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

PROLOZONE 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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CONSENT FOR PROLOZONE TREATMENT

I hereby authorize Dr. Paul Raish to perform the following specific procedures as necessary to facilitate my treatment:

Prolozone Injection

Potential Risks: Localized discomfort, swelling/bruising from needle insertions, and a temporary healing reaction from the treatment.

Notice to Pregnant Women: All female clients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by my physician. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee if such request involves expense to send.

_____	_____
Client's Name (PRINT)	Guardian/Personal Representative's Name
_____	_____
Client's Signature	Guardian/Personal Representative's Signature
_____	_____
Date	Relationship/Representatives Authority

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Prolozone 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?

Unbearable

How much does it hurt when weight bearing?

Unbearable

How much does it hurt with action/motion?

Unbearable

Does this injury effect your
Range of motion ☐ Strength ☐ Focus ☐ Normal function ☐

Are you on pain medication? No

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

_____

Other treatments received for this injury?

Please email to thenaturalpath@protonmail.com