Dr. Eric Ohling, ND
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Patient Intake Form

Full Name:____
LAST NAME FIRST NAME MI

Sex: O Male O Female Females Only: Are you currently pregnant? Yes____ No_____

Preferred Name:_____________________ Date of Birth:________________________

Mailing Address: ____

City: _____________________________________ State: _________________ Zip: _______

Home Phone: _____________________________ Cell Phone: ___________________

Email: ____

Emergency Contact: ___________________________________ Phone: ________________

How did you hear about us? ____

Do you have a primary care provider? O Yes O No

If yes, Name of health care provider or facility: ____________________________________

If no, how do you receive medical care?
O ER O Urgent Care Other:__________________

List your health concerns, describe briefly.

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Informed consent for treatment and privacy:

- I understand that providing incorrect information or omitting information about my health history can be dangerous to my health. I have answered the intake questions to the best of my knowledge. It is my responsibility to inform my doctor at Ohling Natural Health of any major changes in my health status.
- I am eligible to receive a range of services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me.
- I have been advised my medical information is regulated and protected by HIPPA standards. My record will not be given to others without my written consent unless the law authorizes it or compels it (valid court order). I may see my record or get more information about it by contacting Ohling Natural Health.
- In consideration of and in return for services and any other assistance provided to me by Ohling Natural Health and its health care providers, I release them from any and all liability, claims and actions that may arise from injury, harm, from my death and from damage to my property in connection with this activity.
- The signature below authorizes Ohling Natural Health and its health care providers to treat me.
- I certify that I am competent to make this choice and participate in these activities.

Cancellation/No show policy for doctor's appointment:

We understand that there are times when you must miss an appointment due to emergencies or obligations beyond your control. However, when you do not call to cancel or reschedule your appointment, you may be preventing another patient from getting treatment they need. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit due to a seemingly full schedule. If an appointment is not cancelled in advance of at least 48 hours, you will be charged a fee of 50% the cost of your visit.

Scheduled Appointments:

We understand delays can happen; however, we must try to keep other patients and doctors on time. If you know you are going to be late, please call the clinic as a courtesy. We will make every effort to get you in as soon as possible but you may be required to wait until there is space in the schedule. In some instances, you will be asked to reschedule your appointment.

____ ____/____/________

PATIENT SIGNATURE DATE

Consent for Use or Disclosure of Health Information

We are very concerned with protection your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information:

- We may have to disclose your health information to another health care provider of a hospital if it is necessary refer you to them for diagnosis, assessment, or treatment,
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your personal information to communicate with you by email or regular mail in order to remind you of your appointments send you a

thank you for your referrals, invite you to participate in patient appreciation days, send you an office newsletter or informational letter, or send promotional information.

- We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding upon us.

Your Right to Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms and I am also acknowledging that I have received a copy of this notice.

____

PRINTED NAME

____ ____/____/________

PATIENT SIGNATURE DATE

____ ____/____/________

AUTHORIZED PROVIDER REPRESENTATIVE DATE