Prolozone Intake

Name:_____ Phone:_____
Address_____ Phone #2:_____
_____ Birth Date:_____
_____ SS#: _____
Email: _____ Sex: _____
Height _____ Weight_____
Your medical doctor:_____
Other health care practitioners involved in care: _____
Emergency contact and phone#:_____
Occupation:_____
Marital status:_____

IF YOU HAVE INSURANCE WE WILL PROCESS THE VISIT IF YOU HAVE MET YOUR DEDUCTABLE. THE INJECTION FEE IS UNDER THE NON COVERED SERVICE POLICY OF OUR OFFICE AND IS EXPECTED TO BE PAID AT TIME OF SERVICE.

SORRY WE DO NOT ACCEPT MEDICADE OR MEDICARE

I_____ agree to all of the following:

a) I am personally responsible for paying the fees of this service.

b) I will pay for all missed appointments with less that 24 hours cancellation notice.

c) I will pay the fees: At time of service / Within 30 days of billing.

_____ _____
Client or Guardian Signature Date

_____
Client or Guardian Name (print)

INFORMED CONSENT FOR TREATMENT for Dr. Katie Carter

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended treatments and procedures to be used so that you make an informed decision whether or not to undergo the recommended procedure(s) after knowing the benefits and risks involved. This notice is not meant to alarm you; it is simply to inform you that you may give or withhold your consent to treatment.

If you refuse any specific procedure this will not affect your receiving other care or future treatments.

I voluntarily request Dr. Carter as my Naturopathic Doctor to examine and treat me and my health conditions. I understand that the course of care therapy may include the use of multiple modalities of Naturopathic medicine including nutritional supplements, injection therapies, prolozone therapy, intravenous nutrients, ozone and other therapies offered by Dr. Carter. I understand that my verbal consent to a specific treatment and my willing participation in receiving these therapies after explanation of benefits and risks is sufficient to indicate my consent to receive treatment. I waive the option of signing a consent to treat for each and every specific procedure at each treatment date.

I understand that I am free to pursue other medical opinions and treatments including conventional medical care at any time. I understand that I have the right and the opportunity to ask questions about my condition, discuss naturopathic and conventional options at any time. I understand there may be complications and risks related to the recommended procedure(s) and that I may request additional information regarding complications and risks (side effects) and refuse any specific treatment at any time.

I understand that payment is due in full at the time of service. I understand that no warranty or guarantee regarding a promise of cure as a result of care is provided for any condition. All information given now or at any point in the future is confidential. It is Naturopathic Physicians Group's policy to require a medical

release form before releasing medical records to anyone other than the patient. I certify that I have read this form or have had it read to me and that I understand its content and meaning. I have sufficient information to give this informed consent.

Patient Name:_____

Patient Signature:_____

Date:_____

PRESENT COMPLAINT: _____

CURRENT MEDICATIONS. Include medications, vitamins, supplements, herbs, over-the-counter drugs.

Medicine:	**Dose:**	**Began on:**
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		

List more on back if needed

Tobacco use: YES / NO **Quantity:**_____

Allergies:

Hospitalizations (& year):

Diseases in family history:

HAVE YOU EVER HAD AN ASTHAMTIC ATTACK, AN ANAPHYLACTIC REACTION OR DIFFICULTY BREATHING YES / NO

CIRCLE ANY OF THE FOLLOWING SYMPTOMS YOU'VE HAD IN THE LAST MONTH

Fatigue AM/after lunch/PM	Weight gain/loss	Cancer
Pain:	Swelling:	Stiffness
Depression	Anxiety	Memory loss/foggy thinking
Dizziness	Weakness	
Insomnia. I sleep __ hours/night	Numbness/tingling	Bone loss
Restless legs	Cold hands/feet	Varicose veins
Skin problems:	Hair loss:	Headaches:
Eye problems:	Ear problems:	Sinus problems:
Frequent sore throats	Thyroid problems:	Heat/cold intolerant
Difficulty breathing:	Wheezing	Cough
Heart disease:	Hypertension	Palpitations
Digestive problems:	Diarrhea/Constipation	Nausea/vomiting
Liver problems:	Gallbladder problems:	Urinary difficulties:
Kidney stones		
Period begins every ___ days	Irregular cycles	Infertility
Period cramping	Clotting	Breast tenderness
Menopausal	Hot flashes/night sweats	Testicular pain
Prostate problems	Sexual difficulties:	
Metal taste	Toxic exposure:	Other:

Mission Healing Arts
Dr. Katie Carter
420 1st St. E.
Polson, MT 59860
(406)-883-4325 office, (406)-883-4340 fax

Patient's Name:

Non-Covered Service Waiver

NOTE: You need to make a choice about receiving these health care items or services.
The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

YOUR INSURANCE may not pay for the item(s) or service(s) that are described below. Insurances have criteria and strict definitions on what is 'Medically Necessary'. Many insurance companies do not define or cover particular natural therapies or alternative types of testing. The fact that private insurances may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Below is a list of many services that may not be covered by your insurance.

You have the right to ask, and have answered to the best of your practitioner's ability any questions about these services including:

- The description of treatment or procedure
- Explanation of risks known by practitioner
- Explanation of any side effects
- Explanation of alternative procedures
- Consequences of not receiving treatment or avoiding diagnosis

By signing this form, you acknowledge that you have discussed, and have received answers to any questions you had in regards to the below services.

Items or Services: **B12** **Meyer's** **Allergy Testing** **Genetic Testing**
Non-covered diagnostic testing **Weight Loss** **Prolozone**
Neuralprolo **LDA/LDI injections** **Prolo Therapy**

May Be: **Considered Investigational by Insurance** **Genetics non-covered (NC) service**
Vitamin Therapy Not 'Medically necessary' **Weight loss NC service**
NC Manual Therapy

The services listed above will cost approximately $ _____

I would like to receive these services, and have had all my questions answered regarding the non-covered services listed above. I understand that my insurance will not be billed by my provider due to non-payment and/or incorrect payment, so I agree to pay for these services myself. I will not hold my practitioner or their office responsible for billing my insurance company directly.

Signature of patient or guardian: _____ **Date:** _____