GRD Health Center

Intake Form

Date: _____

Patient's name: _____ Legal name: _____

Male___ Female___ Age: _____ Birth date: _____ Social Security number: _____

Single___ Married___ Divorced___ Separated___ Widowed___ Driver's License number: _____

Home phone number: _____ Work Number: _____

Cell number: _____ E-mail: _____

Home address: _____

Employer: _____ How long _____ Occupation _____

Who referred you to our office _____

In the case of an emergency, whom should we contact? _____ Relation _____ Phone _____

Main Complaints: What brought you to our office, how long has it been going on?

1. _____
2. _____
3. _____

Minor Complaints: List other symptoms that we may be able to help you with.

1. _____
2. _____
3. _____

Major Illness in the past: Please state the type of illness and your approximate age at the time of illness.

1. _____ 2. _____

Allergies:

_____ _____

Surgeries:

_____ _____

Prescription medicine: Please state the medication and reason for taking it.

_____ _____

_____ _____

List prescription medicine that you have taken a lot of in the past and for what it was used.

_____ _____

Are you currently taking any herbs or food supplements?

_____

How much and why?

_____

When was your last X-ray taken? _____

205 Los Alamos Hwy, Ste C Espanola, New Mexico 87532 505.753.3369 Fax 505.753.4006

Shakti Health Inc.
GRD Health Center
Dr. Jiwan S. K. Khalsa, D.O.M.
510 N. Paseo de Onate Espanola, NM 87532
(505) 753-3369

Informed Consent to Health Care by a Doctor of Oriental Medicine

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by Dr. Jiwan Shakti K. Khalsa and or other licensed doctors of oriental medicine who now or in the future treat me while employed by, working or associated with or serving as back-up for medical procedures including diagnostic techniques such as questioning, pulse evaluation, acupuncture, injection therapy, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as massage, manipulation of joints and/or viscera, heat and or cold therapy and electrical and/or magnetic stimulation; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendation; exercise advice and healthy lifestyle counseling.

I have had an opportunity to discuss with my Doctor and/or with other clinic personnel the nature and purpose of acupuncture, oriental medical procedures and injection therapy. Although I am aware that acupuncture and the other procedures used in oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of oriental medicine and injection therapy there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible I understand that these risks include but are not limited to: bleeding, bruising, pneumothorax (punctured lung), puncture of other organs, pain or other strong sensation at the location where a needle is inserted or radiating from that location, nerve pain, burns, infection, aggravation of current symptoms, appearance of new symptoms, general aches, sprains, strains, dislocation, fractures, disc injuries and strokes. I understand that there are risks associated with acupuncture when pregnant, such as abdominal cramps and possible miscarriage, if I am pregnant I have informed the doctor and I accept responsibility for the outcome of the treatment. I understand that joint regenerating injections work by creating mild inflammation, but on rare occasion there can be stronger inflammatory responses for some days after injection. I understand that infection is possible with any needling, yet it is extremely rare. I understand that herbs, supplements, other oral/injected medicines, or even recommended natural foods can cause strong allergic or other reactions, even dangerous or deadly ones, though such reactions are very rare. I will always retain the right to accept or reject any diagnostic procedure or any treatment, before or during any procedure. 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 such judgment, during the course of my treatments, as the doctor feels at the time, based on the facts then known, to be in my best interest.

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment form Dr.(s) Khalsa.

Patient's Name (Print)_____Patient's Signature _____Date___
Witness_____
Printed name of Patient's Representative (if applicable)_____
Signature of Patient's Representative (if applicable)_____
Relationship or Authority of Patient's Representative_____

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FINANCIAL POLICY

Please read our financial policy and indicate your agreement by your signature. We are committed to providing you with the best possible care and we are please to discuss our professional fees with you at any time. You clear understanding of our financial policy is important to our professional relationship. If you have any questions, please do not hesitate to ask.

FULL PAYMENT IS DUE AT TIME OF SERVICE

We accept cash, checks and credit cards.

If you would like us to bill your insurance, we will contact your insurance and bill them based upon the non-guaranteed information they provide us.

You are responsible for all co-payments, deductibles and other adjustments made by your insurer. There may be an additional charge not covered by your insurance plan that you will be responsible to pay.

Insurance companies may reimburse differently than the information they originally provide to us. You are responsible for and will be billed for any resulting unpaid balance.

Thank you for your courtesy and understanding. If you have any questions or concerns, please feel free to discuss them with the Office Manager

CANCELLATION POLICY AGREEMENT
For Massage Therapy Treatments

GRD Health Center is committed to providing all of our patients with exceptional care. We understand that situations arise in which you must cancel your appointment. We request if you must cancel your appointment, please provide 24 hours of notice. To cancel a Monday appointment, please call our office on Saturday before 12:00pm.

Patients who are not able to keep their appointments are required to give our office 24 business hours cancellation notice or there will be a $35 fee. This fee is NOT covered by insurance.

GRD Health requires that a credit card be kept on file. If you do not cancel your appointment within the required 24-hour notice period, you authorize GRD Health to charge $35 to this card.

Visa, Mastercard, Discover number: _____

Name on card: _____

Exp date: _____ Sec code: _____

Authorized signature: _____

GRD Health reserves the right to terminate the doctor/patient relationship for lack of payment for any reason.

Please sign below to consent to these terms

_____ Date ____/____/____
Client Signature (Client's Parent/Guardian if under 18)