICANT MEDICAL INJURIES: ____________________

PLEASE IDENTIFY ANY OF THE HEALTH CONDITIONS IF YOU HAVE THEM NOW OR HAVE HAD THEM IN THE PAST:

☐ HEART ATTACK OR STROKE ☐ NUMBNESS ON ONE SIDE OF YOUR FACE OR BODY ☐ CHEST PAIN / PALPITATIONS

☐ HIGH/LOW BLOOD PRESSURE ☐ SHORTNESS OF BREATH ☐ FEVER, NAUSEA, BODY ACHES ☐ CANCER

☐ DIABETES ☐ CHILLS OR SWEATS ☐ UNEXPLAINED FATIGUE ☐ EXCESSIVE BLEEDING OR BRUISING

☐ UNEXPLAINED WEIGHT LOSS OR GAIN ☐ PAIN THAT WAKES YOU UP AT NIGHT ☐ BLOOD DISORDER

☐ HEPATITIS ☐ HIV/AIDS ☐ FAINTING ☐ FIBROMYALGIA ☐ AUTOIMMUNE DISORDER ☐ NONE

☐ OTHER: ____________________

CONSENT FORMS

HIPAA PRIVACY PRACTICES NOTICE AND CONSENT

DR. GREGORY FREITAG AND GREEN LOTUS YOGA AND HEALING CENTERS (GREEN LOTUS) ARE COMMITTED TO THE PRIVACY AND CONFIDENTIALITY OF YOUR PERSONAL HEALTH INFORMATION

- WE MAY DISCLOSE YOUR PERSONAL HEALTH INFORMATION TO COORDINATE CARE WITH OTHER PROVIDERS
- YOU HAVE THE RIGHT TO REQUEST THAT WE DO NOT DISCLOSE YOUR HEALTH INFORMATION TO SPECIFIC INDIVIDUALS, COMPANIES OR ORGANIZATIONS. LIST IF APPLICABLE: ____________________
- YOU HAVE THE RIGHT TO REQUEST THAT WE AMEND YOUR PATIENT RECORD

☐ *I ALLOW DR. GREGORY FREITAG TO USE OR DISCLOSE MY PERSONAL HEALTH INFORMATION TO OTHER PROVIDERS TO COORDINATE CARE.* ***(REQUIRED)***

TREATMENT AUTHORIZATION

☐ *I ALLOW DR. GREGORY FREITAG TO EXAMINE ME FOR EVALUATION AND TREATMENT. I AUTHORIZE DR. GREGORY FREITAG TO PROVIDE CHIROPRACTIC TREATMENT UNDER THIS STATE'S STATUTE.* ***(REQUIRED)***

PATIENT ELECTION TO SELF-PAY FOR SERVICES

THE CARE THAT DR. GREGORY FREITAG PROVIDES AT GREEN LOTUS IS CLASSIFIED AS MAINTENANCE OR WELLNESS CARE AND IS NOT COVERED BY HEALTH INSURANCE.

- BY SIGNING THIS PATIENT ELECTION TO SELF-PAY FOR SERVICES CONSENT FORM, I ACKNOWLEDGE, UNDERSTAND, AND AGREE TO PAY OUT-OF-POCKET FOR ALL SERVICES I RECEIVE FROM DR. GREGORY FREITAG AT GREEN LOTUS.
- I UNDERSTAND THAT PAYMENTS MADE TO GREEN LOTUS FOR CHIROPRACTIC SERVICES ARE NOT REIMBURSABLE BY MY HEALTH INSURANCE, NOR WILL THEY BE SUBMITTED TO MY HEALTH INSURANCE PLAN FOR REIMBURSEMENT.
- I UNDERSTAND THAT DR. GREGORY FREITAG OR GREEN LOTUS WILL NOT PROVIDE ME WITH AN ITEMIZED AND CODED INSURANCE CLAIM FORM FOR HEALTH REIMBURSEMENT PURPOSES.
- I UNDERSTAND THAT A HEALTH SPENDING ACCOUNT MAY BE USED TO PAY FOR CHIROPRACTIC SERVICES AT GREEN LOTUS.

☐ *I HAVE CHOSEN TO SELF-PAY FOR SERVICES PROVIDED BY DR. GREGORY FREITAG AT GREEN LOTUS.* **(REQUIRED)**

INFORMED CONSENT TO CHIROPRACTIC CARE

CHIROPRACTIC CARE IS A SAFE AND EFFECTIVE TREATMENT FOR MANY CONDITIONS. THOUGH RARE, THERE ARE SOME RISKS ASSOCIATED WITH CHIROPRACTIC TREATMENT INCLUDING BUT NOT LIMITED TO THE FOLLOWING:

- TEMPORARY SORENESS AND INCREASED SYMPTOMS
- DIZZINESS, NAUSEA, AND FLUSHING – PLEASE NOTIFY DR. GREGORY FREITAG OR GREEN LOTUS STAFF IF THESE OCCUR.
- EXTREMELY RARE OCCURRENCES ASSOCIATED WITH MANUAL ADJUSTMENTS (TWISTING, POPPING, CRACKING) MAY INCLUDE STRAINS, SPRAINS, DISLOCATIONS, FRACTURES, DISC HERNIATIONS, AND STROKE – PLEASE SEEK IMMEDIATE MEDICAL CARE AND NOTIFY DR. GREGORY FREITAG OR GREEN LOTUS STAFF IF THESE OCCUR.

☐ *I ACKNOWLEDGE AND UNDERSTAND THAT NO GUARANTEE CAN BE MADE REGARDING THE RESULTS OR OUTCOME OF MY CHIROPRACTIC CARE. I AGREE TO BE TREATED BY DR. GREGORY FREITAG AND WAIVE HIS RESPONSIBILITY FOR THE CAUSE OF ANY SIDE EFFECTS, INCLUDING BUT NOT LIMITED TO THOSE LISTED ABOVE.* ***(REQUIRED)***

SIGNATURE: ____ DATE: ____________

NAME: ____