

Dr. Cheryl Granger
17100 N 67th Avenue, Suite 300
Glendale, AZ 85308
(623) 878-8999

MESOTHERAPY
CONFIDENTIAL PATIENT INFORMATION
PLEASE FILL IN ALL PORTIONS OF THIS FORM
PLEASE ASK IF YOU NEED HELP

(Please ask if you need help)

How did you hear about us? Yellow pages _____ Newspaper _____ Supermarket _____
Location/Sign _____ Other (list) _____

Referred by _____

Name of Patient _____

Permanent Address _____

City _____ State _____ Zip _____

Temporary Address _____

City _____ State _____ Zip _____

Age _____ Date of Birth _____ Marital Status _____

Phone (Permanent) _____ Cell _____

Fax _____ E-mail _____

Work Phone _____ SS# _____

Employed by _____ Occupation _____

Name of spouse (or parent if minor) _____

Work Phone _____ SS# _____

Employed by _____ Occupation _____

Name of relative not living with you _____

Whom may we contact in case of emergency? _____

Phone _____

CLINIC POLICY REQUIRES PAYMENT AT TIME OF SERVICES

I WILL BE PAYING TODAY BY:

CASH _____ CHECK _____ VISA _____ MASTERCARD _____

At time of payment, you will be given a copy of your superbill from our office. This will show diagnosis, services and charges. You can submit this form for reimbursement directly to your insurance company. Please let our front office know if you plan to submit your bill to your insurance. This will enable us to give you the appropriate information.

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. I hereby authorize the undersigned physician to furnish medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible. I also understand that if I suspend or terminate my care and treatment any fees for professional service rendered me will be immediately due and payable. Further more, any charges, fees or court costs incurred as a result of collection efforts will be added to my account balance.

Releases may be requested prior to specific procedures being performed (i.e. minor surgery, etc.)

Patient Signature

Date

Parent/Guardian Signature

Name: _____

Date: _____

CURRENT MEDICATIONS: (Do you take or use the following?)

Laxatives	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pain relievers	<input type="checkbox"/> YES <input type="checkbox"/> NO	Antacids	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cortisone	<input type="checkbox"/> YES <input type="checkbox"/> NO	Appetite suppressants	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sleeping pills	<input type="checkbox"/> YES <input type="checkbox"/> NO
Tranquilizers	<input type="checkbox"/> YES <input type="checkbox"/> NO	Thyroid medication	<input type="checkbox"/> YES <input type="checkbox"/> NO		

Please list prescription medications, over the counter medications, vitamins or other supplements you are taking:

- | | | |
|----------|----------|-----------|
| 1) _____ | 5) _____ | 9) _____ |
| 2) _____ | 6) _____ | 10) _____ |
| 3) _____ | 7) _____ | 11) _____ |
| 4) _____ | 8) _____ | 12) _____ |

List ALLERGIES: (Drugs, chemicals, foods) Please list type of reaction.

HOSPITALIZATION AND SURGERY (Please list all surgeries and hospitalization you have had.)

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MESOTHERAPY CONSENT FORM

Mesotherapy is a treatment protocol for cellulite and lipolysis of adipose tissue that involves mesoderm injections of both non-prescription and prescriptive type medications. These injections are being performed by a licensed physician, Dr. Cheryl Granger.

By signing this form you are consenting that you as the patient have been instructed that this procedure “mesotherapy” is not approved by the Federal Drug Administration (FDA) for removal of cellulite or fat. This procedure has not been reviewed by the FDA, however the medications and non-prescriptive medicinals all have FDA approval for their respective mechanisms of action.

The risks of this procedure have been described and are (but not limited to) the following: localized cellulites at the site of injection, ecchymosed or bruising of the skin, pruritis, allergic reactions to the constituents of the injectables, and tissue necrosis. The treatment may also not provide the degree of fat loss or sculpting of the body that the patient may have expected. I understand that once a treatment package has been purchased, no refunds will be given.

By signing this form you are testifying that all of the medical information you have provided is current and factual to the best of your knowledge.

I understand that the results may or may not be permanent and that I may require multiple sessions for optimal results.

I agree that this constitutes full disclosure and that it supercedes any previous written or verbal disclosure and that I have read and fully understand the above paragraphs and that I have had sufficient opportunity for discussion and to ask questions. I consent to mesotherapy treatment today and for all subsequent treatments.

I will call to inform my practitioner of any complications or concerns I may have as soon as they occur.

I also authorize the taking of clinical photographs and their use for scientific purposes, both routinely in my formal medical records, as well as in scientific publications and presentations. I also agree to let my photographs be used for promotional purposes. I understand my identity will be protected, and that I may examine the photographs in my patient chart.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

**Granger Naturopathic Clinic, Inc. Policy for:
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: _____

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.

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..

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MESOTHERAPY
AFTER CARE INSTRUCTIONS

- * Eat protein prior to and after treatment
- * Drink plenty of water before and after procedure
- * No lotions should be applied to treated area for at least 6 hours
- * Use traumeel gel on treated area to decrease bruising as directed by your physician
- * If itching occurs use Tolereen or Benadryl

SIDE EFFECTS

- * Nausea
- * Itching
- * Bruising