

Personal Patient Information
Dr. Jeff Hanson, ND
Doctor of Naturopathic Medicine
Embodiment Wellness Naturopathic, PC

Name _____ Today's Date _____

Mailing Address _____

City _____ State _____ Zip Code _____

Phone (Cell) _____

Phone (other) _____

Is it ok to communicate to you via: Texting? Yes No E-mail? Yes No

E-Mail Address _____

Date of Birth _____ Age _____ Gender: Male Female

Marital Status Married Single Height _____ Weight _____

Occupation _____

How did you hear about Dr. Jeff Hanson, ND? Website Brochure Word of Mouth

Referral Other _____

Who referred you? _____

Emergency Contact Person _____

Phone Number _____ Relationship To You _____

Notice of Privacy Practices

Dr. Jeff Hanson, ND is required by law to protect the privacy of your medical and personal information. We will provide you a detailed Notice of Privacy Practices handout for you to read upon request. Sign below that you have been offered to receive a copy of the privacy notice.

Signature _____

Prolozone Initial Intake Form

Reason for Visit (Area of Pain) _____

Onset of the problem? _____ **Trauma?** Yes No

Seen by Orthopedic Surgeon? Yes No

What was Recommendation? _____

What Imaging Studies have you had for this problem(s)? _____

Current Medications and Supplements None See List

Drug Allergies No Known Drug Allergies

Medication _____ Reaction _____

Medication _____ Reaction _____

Medication _____ Reaction _____

Surgeries None

Year _____ Surgery _____

Year _____ Surgery _____

Year _____ Surgery _____

Year _____ Surgery _____

Chronic Health Problems (List) None

Informed Consent for Treatment

Dr. Jeff Hanson, ND

Doctor of Naturopathic Medicine

Embody Wellness Naturopathic, PC

This document is a binding agreement (the “Agreement”) between Dr. Jeff Hanson, ND and Embody Wellness Naturopathic, PC (“Dr. Jeff Hanson, ND” or EWN)(ND defined as Naturopathic Doctor) and the individual patient whose name and signature appears below (“You” “Your”). In consideration of the health care services which may be provided to you by Dr. Jeff Hanson, ND at the present and at all times in the future. You agree as follows (your agreement indicated by placing your initials on the lines following each section and by signing in the space provided):

1. **Consent For Treatment.** You understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risk of injury or death. You hereby consent to and authorize Dr. Jeff Hanson, ND to provide You with health care treatment which, depending on Your health conditions, may include one or more of the following procedures: Naturopathic Medicine, Intravenous Infusions, Intramuscular Injections, Hormonal Replacement Therapy, Herbal Medicine, Intra-Articular and Extra-Articular Injection Therapy, Hcg Weight loss Diet Program, Dietary and Nutritional Consultation, Prolozone, Platelet Rich Plasma Injections, Exosomes, Low Dose Antigen Therapy, and Chelation Therapy; together the “Treatments” administered by Dr. Jeff Hanson, ND. You acknowledge that Dr. Jeff Hanson, ND has not made any guarantees or promises as to the outcome or the safety and efficacy of the above listed Treatments. (Initials) _____
2. **Experimental Nature of Treatments.** You acknowledge and agree that the Treatments may consist in whole or part of experimental procedures and methods, in which no governmental (including the U.S. Food and Drug Administration), scientific or medical authority has confirmed the safety or efficacy thereof. You acknowledge that the safety and efficacy record of the Treatments is based only on empirical and anecdotal evidence, which only shows that the Treatments appear to be relatively safe and effective. Dr. Jeff Hanson, ND has informed You that the Treatments may alter, address, or decrease Your pain, symptoms, or complaints, but also may have no effect. (Initials) _____
3. **Intravenous Therapy, Prolozone, Injection Therapy Risks, Side Effects, Complications.** Dr. Jeff Hanson, ND hereby inform You that there are certain unavoidable risks and potential side effects and complications to the Treatments, including without limitation swelling, severe pain, bleeding, dizziness, numbness, scarring, allergic reactions, itching, headaches, soreness, inflammation, bruising, phlebitis, vomiting, fainting, metabolic disturbances. Treatments may very rarely cause infection, injury to nerves, Frozen Shoulder, Pneumothorax (temporary lung collapse), the need for additional surgery or hospitalization, or other serious or debilitating injuries or death. (Initials) _____
4. **Description of Treatments.** The exact procedure, as well as the recommended sequence of Treatments, will be explained to You when Dr. Jeff Hanson, ND actually administer the Treatments. You acknowledge that any of the Treatments may involve insertion of needles into Your skin and veins and the injection of standardized formulas which may include various nutritional substances, hormones, homeopathic medicine, chelation agents, and FDA approved prescriptive medicines, local anesthetic (i.e. Procaine), concentrated sugar water (Dextrose), concentrates of your own blood (platelet rich plasma), Exosomes, and other substances which will be explained to You before injections. (Initial) _____

- 5. **Information You Provide EWN.** You have provided EWN with a complete list of all prescription and non-prescription medications and dietary supplements You are currently taking, and a complete list of all known allergies You may have, and all allergic or adverse reactions You have had in the past to any medicines, dietary supplements, or medical treatments of any kind. You agree to update EWN periodically should this list change. (Initials) _____
- 6. **Assumption of Risk.** You hereby, acknowledge that after having read carefully and understood fully the terms of this Agreement, and after having adequate time to ask any questions about this Agreement of the Treatment that You have, You are willing to assume any and all risks associate with the Treatments, including without limitation those described in the Agreement. You acknowledge that no explanation or description of the Treatments can ever fully explain every possible risk, side effect or complication that may/or could arise from the Treatments, but that by initialing and signing this Agreement, You nevertheless acknowledge Your willingness to assume such risks and that Your consent to the Treatments is willing, voluntary and informed. (Initials) _____
- 7. **Alternatives.** You have been informed that there are alternatives to the Treatments including surgery, other types of injections, prescription medications and taking no action. (Initials) _____
- 8. **Miscellaneous.** You agree that this Agreement constitutes the entire agreement between You and EWN regarding the subject matter hereof. No promise, representation, guarantee or warranty not included in this Agreement has been or is being relied upon by You. This Agreement shall be binding on You and Your successors, heirs, legal representative and assigns. In case anyone of the provisions of this Agreement is held invalid or illegal, such provisions shall be curtailed, limited, or severed only to the extent necessary to remove such illegality or invalidity. This Agreement shall be governed by the laws of the State of California without regard to any choice of law principal. (Initials) _____

By signing this Agreement, You indicate that You have read, understood and agree to its terms, You have received a copy of this Agreement, and that You are the patient, Guarantor, the patient’s legal representative or legally authorized to sign this Agreement and accept its terms.

Patient Name (Print) _____ Legal Guardian Name _____
 Signature _____ Signature _____
 Date _____ Date _____

Naturopathic Doctor Certification: I Dr. Jeff Hanson, ND, nearby certify that I have explained to the patient or authorized person the nature of the proposed treatments, the medically significant alternatives, and in lay terms the purpose, likelihood of success, benefits, and reasonably foreseeable risks, complications, and consequences of treatment. The patient or person authorized has had the opportunity to ask questions and has stated that no further explanation was desired.

Naturopathic Doctor Signature (Dr. Jeff Hanson, ND) _____ Date _____