



Adult Intake Form

MAIN OFFICE—5411 State Road 50, Delavan WI 53115

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SKYPE NAME: **elementals.living**

www.elementalsliving.com

Personal Medical Information

Please print legibly. This form needs to be submitted prior to your appointment to ensure timely process.

Date: _____

Patient Name: _____
Last First

Street Address: _____

City State Zip Country

Home Phone: _____ Cell Phone: _____

Work Phone: _____ FAX: _____

Email address: _____ Skype Acct Name: _____

Preferred method of contact: _____

Marital Status: _____ Date of Birth: _____ Age: _____

Sex: _____ Height: _____ Weight: _____ Blood Type: _____

Known drug allergies: _____

Primary Care Physician: _____ Specialty: _____

Address: _____

Phone: _____

Insurance Company: _____

(Disclaimer: We do not accept insurance and are not a Medicare provider. This information is for office use only.)

Patient's Name: _____

CLIENT ASSESSMENT

Vaccination History:

Last Flu Shot _____ Last Pneumonia Shot _____

Typhoid Y/N _____

Recent Travel Overseas: Y/N If yes, what country: _____

History of mental illness? Y/N If yes, please explain _____

Have you tested positive for any communicable disease? Y/N

Have you ever had the following?

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Circulatory Issues |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Barrett's Esophagus |

Other: _____

List Major Surgeries / Hospitalization / Current Treatments: _____

Indicate any Food Allergies _____

List any medications including over-the-counter meds/dosages you currently take and for what conditions. ***(It's very important to have the correct spelling and dosage)***

Medication	Dosage	Reason Taking

List any supplements you currently take and for what conditions

Supplement	Dosage	Reason Taking

Patient's Name: _____

Family Member	Health Status	Arthritis	Cancer	Diabetes	Heart Disease	Lung Disease	Mental Illness	Stroke	
Father									
Mother									
Siblings									
Siblings									
Siblings									
Siblings									
Siblings									
Siblings									
Siblings									
Children									
Children									
Children									
Children									
Children									
Children									
Children									

Patient's Name: _____

Please list, in order of importance, the five (5) main concerns that you have:

- 1) _____
Duration: _____
- 2) _____
Duration: _____
- 3) _____
Duration: _____
- 4) _____
Duration: _____
- 5) _____
Duration: _____

How are you addressing these concerns now?

Patient's Name: _____

PATIENT BILL OF RIGHTS

Elementals Living, LLC is dedicated to quality patient care. We realize that patients and providers share responsibilities in achieving the best possible health care.

Patients' Rights

- Courteous, considerate, and respectful treatment at all times.
- Candid discussions of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit options.
- Access to preventive health care services.
- Information about benefits, where and how to seek care, and the risks involved in treatment.
- Timely response to requests for services, inquiries, and complaints.
- Second opinion when medically appropriate.
- Titles and specialties of the health care professionals responsible for your care.
- Privacy and confidentiality regarding your medical and health conditions.
- Recognition of your rights to make decisions regarding your medical care.

Patients' Responsibilities

As your healthcare partner, we ask that you:

- Provide professional staff with all pertinent health care information needed to ensure the best possible outcome.
- Communicate when you have questions or concerns about your health care.
- Adhere to instructions and guidelines given for health care services.
- Be aware of your health benefits and services and how to correctly obtain them.

GENERAL CONSENT TO CARE

General Consent to Care

I, the undersigned, hereby consent to medical care and treatment as deemed necessary and proper by the medical staff of Elementals Living. If patient is a minor under the age of 18, parent or legal guardian must sign this agreement.

Billing Policy

It is our policy that patients pay for all services and supplements at the time of your scheduled appointment. A 72 hour notice of a cancelled appointment is required, otherwise a fee of \$100.00 will be charged to your account. It is the patient's responsibility to file insurance claims to their carrier. A universal insurance form will be provided along with all the necessary information so that claims can be filed properly. Credit Cards and Personal checks are accepted. Returned checks will incur an additional \$30.00 fee.

Financial Responsibility

I understand that I am financially responsible to **Elementals Living** and I agree to pay Elementals Living for all charges rendered at time of service.

Insurance

Elementals Living does not contract with any insurance plans. Elementals Living is NOT a Medicare Provider and patients who have Medicare will need to sign our Medicare Opt out form prior to being seen by Doctor.

Case Management Fee

I understand that there is a charge for case management and medical letters.

Notice to Patients:

- Dr. Hicks does not practice routine care as a Primary Care Physician. In case of an emergency, please contact your Primary Care Physician or call 911.
- Dr. John H. Hicks routinely utilizes the services of a "medical intuitive" when assessing patients. There is no scientific research to support the validity of the medical intuitive contribution to your care. If you would prefer that the medical intuitive not be involved in your care, you have the right to inform Dr. Hicks and he will treat you without the involvement of the medical intuitive.

I certify that I have read these policies and agree to abide by all requirements.

Patient/Guardian

Signature _____ **Date** _____