HANSEN CLINIC

NATURAL MEDICINE | AESTHETICS | MESOTHERAPY

CONFIDENTIAL PATIENT INFORMATION

Dear Patient; please respond to the following questions as completely and accurately as possible. Your cooperation is greatly appreciated. This information will enable us to serve you better. ***PLEASE PRINT.***

Patient Name: _____ Date:_____

Home Phone: _____ Date of Birth: _____ Sex: _____ Age: _____

Home Street Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Email: _____

Spouse's Name: _____ Phone: _____

Name of Parents if Patient is a dependent child: _____

Nearest Relative not living with you: _____ Phone: _____

Emergency Contact Person: _____ Phone: _____

How did you hear about us? _____

PATIENT HEALTH HISTORY

What is your primary concern: _____

_____

Other concerns: _____

How long has this been a concern: _____

_____

Have you ever had this or a similar concern in the past? _____

How long has it been since you REALLY felt good? _____

List previous diagnosis and treatments you have received prior to your present concerns: _____

_____

List any Serious Illnesses or surgical operations with dates or approximate dates: _____

_____

List all medications that you are currently taking, both over the counted and prescription. Please include pill strength and number taken per day. (Use the back of this page, if needed)_____

_____

_____

FAMILY HEALTH HISTORY

Many health conditions are the result of hereditary predisposition; information about your family members will give us a better perspective of your total health picture.

Relationship to Yourself	Please List Any Significant Health Concerns

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GENERAL CONSENT FOR MEDICAL SERVICES

I am requesting health care services to be provided by Dr. Clark Hansen, N.M.D., his designated associate staff members and technicians as directed by him, as he may determine to be required for my care. I understand that this agreement to accept these services is called a General Consent and that it includes routine diagnostic, and laboratory testing procedures or treatments such as blood drawing, physical examination, EKG, the use of local anesthesia, as well as the administration of medications by Intramuscular or Intravenous injections.

I understand that, as with all medical procedures, the results of the medical treatments and procedures at the Hansen Clinic cannot be entirely predicted or guaranteed. Although, Dr. Hansen has had great success in treating thousands of patients over his 35+ years of practice, neither he nor his staff can give any certain guarantee of the individual outcome or success any patient may have. However, I also understand that Hansen Clinic promises to treat each patient with our full attention and integrity using the best of our expertise and years of experience.

Signature of Patient: _____ Date: _____

COMPLIANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

I understand that The Hansen Clinic of Natural Medicine is required by law to abide by the standards and requirements of *HIPAA* (the Health Insurance Portability and Accountability Act), which was established in 1996 to protect the privacy of the individuals' medical records and other personal health information. I authorize the Hansen Clinic to comply with these privacy laws and to release all or part of my medical records to other referred health care providers, insurance companies, or medical entities as required for my medical care, as part of my treatment plan with Hansen Clinic, or as required by law.

I also understand that Hansen Clinic may not release my records to outside facilities or third-party providers not directly related to my care at the Hansen Clinic, except where I have given specific written permission to disclose such information. I further understand that I may withdraw this permission at any time with written notice.

Signature of Patient: _____ Date: _____

APPOINTMENT SCHEDULING AND FEES FOR MISSED APPOINEMENTS

If you need to cancel your appointment, we ask that you provide a 24-hour notice. Your consideration in this matter will allow us to accommodate other patients who could benefit from an appointment. If you are unable to keep your appointment and do not provide a 24-hour notice or do not show for your appointment, there is a $75 fee that will be applied.

The Hansen Clinic is implementing a new appointment reservation fee policy beginning January 1, 2023. New Patients will be asked to pay $150 towards their first visit, at the time of making their appointment. When New Patients arrive for their appointment, the fee will be applied as credit toward their scheduled appointment. This allows us to reserve your appointment time and ensure that we're optimizing the time spent with each patient.

Clients canceling their appointment more than 24 hours prior to the scheduled appointment may reschedule at no additional cost. For Monday appointments the cancellation must be called in before 4 pm on Thursday to avoid a cancellation fee.

The Hansen Clinic will do its best to accommodate you if you arrive a few minutes late to your scheduled visit, although that is not always possible. If you arrive more than 15 minutes late, we may need to reschedule your visit.

Missed appointments or appointments cancelled less than 24 hours in advance are subject to a $75 charge for the prevention of services that could have been provided to another patient during that time.

Initials: _____

PHARMACY AND COMPOUNDING SERVICES

Orders placed with the Hansen Clinic pharmacy will be filled within-24 hours, except in cases that require fulfillment by outside pharmacies. All prescriptions will be verified prior to filling. Please note, some refills cannot be completed unless the associated lab tests are up to date.

Orders may be placed either by phone to 480-991-5092 or through the secure, online patient portal: https://www.optimantra.com/optimus/om/patient/login

Initials: _____

TERMS OF PAYMENT

Payment, for the services and Pharmacy items, is due in full at the time such services are rendered, or products are dispensed. All sales are final. No refunds can be given for medical services or prescriptions. Supplements may be returned only if the seal is unbroken. The Hansen Clinic accepts cash, checks, MasterCard, Visa, American Express, or Discover Cards. Returned checks are subject to a $25.00 collection fee in addition to any bank fees.

Signature of Patient:_____ Date*:* _____