Rose Cabinet Medicine
Dr. Louise Rose, ND
CRANIAL THERAPY INTAKE FORM

Patient Name: ___________________________________

Date of Birth: ___________________________________

Address: ____

Email: ________________________OK to leave confidential messages: YES NO

Home Phone: __________________ OK to leave confidential messages: YES NO

Cell Phone: __________________OK to leave confidential messages: YES NO

Emergency Contact (name and number): ____
Insurance Company (if applicable):____
ID#__________________________ Group#_____________________________________

Please list any previous medical problems and surgeries: ________________________________
____
____

Please list any medications, supplements, or herbs you are currently taking: _________________
____
____
____

What are you goals that you would like to achieve via Cranial Therapeutics?

____

____

____

Would you be interested in receiving educational newsletters and updates from Rose Cabinet Medicine via email? YES NO

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree than you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent. All HIPPA Policies are effective April 14th, 2003

Consent for Treatment

Naturopathic Medical Consent: I consent to services rendered and treatment provided by Dr. Rose at Rose Cabinet Medicine. I recognize that Dr. Rose is a licensed Naturopathic Physician. I have the right to refuse any treatment suggested that I am uncomfortable with. I have the right to ask questions to my satisfaction. Dr. Rose has the right to treat me within the scope of her practice. Dr. Rose has the right to refuse treatment or to make referrals to outside physicians if she feels that she can not be of service to my case.

Patient Name: ____

Patient/ Guardian Signature:____

Relationship to Patient: ____

Date: ___________________________

YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that *you identify* who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds.
- Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please check all that apply:

___Please do not phone me at home. Use this alternate phone number:______________

___Please do not phone me at work. Use this alternate phone number: _________________

___Please do not leave messages on my answering machine.

___Please do not contact me by email.

___Please send mail, including my bills, to this alternate address:_______________________

____

___Other request (please describe): ____

____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

____ ___/_____/_____

Patient Signature (Parent/guardian signature if minor) Date