

Granger Naturopathic Clinic, Inc.

20325 N. 51st. Avenue, Suite 112

Glendale, AZ 85308

(623) 444-4482

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (home) _____ (work) _____ (cell) _____

Fax _____ e-mail _____

Date of Birth: _____ Age: _____

Marital Status: _____ Sex: M - F

List current medications: _____

List drug allergies: _____

List other allergies: _____

What supplements are you currently using _____

Name of Physician: _____

Source of referral: _____

How did you learn of Colon Hydrotherapy Treatment: _____

| DAILY HABITS | HEAVY | MODERATE | LIGHT | NONE |
|---------------------|--------------|-----------------|--------------|-------------|
| Alcohol | | | | |
| Coffee | | | | |
| Tobacco | | | | |
| Drugs | | | | |
| Exercise | | | | |
| Sleep | | | | |
| Appetite | | | | |

**GENERAL
(Please check)**

- Headaches
- Insomnia (Loss of Sleep)
- Loss of weight
- Dizziness
- Fainting spells
- History of seizures
- Fatigue
- Depression
- Enlarged thyroid
- Double/blurred vision
- Other

**GASTRO INTESTINAL
(Please check)**

- Colitis
- Constipation
- Crohn's Disease
- Ulcerative Colitis
- Diverticulitis
- Diverticulosis
- Gall Bladder Disease
- Hemorrhoids
- Fissures/Fistulas
- Liver trouble
- Cirrhosis
- Rectal bleeding
- Vomiting of blood
- Cancer
- Family History-Colon cancer

**RESPIRATORY
(Please check)**

- Shortness of breath
- Chronic cough
- Vomiting blood
- Emphysema
- Bronchitis
- Asthma (wheezing)

**MUSCLE AND JOINT
(Please check)**

- Arthritis
- Bursitis
- Low back pain
- Neck pain
- Other pain
- Swollen joints

**CARDIOVASCULAR
(Please check)**

- High blood pressure
- Hardening of the arteries
- Angina (chest pain)
- Poor circulation
- Rapid heart beat
- Irregular heart beat
- Congestive heart failure
- Swelling of ankles

**SKIN
(Please check)**

- Bruise easily
- Dryness
- Itching
- Rash

**GENITO-URINARY
(Please check)**

- Kidney Infection or stone
- Painful urination
- Prostate trouble
- Kidney failure

**WOMEN
(Please check)**

- Painful menstruation _____
Last menstrual period _____ DATE
- Vaginal discharge
- Breast pain
- Are you pregnant? Yes/No

Patient's Name _____ Date _____

1. Have you ever had a Colon Hydrotherapy Treatment before? Yes No

If yes, when and where? _____

2. Do you use any of the following? _____ Laxatives _____ Enemas _____ Antacids

3. Are you presently taking any medications? Yes No If yes, give details _____

4. Have you had any surgery in the last year? Yes No If yes, give details _____

5. Have you been hospitalized in the last year? Yes No If yes, give details _____

6. Do you have a history of Colon Cancer in your family? Yes No

7. Your Physician's name and address _____

8. How often do you undergo Colon Hydrotherapy Treatment?

- Treatments per month
 treatment per 3 months
 treatment per _____ years

9. Do you feel that Colon Hydrotherapy is beneficial? yes no

Explain _____

10. Do you find the Treatment painful or unpleasant in any way? Yes No If so, explain

11. Please briefly describe symptoms/complaints prior to taking Colon Hydrotherapy Treatments

Constipation bloating gas pain diarrhea colitis

other, explain _____

12. Please comment on benefits/drawbacks obtained from the Colon Hydrotherapy Treatments:

- | | | | |
|---------------------------------------|-----------------------------------|------------------------------------|-------|
| <input type="checkbox"/> Constipation | <input type="checkbox"/> improved | <input type="checkbox"/> no change | _____ |
| <input type="checkbox"/> Gas pain | <input type="checkbox"/> improved | <input type="checkbox"/> no change | _____ |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> improved | <input type="checkbox"/> no change | _____ |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> improved | <input type="checkbox"/> no change | _____ |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> improved | <input type="checkbox"/> no change | _____ |

Granger Naturopathic Clinic, Inc.:
Rescheduled / Cancelled Appointments
After-hour / Emergency Appointments
NSF Check Fees
Insurance Reimbursement

PLEASE BE AWARE:

Appointments:

The patient is ALWAYS responsible to call **24 hours prior to the scheduled appointment time** to reschedule or cancel. Failure to do so will result in a \$ 45.00 charge to the patient for the missed appointment.

If you need to reach a doctor after regular business hours, there will be a \$75 fee for the urgent phone call. If you have an emergency, please call 911.

NSF Checks:

NSF checks that are returned to us will automatically mean a charge to the patient account of \$25. The patient will be responsible to replace the amount of the check in addition to the \$25 Non-Sufficient Funds amount.

Payment for services:

An insurance policy is a contract between you and your insurance company. The patient is ALWAYS responsible for payment of all charges incurred regardless of any insurance or other third party payment arrangements.

- Payment will be collected at the time of service.
- Most insurance companies do not cover Alternative Medical procedures. This includes but is not limited to Acupuncture, Colonics, Vitamin injections, Microscopy, Intravenous Nutrition and Metabolic Therapy.

The natural medicines that are prescribed by the center's physicians may be purchased here or at the pharmacy of your choice.

I certify that I have read and understand the above policies. I guarantee payment of all charges incurred as a patient of Granger Naturopathic Clinic, Inc..

Signed: _____

Parent or Guardian (if minor): _____

Date: _____

Granger Naturopathic Clinic, Inc.

17100 N. 67th Avenue, Suite 300
Glendale, AZ 85308

Phone 623-878-8999
Fax 623-878-4877

COLON HYDROTHERAPY CONSENT AND RELEASE FORM

Client Name _____

Address _____

City, State, Zip _____

I, _____, certify that I am over 18 years of age, or that I am the father/mother/legal guardian of (minor's name) _____. For receiving sessions and instruction at this facility, I release and forever discharge all persons associated with Granger Naturopathic Clinic, Inc. from any and all responsibility or liability arising from these procedures and demonstrations. I have not been promised anything to submit to these procedures, or to sign this release form. No guarantees or warranties have been made to me or to the success, value, or benefit of such procedures. I realize and acknowledge that the instructions, recommendations and services are not medical treatments or prescriptions. Any changes or additions in my diet, exercise, or supplementation are of my own choosing. I have been instructed and understand that I should consult my physician before entering into any lifestyle changes and am free to withdraw my consent and discontinue visits here at any time. This form had been fully explained to me and I certify I understand its contents.

Client Signature

Date

_____ Asked about personal insertion

Witness Signature

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Granger Naturopathic Clinic, Inc. Notice of Privacy Practices.
(Attached)

Patient or legally authorized individual signature Date

Printed Name if signed on behalf of the patient Relationship (parent, legal guardian,
personal representative, etc.)

Revisions (if any):

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained because (please specify):

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.
9. In cases of suspected child abuse or dependent adult or elder abuse, for which we are required by law to report.
10. If a client is threatening serious bodily harm to another person(s), we must inform the intended victim.
11. If a client intends to harm himself or herself, we must act to protect the life of the client.

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Granger Naturopathic Clinic, Inc., 17100 N 67th Avenue, Suite 300, Glendale, AZ 85308. Note: *We must respond to this request within 30 days.*
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Granger Naturopathic Clinic, Inc., 17100 N 67th Avenue, Suite 300, Glendale, AZ 85308. You must provide us with a reason that supports your request for amendment.

Note: *We must respond within 60 days. The Privacy Officer or the patient's physician will usually do this. If the physician believes the information is complete and accurate, the physician can refuse to make any changes.*

5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the front desk receptionist.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager at Granger Naturopathic Clinic, Inc., 17100 N 67th Avenue, Suite 300, Glendale, AZ 85308. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the Office Manager at Granger Naturopathic Clinic, Inc.