Personal Info

First Name		Last Name		Age	
Date of Birth		Email		Gender	

Height		FT.		IN.	Weight		LBS

Home Address		City		State		Zip	
Phone		Type		2nd Phone		Type	
Preferred Method of Communication		Permission to send text messages					

Employer Information

Employer		Work Address	
City		State		Zip	

Emergency Information

Emergency Contact		Relationship		Phone	

Insurance Information

Are you Medicare Eligible?		Yes		No

Do you have a Health Savings Account or Flexible Spending Account?		HSA		FSA		None

How did you hear about our office?	
If you were referred by an existing patient, please tell us who so we can thank them:	

Primary Care Physician		Primary Care Phone	

Current Medications (Please include name and dosage. If you need more space, please provide a separate list.)
Current Supplements (Please include name and dosage. If you need more space, please provide a separate list.)

Medical & Surgical History

First Name		Last Name			
Date of Birth		Age		Gender	

Surgeries and Hospitalization

Surgeries:		Less than 1 month ago		1-6 months ago		6-12 months ago		Yrs ago
Fractures:		Less than 1 month ago		1-6 months ago		6-12 months ago		Yrs ago
Hospitalized:		Less than 1 month ago		1-6 months ago		6-12 months ago		Yrs ago
If you answered yes to any of the above, please describe:								

Past Medical History (Check all that apply)

	AIDS/HIV		Chronic fatigue		Glaucoma		Kidney disease		Sleep apnea
	Alcoholism		Dental problems		Gout		Liver disease		STI
	Allergies		Depression		Headache		Mental illness		Stroke
	Alzheimer's Disease		Diabetes, Type 1		Heart Disease		Migraine		Substance abuse
	Arthritis		Diabetes, Type 2		Hepatitis		Motor vehicle accident		TB
	Asthma		Digestion problem		Hernia		Neurological disease		Thyroid problem
	Athlete's foot		Diverticulitis		Herniated disc		Obesity		Ulcer
	Autoimmune Disease		Eating disorder		High Blood Pressure		Osteopenia		UTI
	Blood clots		Emphysema		High Cholesterol		Osteoporosis		Varicose veins
	Bronchitis		Epilepsy/seizure		IBD/Colitis		Pacemaker		
	Bruise easily		Food intolerance		IBS		Pneumonia		
	Cancer, tumors		Fused/Fixated Joints		Infection, chronic		Rash		
	Carpal tunnel syndrome		Genetic disorder		Jaw pain/TMJ		Scoliosis		
	Chest pain		GERD (refux)		Joint replacement		Skin problems		

Family Medical History (Check all that apply)

	Alcoholism		Diabetes, Type 2		Heart Disease		Mental illness		Substance abuse
	Alzheimer's Disease		Eating disorder		Hepatitis		Migraine		TB
	Autoimmune Disease		Emphysema		High Blood Pressure		Neurological disease		Thyroid problem
	Cancer, tumors		Epilepsy/seizure		High Cholesterol		Obesity		
	Depression		Genetic disorder		IBD/Colitis		Pacemaker		
	Diabetes, Type 1		Headache		IBS		Stroke		

Reproductive Health History (Check all that apply)

	BPH		Hair loss		Low Libido		Prostate Cancer		
	C-section		Infertility		Low mood		Vaginal infection		
	Decreased erection		Irregular periods		Menopause	Other:			
	Decreased strength		Irritability		Ovarian cyst				
	Endometriosis		Lack of energy		Perimenopause				
	Fibroids		Loss of height		Pelvic inflammatory dz				

Social Health History

Tobacco use:	Current smoker		Packs per day		For how long?		Non-smoker	
Alcohol use:	Rarely		Weekends		Daily		Non-drinker	
When you drink, how many do you typically have?		1-2		2-5		5-7	More than 7	

Caffeine & Energy Drinks:	Never		1-3x per week		Daily		+1x per day	
Exercise Habits:	None		1-2x per week		3-4x per week		+5x per week	
Hours Sleep per night:	9-10 hours		7-8 hours		5-7 hours		Less than 5	

Naturopathic History

First Name		Last Name			
Date of Birth		Age		Gender	

Have you seen a naturopathic physician before?		Yes		No	If yes, how long ago?	
When did you last have lab work?						

Reason for Today's Visit

	Hormone Consult		Diabetes Consult		Digestive Complaint	
	Other (please describe):					

Are you pregnant?		Yes		No	If yes, how many weeks?	

Are you currently experiencing any of the following? (Check all that apply)

	Constipation		Diarrhea		Urinary complaints		Low Libido		Mood changes
	Brain fog		Low Energy		Heart burn		Depression		Anxiety

If you answered yes to any of the above, please describe:

Did you receive any of the COVID-19 shots?			Yes		No					
If Yes:		Moderna		Pfizer		J & J	# of Doses:	1	2	3	4	5+

What types of therapies have you tried for these problems or to improve your overall health? (Check all that apply)

	Diet Changes		Fasting		Vitamins		Homeopathy		Herbal Medicine
	Chiropractic		Acupuncture		Prescriptions		Surgery		Other

If you answered "other", please describe:

Please rate your stress level on a scale of 1-10 (1=lowest, 10=highest)					
Please rate your energy level on a scale of 1-10 (1=lowest, 10=highest)					
Your weight today:		Your weight at age 20:		Your "ideal" weight:	

Do you have any known allergies to:							
	Foods		Medications		Environmental		Other

If you answered yes to any of the above, please describe:

INFORMED CONSENT AND REQUEST FOR NATUROPATHIC MEDICAL CARE

You have the right to inspect and copy your protected health information:

I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed by discussing the potential benefits, risks and hazards involved.

I hereby request and consent to examination and treatment with licensed naturopathic physicians, or licensed acupuncturists who may serve as substitutes for one another in cases of my primary provider's absence, hereafter called allied health care providers.

I understand that as part of the practice of naturopathic medicine evaluation and treatment may include, but are not limited to:

- Physical exams (e.g. general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Common diagnostic procedures (e.g. venipuncture, pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Soft tissue and osseous manipulation (e.g. therapeutic massage, deep tissue massage, neuro- muscular technique, naturopathic/osseous manipulation of the spine and extremities), muscle energy techniques (e.g. BodyTalk, cranio-sacral therapy, others)
- Physiotherapeutic treatments (e.g. acupuncture, cupping, gua sha, moxa, therapeutic ultrasound, interferential, Pulsed Electromagnetic Frequency - PEMF)
- Dietary advice/therapeutic nutrition (e.g. use of foods, diet plans, nutritional supplements and intra- muscular vitamin injections)
- Trigger point injection therapy with vitamin substances
- Botanical/ herbal medicines, prescribing of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures (which may contain alcohol), suppositories, tropical creams, pastes, plasters, washes, or other forms
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Counseling (including but not limited to visualization for improved lifestyle strategies)
- Over the counter or prescription medications, consistent with the Arizona Board of Naturopathic Physicians' Formulary

Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, pneumothorax, allergic reaction to prescribed herbs, supplements; soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms.

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy.

Notice to individuals with bleeding disorders, pacemakers, and/ or cancer: For your safety it is vital to alert your providers of these conditions.
Naturopathic doctors will only prescribe medications if they believe that they are in the best interest of myself, the patient.

I understand the US Food and Drug Administration has not approved nutritional, herbal and homeopathic substances; however these have been used widely in Europe, China and the USA for years.

Naturopathic doctors are not psychologists or psychiatrists. Counseling services are provided for the support of improved lifestyle strategies. I do not expect the naturopathic physicians, and/or any allied healthcare providers to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that the doctor explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me.

________ **Acupuncture and Traditional Chinese Medicine:** Potential risks of acupuncture include: bruising, numbness or tingling near the needling site that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping therapy. Unusual and rare risks of acupuncture include: spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses disposable sterile needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

________ **IV Therapy:** Intravenous (IV) therapy is the administration of liquid substances directly into a vein. The word, “intravenous” literally means “within a vein.” The most commonly used vein is in the antecubital fossa, or the “inside” part of your elbow. Other commonly used veins are on the top of the hand or the forearm. Usually the IVs are delivered with a teflon-coated angiocatheter, but sometimes a metallic “butterfly” needle is utilized. These are both temporary types of devices. Our clinic **does not** offer IV therapy administered through a permanent port or central catheter.

________ **General risks of IV therapy include, with decreasing frequency:** discomfort during the infusion, bleeding, irritation of the vein, damage/inflammation (phlebitis) or scarring of the vein, hematoma (bleeding under the skin; a bruise) at the IV site or site of needle stick, blood pressure changes, dehydration/thirst, hypoglycemia/low blood pressure, headache/dizziness, electrolyte changes, blood clot, or death. It is also possible that there is a failure to achieve a substantial benefit. It is necessary to list these potential risks, however, the vast majority of patients have no adverse effects at all when undergoing IV therapy.

By signing and submitting this form I acknowledge that I have been provided ample opportunity to read this document or that it has been read to me.

I understand all of the above and give my oral and written consent to the evaluation and treatment to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

______________________________ ______________________________

Print Patient Name Sign Patient Name

____

Today’s Date

Agreement of Financial Responsibility

Thank you for choosing us as your healthcare provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment. Downtown Gilbert Healthcare requires payment in full at the time services are rendered. For your convenience we accept Check, Cash, Visa, MasterCard, Discover, and American Express payments, along with most Flex Spending and HSA debit cards.

INSURANCE

Chiropractic only contracted with Medicare Part B and Triwest as the primary insurance. We can submit the chiropractic claims to your insurance to determine if you have any chiropractic out of network coverage. Generally, if there is out of network coverage it will go towards your out of network deductible. If your deductible has been met, you may receive our reimbursement payment, in turn we ask that you cash the check and in turn pay Triad of Health, LLC. Whatever is not covered by your insurance, we do not pass it on to you the patient. **Naturopathic and Massage services are not covered by insurance and are cash pay.**

ATTORNEY and LIABILITY

Please understand that monthly statements and health insurance payments may be sent directly to you. If you receive a reimbursement from your insurance company you agree to sign such reimbursement over to Triad of Health, LLC for any and all charges incurred for treatment. Should my attorney fail to make payment directly to Triad of Health, LLC upon settlement of my personal injury case or no settlement is obtained. I understand and agree that I am responsible for any balance that is outstanding with Triad of Health, LLC. I will notify Triad of Health, LLC of any changes in my case, such as obtaining a new attorney; case is lost or dismissed, etc.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card/debit card, or payment by cash or check at time of services has been verified.

NO-SHOW and CANCELATION POLICY

A credit card is required to be kept on file for all of your Naturopathic and Massage appointments.

_____ I agree that I will cancel or reschedule my appointments no later than 24 business hours in advance. If I am unable to do so I agree to pay for the missed/canceled appointment ($100 for Naturopathic appointments and $75 Massage appointments).

_____ I agree that if I am going to be more than 10 minutes late to my appointment, I will need to reschedule or understand my appointment time will be limited and I will be responsible to pay the full amount for the appointment.

_____ I have been informed and agree: There are multiple ways to give 24 hour notice to the office that I need to cancel or reschedule my appointment. All of the following are acceptable.

Text message to the front desk: 480-518-3681
Text message to Dr. Bradford: 480-442-7133
Phone call/voicemail to office: 480-219-6354
Email to office: info@downtowngilberthealthcare.com

_____ As a courtesy, I may receive an automated notification reminder from Triad of Health LLC via text message, email, and/or phone call prior to my appointment. I agree that I am still responsible to notify the office of cancellation through the options listed above.

I have read the financial agreement and understand that I am ultimately responsible for debt incurred for treatment at Triad of Health LLC. My insurance benefits have been explained to me and I fully understand what my insurance has verified that they will pay. I also understand verification of benefits is not a guarantee of payment and I am ultimately responsible for any balance with Triad of Health, LLC. By signing below, I have read and agreed to the Financial Agreement.

X____ Date ______________
Signature of Patient or Responsible Party

TRIAD OF HEALTH, LLC
% Downtown Gilbert Healthcare
P: 480-219-6354 F: 833-918-2213

CREDIT CARD AUTHORIZATION

A credit card is required to be kept on file for all of your ***Naturopathic*** and ***Massage*** appointments. There are 2 scenarios your credit card will be charged:

NO SHOW You did NOT show up for your scheduled appointment. Your card will be charged $100 for a Naturopathic appointment and $75 for a Massage appointment.

LATE CANCELLATION - You canceled your appointment WITHOUT providing at least a 24-hour notice. Your card will be charged $100 for a Naturopathic appointment and $75 for a Massage appointment.

The above scenarios are the ONLY instances in which the card you provide will be charged. By signing this form, you authorize charges to your credit card through Square. These charges will appear on your bank/credit card statement as Triad of Health LLC, and you have the right to request a paper copy of this document.

I authorize Triad of Health, LLC to charge my credit card. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Triad of Health, LLC in writing of any changes in my account information or termination of this authorization.

I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company as long as the transactions correspond to the terms indicated in this authorization form. I acknowledge that credit card transactions could be linked to Protected Health information.

I have read and agree to the above credit card authorization policies.

____ ____________________
Print Patient Name Date of Birth

____ ____________________
Patient's Signature Today's Date

HIPAA NOTICE OF PRIVACY PRACTICES
As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our Provider person or by phone at 480-219-6354

Associated companies with whom we may do business such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.