HOPE ND

Today's Date _____ Date/Time of appointment _____

This is a confidential record of your medical information and will not be released, except under the guidelines of the Notices of Privacy Practices.

Please complete all areas to the best of your ability

Name: _____ Date of Birth: _____Age: _____

Sex:_____Birth sex (if different from current):_____

Address: _____
City:_____ State: _____ Zip: _____

Telephone: Home _____ Work _____ Cell _____

Please circle the phone number you prefer to be reached at.

Is it okay to leave messages regarding your medical care at: Email [ ] Home [ ] Work [ ] Cell [ ]

Email: _____ Occupation: _____

Employer _____

Emergency Contact: _____ Relationship_____

Phone _____

Other current health care providers: _____
_____

How did you hear about Hope ND? _____

Do you have any allergies (medications, foods, dust, dander, pollen, topical agents, etc)? Please list, if yes: YES NO

If yes, please describe: _____

HOPE ND

Name: _____Date:_____Age:_____

Please list all medication/supplements that you are taking (include doses, date started, and **reason for taking):**

_____
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HOPE ND

Cancellation Policy: Hope ND, LLC requires **at least 48 hours' notice of cancellation** in advance of the scheduled appointment time. Missed appointments without notification, cancellations after appointment start time, or showing up more than 15 minutes late will be charged $100.00. Cancellations with less than 48 hours' (weekends excluded) notice will be charged $50.00. • I agree to pay for services rendered at time of service. Payment is expected in full at time of service. I acknowledge that I may request the fees for various procedures (although, these cannot always be guaranteed not to change) before they occur and include that information in my decision regarding healthcare. I consent to treatment by Hope ND, LLC and use of my medical records as provided by law. Any therapy will proceed only with our mutual consent, and I understand that any and all results of treatment are not guaranteed. I agree to discuss any problems/concerns in my care with the practitioner.

Declaration: I state that I am over 18 years of age and am here in my private capacity and not on behalf of any private, local, county, state, or federal agency or organization of the United States, without so stating. **I have read, understand, acknowledge and agree to the above statements.**

Printed name of patient _____

Signature of Patient or Authorized Representative _____

Date _____