Traditional Healing for Modern People

Today's
Date_____

Name _____Date of Birth_____

I identify my sex as: Female Male Intersex MtF-Female FtM-Male
I identify my gender as: _____
My preferred pronoun: _____

I live with: Spouse Partner Parents Children Friends Alone Roommates

Occupation _____ Hours per week _____

Race/Ethnicity/Religion_____

Home Address _____
City _____ State _____ Zip Code_____

Communication: What is the best way to reach you?

(home)_____
(work) _____
(cell)_____ Is it O.K. to leave a message? Y/N

email_____
Would you like to receive occasional email newsletters about events at Rose Cabinet Medicine? Y/N

How did you hear about Rose Cabinet Medicine/Dr. Louise Rose?
_____

Emergency Contact _____
Relationship _____ Phone _____

My Primary Care Provider is:
_____

When and where did you last receive medical or health care?
_____

What was the reason? _____

What are your most important health problems? List as many as you can in order of importance.

1) _____
2) _____
3) _____
4) _____
5) _____

Can you identify any potential obstacles in addressing lifestyle factors which may be undermining your health or which may interfere with your ability to adhere to therapeutic protocols?

_____
_____

General

Weight _____ lbs. Weight one year ago_____lbs.
Maximum Weight _____lbs. When_____
Height_____ At what time is your energy the best?_____
Worst
_____

Please list any **prescription medications**, **over the counter medications, vitamins,** or **supplements** you are currently taking, and *what they are indicated for*.

1)_____ 2)_____
3)_____ 4)_____
5)_____ 6)_____
7)_____ 8)_____

Allergies

Are you hypersensitive to:
Indicate your reaction: ie "rash" "can't breathe" and the **level of severity** (mild-severe)
Any drugs_____

Any foods?_____

Anything in the
environment_____

Family History

	age (if living)	health issues	age at death/cause of death
mother			
father			
siblings			
maternal GM			
maternal GF			
Paternal GM			
Paternal GF			

Circle those Applicable and indicate which family member

Cancer
Diabetes
Heart Disease
High Blood Pressure
Stroke
Epilepsy
Mental Illness
Asthma/Hayfever/Hives
Allergies
Eczema/Psoriasis
Addiction
Anemia
Kidney Disease
Glaucoma
Parkinsons/ALS/MS
Tuberculosis
Auto immune disorder
Other

Hospitalization and Surgery

What hospitalizations, surgeries, or serious illness have you had?

_____ year:_____

_____year:_____

_____ year:_____

_____ year:_____

Welcome! I'm happy to serve you. If you have any questions, please ask!

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.

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

_____ ___/_____/_____

Patient Signature (Parent/guardian signature if minor)

_____

Terms and Conditions of Treatment

Consent for Treatment:

I understand my healthcare as a patient of Rose Cabinet Medicine / Dr. Jennifer Louise Rose ND. I consent to services rendered and provided to me under the instructions of Rose Cabinet Medicine / Dr. Jennifer Louise Rose ND. As a Naturopathic physician Dr. Rose is trained in several disciplines including nutrition, homeopathy, biotherapeutic drainage, flower essences, lifestyle counseling, botanical medicine, physical medicine, Shiatsu massage, Cranial therapeutics, hydrotherapy, Low Energy Neurofeedback System, and stress management. Working from a paradigm of health that aims to address the cause of disease, and not just to treat symptoms, Dr. Rose will be honored to work with you on your lifelong journey toward wellness.

I have fully read and understand the above agreements and authorizations.

_____ _____

Patient (18 years or older) Date

_____ _____

Parent, Guardian, Responsible Party Date

Statement of Financial Responsibility: I understand and agree to the following:

Payment for services rendered are my responsibility as the patient or patient's responsible party.

I am responsible for paying for all services, including lab tests, rendered at the time of service.

If I am receiving a discount of any sort, I am responsible for providing accurate and thorough documentation supporting it and I am responsible for paying in full at the time of service. **I understand I may be charged $50 for not providing 24 hours or more notice before canceling an appointment.**

_____

Signature of patient or patient's responsible party
Date

Insurance billing: If I am billing insurance for services rendered, I understand and agree to the following:

I authorize Rose Cabinet Medicine /Dr. Jennifer Louise Rose to release pertinent medical records related to billing directly to my insurance carrier. This release applies to support of the insurance billing process only.

I am responsible for any and all charges that my insurance company will not cover.

_____

Signature of patient or patient's responsible party
Date