New Patient Form

35 Circle Dr., Charleston, IL 61920 I Tel 217.345.1416 I Fax 217.345.1460
2902 Crossing Ct., Suite D, Champaign, IL 61821 I Tel 217.359.7400 | Fax 217.345.1460
KlepzigNaturalHealingClinic.com

Date

PERSONAL INFORMATION

Name

Address

City/State/Zip

Home Phone | Work Phone | Cell Phone

Email | Preferred form of contact: Home Work Cell Email

Date of Birth | Age | Sex | Marital Status

Occupation | Referred By

Emergency Contact Name/Phone

REASON FOR VISIT

What is the main reason you are seeking care at this time?

Please list the symptoms you have been experiencing recently, in order of importance to you.

How long have these concerns been present?

Please list any chronic or ongoing health conditions and medical diagnosis you are currently managing.

List any providers you have seen for these concerns (past or present).

What types of treatments did you receive, and what was the outcome or your response to them?

Please list any prescription medications you are currently taking.

Please list vitamins, minerals, or herbs you take regularly (including over-the-counter).

Please list past surgeries or major procedures and the approximate years they occurred.

Is there any additional information about your health journey or specific outcomes you hope to achieve that we haven't covered?

DISCLAIMER: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this form.

CONSENT TO PAYMENT

I understand that all services are rendered on a cash, check, or credit/debit card basis. I agree to pay for each appointment at the time of the appointment. I understand that I am responsible for any debts incurred at this office.

PATIENT NAME

PATIENT SIGNATURE ______________________________ DATE

CONSENT TO EXAMINATION AND TREATMENT

Dr. Brian Klepzig utilizes Applied Bio-Energy Analysis (ABEA) testing as part of his evaluation process. ABEA does not diagnose pathological medical conditions or disease processes. ABEA does evaluate for and diagnose functional health conditions.

Dr. Klepzig combines the information he obtains from any medical testing that might be indicated with ABEA testing, a medical history and systems survey to arrive at a clinical diagnosis and treatment plan.

I hereby give permission to the doctor to administer treatment and perform such general procedures, as he may deem necessary in the diagnosis and treatment of my condition. I have read and agree with the above statements.

PATIENT NAME

PATIENT SIGNATURE ______________________________ DATE

NOTICE OF PRIVACY PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health research, and law enforcement activities.

Any other disclosures for the purpose of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures. This provision does not apply to the transfer of medical records for treatment. Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure.

We maintain a history of protected health information disclosures that is accessible to you. You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage, and preparation.

In the future we may contact you by mail, email, or telephone for appointment reminders or announcements. Our practice is required to abide by this notice. We have the right to change this notice in the future.

PATIENT NAME

PATIENT SIGNATURE ______________________________ DATE