

Paul Raish, N.D.
215 S. Complex Drive, Kalipsell, 59901

STEM CELL INTAKE

NAME _____ Today's date _____
GENDER: _____ SS# _____ - _____ - _____ AGE _____ BIRTH DATE _____
Address: _____

Phone Home: (____) _____ - _____ Work: (____) _____ - _____ Cell: (____) _____ - _____
E-mail: _____ Preferred number to contact you? _____

May we leave messages on your: home phone work phone cell phone email

In Case of Emergency, Contact: _____ Relationship: _____
PHONE: Home: (____) _____ - _____ Work: (____) _____ - _____ Cell: (____) _____ - _____

Please tell us how you found out about our office or who you were referred by:

Financial Policy

Payment is due in full at time of service for all procedures. We gladly accept cash, check, Visa, Mastercard, American Express and Flex/Health Savings cards.

It is the patient's responsibility to verify their insurance coverage and whether they accept Naturopathic Doctors on the insurance plan. We can give you a coded superbill for you to submit to your insurance company for reimbursement. Please ask our office staff if you would like one created.

All phone consultations will be paid via credit card before the consultation begins.

All supplements used by Dr. Raish's office are of the highest quality. Dr. Raish has and continues to spend significant time researching products and companies ensuring that the products he prescribes are of the greatest integrity and provide the best care. All supplements are paid for at time of service.

If you need to cancel an appointment, please do so at least 24 hours ahead of time. There will be a \$50 fee assessed for no shows. Special circumstances for absence can be discussed.

I have read and understand my financial responsibility.

Print Name

Signature

Date

Stem Cell Intake Form

Date: _____

Name: _____ DOB: _____

Where is the pain: _____

How long has it been hurting you? _____ Has it gotten worse overtime? _____

When was it injured? _____

How was it injured? _____

Any surgery on this joint? _____

How much does it hurt in a relaxed position?

How much does it hurt when weight bearing?

How much does it hurt with action/motion?

Does this injury effect your

Range of motion _____ Strength _____ Focus _____ Normal function _____

Are you on pain medication?

Which one (s): Dosage and how many times a day?

Other treatments received for this injury?

Please email to thenaturalpath@protonmail.com