**The Elements of Health AZ** *...Natural & Functional Healthcare*

8711 East Pinnacle Peak, Suite F113 Scottsdale, Arizona, USA 85255
Phone 480-563-4256 / fax 480-563-4269 / www.teohaz.com

## Welcome to the Elements of Health Arizona

Please take a few moments to give us some information about yourself and your lifestyle so that we can serve you more efficiently. *Please **print** all information as clearly as possible. Thank you!*

**We really like E-mail correspondence**

Home E-mail address:_____

Would you like to be placed on our monthly newsletter? _____Yes _____No

First Name:_____Last Name:_____

Address:_____

City:_____State:_____ZIP:_____

Birth Date:_____

Mobil Phone #_____

Please list any allergies to medications:_____

_____

Home Phone #_____

Work Phone #_____

Name of Spouse:_____

Name(s) of Children_____

Emergency Contact:_____Relationship:_____Phone#:_____

Pets, hobbies, travels, daily routines, diet style, concerns thoughts or comments. Anything to help us get to know you and your lifestyle better. Your lifestyle reflects your health and your health reflects your lifestyle.

_____

_____

I heard about your office thru? : ☐Internet ☐Newspaper ☐Person ☐Other

Name and/or relationship to Person:

_____

(Patient referrals are important; the person who referred you will receive a complimentary $60.00 visit.)

# Financial Policies

## Payment Methods

***Payment is expected as services are rendered***. You have the options of paying with cash, check or credit card. We accept most major credit cards, VISA, Master Card, American Express and Discover Card.

Some people pay a retainer to their account at the beginning of their care. The cost for care are then drawn against credit on account. If you choose to leave a retainer of $500 a 10% discount will be applied to your office visits and any in house services you may have. The 10% discount is not, however, applied towards any products you may purchase.
A retainer increases commitment and follow-through, although the credit on your account is still under your control. You can receive a full refund on the unused portion at any time.

Another option is to keep your credit card on file with our office. This arrangement makes appointments smoother and saves you time. At the end of your appointment you can get whatever you need up front and immediately leave. We will then send you a receipt in the mail with an itemized statement. If you choose this option please fill out authorization form provided in this packet.

## Appointment Cancellations

Please note (AND initial on the line that you read and understand our policy) that there will be a $40.00 charge for appointments missed without 24-hour prior notification. _____
*(please initial)*

I, _____, have read, understand, and agree to the financial Policies as
(*Please Print Name*)
stipulated above.

Signature_____Date_____

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The undersigned person, from this office, has explained the financial policies, as well as the above named patient's options and responsibilities.

Signature_____ Date_____

# Protocol for Preservation of Patient Records

Pursuant to ARS 32-3210 and the requirements of the State of Arizona for the preservation of patient records, this documents the intended to inform all patients of The Elements of Health Arizona of their rights and obligations.

Patients or their representatives may request copies of their records, in writing. The Elements of Health Arizona agrees to comply with Arizona law for the production of these records and will timely respond to any reasonable requests.

The Elements of Health will maintain your records for a period of seven (7) years following your last date of service. After 7 years from the last date of service, The Elements of Health reserves the right to destroy your records. Should The Elements of Health exercise that right, The Elements of Health Arizona will first attempt to contact you and inform you of your right to obtain a copy of these records. The Elements of Health Arizona will attempt to contact you by regular mail, at your last known address, and will give you thirty (30) days to request that your records not be destroyed. If you do not respond to this notice, you will be waiving your rights to have your records preserved.

Should The Elements of Health Arizona cease to practice or sell the practice to another health care professional, The Elements of Health will notify all eligible patients, by regular mail, concerning the location of their records and how they may request copies of those records. The required notice will be sent to each eligible patient!s last known address.

_____

Patient Signature

I acknowledge receipt of this document

**Acknowledgement and Agreement:**
**Patient Protocol for Records Preservation**

I, _____, patient of The Elements of Health, do hereby acknowledge I have read and understand the doctor's protocol for the preservation of patient records. I agree to inform The Elements of Health Arizona of any address changes and acknowledge that all requests for records, either by me or by my representatives, must be in writing. I agree that the doctor's office may comply with all statutory notification requirements to me by regular mail to my indicated address.

Signature of Patient_____Date_____

Address of Patient _____

# DISCLOSURE & CONSENT for TREATMENT

**TO THE PATIENT:** You have the right as a patient to be informed about your condition and the recommended treatment and other physical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you: it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of treatments, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by Dr. Angela Darragh and/or other licensed Doctors or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor named below.

I have had the opportunity to discuss with the doctor named below, my diagnosis, other procedures and alternatives.

I understand and I am informed that there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and back or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the ensure course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**To be completed by the patient**

_____
**print name**

_____
**signature of patient**

_____
**date signed**

**To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or physically or legally incapacitated:**

_____
**print name of patient**

_____
**signature of patient's representative**

**as:**_____

# Pre-Authorized Credit Card Billing Form

I authorize The Elements of Health AZ, to keep my signature on file and to charge my Visa/MasterCard/Discover or American Express account for all recurring charges (on-going treatments) or supplements purchased.

I understand that this form is valid until I cancel the authorization through written notice to:

The Elements of Health AZ
8711 East Pinnacle Peak, Suite F113
Scottsdale, AZ 85255
480/563-4256

Please circle Card to be put on file:

Visa MasterCard Discover AMEX

Credit Card #_____

Signature_____

Expiration Date_____

How would you like your receipts send to you:_____Mail_____Email

Email address_____

# Auto Remind

The Elements of Health AZ has a program that allows our computer to send you an alert to remind you of your appointment a day or so before.  We just need to know how you would like to get your reminder.

Please check how you would like to receive your reminder

Email_____Mobil Phone Voice Message_____Home Phone Voice Message_____

Text message_____

If you want to use a different email address for AutoRemind than you have entered on the first page please enter it here:

_____

How many days before your appointment you would like to get your reminder:

One day before your appointment _____or Two days before your appointment_____

Please remember that the email and voice reminders will prompt you to respond to let us know you will be attending your appointment.  Unfortunately the program does not have a response if you can not make your appointment.  So in this case we would ask you to please call or email the office as soon as you can.