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

IV INTAKE

NAME _____ Today's date _____
GENDER: Female / Male SS# _____ - ____ - _____ AGE _____ BIRTH DATE _____
ADDRESS _____
CITY/STATE/ZIP _____
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

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Name:_____ Date of Birth:_____

IV desired:_____

Purpose of treatment:

_____

_____

Please be as thorough as possible with the following information:
Current Medications:

_____

_____

_____

Health Conditions and when diagnosed:

_____

_____

_____

Anything you think we should know: (allergies, health concerns, etc...)

_____

_____

_____

By signing below you affirm that you have listed all medications and described your health condition thoroughly. Especially heart and kidney issues. These issues do not necessarily exclude you from treatment but need to be taken into advisement. You also affirm that you willingly accept treatment and have payed for that treatment.

Patient Name: _____ Patient Signature:_____
Date: _____ Height: _____ Wt: _____

Intake Sheet reviewed by: _____ BP:____/_____ P:____ Date:_____
Other suggestions made:

_____

_____

_____

IV administered by: _____

Please email to thenaturalpath@protonmail.com