FRELSI HEALTH

Consultation Intake Form

Patient's Full Name _____ Date of Birth _____Age _____

Gender_____ Parent/Guardian Name _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Email _____ Cell phone _____

Occupation _____ If married, Name of Spouse _____ # of Children ____

In case of emergency, please notify _____ at Phone # _____

Primary Care Physician _____ Chiropractor _____

How did you hear about us? _____

PLEASE READ: Welcome to Frelsi Health! This informed consent, waiver and patient health information document is important and binding, so please read it carefully to have a clear understanding of the consultation services. We want you to have the best understanding of our consultation services possible. The consultations will facilitate a better understanding of your body and advocate for the best next steps to get you on the path of optimal wellness. To make the most of our time, at least 2 days prior to your visit, provide copies of any tests/lab work you've had in the last 12 months.

Payment: I understand the fee for today's 40 minute Discovery Consultation is $100 and is due at the time of service. Consultations, lab tests and supplements are not billable to any kind of insurance and pricing for these services will be discussed in the consultation. I understand if I need and agree to more time, there will be additional cost. **Initial** _____

Cancellation/No-Show Policy: I am aware that Frelsi Health requires 24 hours notice if I should need to reschedule or cancel my consultation. As a courtesy, Frelsi Health will send out reminders 26 hours ahead of my consultation time, so I understand they reserve the right to charge me $50 if I do not give proper notice that I need to reschedule my reserved time. **Initial** _____

Release of Medical Information: I authorize the release of medical information to the recommended lab testing companies that I choose to process samples through & ordering/consulting providers. I understand that I will pay Frelsi Health directly for lab tests. **Initial** _____

Acknowledgement of receipt of Privacy Practices: I am aware that Frelsi Health, LLC has a Notice of Privacy Practices, which states how my health information legally may be used/disclosed. I acknowledge that I have reviewed it and a copy has been made available to me. I may ask to receive a copy at any time. **Initial** _____

Consultation Services/Waiver: I give consent to work with Frelsi Health's Health Advocate Nurse and understand that the information received is not medical advice, medical diagnosis or treatment of any disease. I understand I should always seek the advice of my primary medical physician with any questions about lab results, nutritional supplementation or dietary alterations and will not delay seeking treatment because of information learned during my consultations. I acknowledge and take full responsibility for my life and well-being, as well as my decisions to gain wellness during and after my consultations. **Initial** _____

_____ _____

Patient or Guardian Signature Date

Case History

Please describe the main concern(s) that brings you here, for your initial consultation:

Please describe other providers you've seen for this concern, and the approximate date of that visit:

Current Medications & Supplements (Including dose, frequency & reason for taking):

I confirm understanding of and accuracy of all information listed on all pages of this Frelsi Health, LLC intake form.

Patient or Guardian Signature Date