WELCOME TO FREEZE WELLNESS

9221 S San Pablo Dr
Goodyear AZ 85338
Tel: 623-824-9600/ Email: admin@mydrfreeze.com

Website: www.mydrfreeze.com

Name:_____ Date:_____

Email:_____

Address: _____

City:_____ State: _____ Zip:_____

Tel (C)_____(W)_____

Age:_____ Date of Birth:_____ Gender: F or M

Occupation:_____ Hours per week:_____

Live with:_____

Health Insurance name and address: _____

_____

Policy Holder's Name:_____

Relationship to policy holder_____

Group#:_____ Policy #:_____

Employer_____

How did you hear about our clinic? _____

Have any other family members been to our clinic: _____

Person to contact in case of emergency: _____

Relationship:_____ Phone Number# _____

Any person(s) you authorize us to share your medical information with_____

Are your currently receiving healthcare? _____

If yes, where and from whom? _____

What health concerns do you have today?

1) _____

2) _____

3) _____

4) _____

Any family history of the following: please put an **X** next to any the apply

Cancer ☐	Stroke ☐	Kidney Disease ☐
Diabetes ☐	Mental Illness ☐	Glaucoma ☐
Heart Disease ☐	Allergies ☐	Autoimmune ☐
Blood Pressure ☐	Anemia ☐	Chronic Infections ☐
Epilepsy ☐		

Other_____

Any Hospitalizations/ Surgery _____

When _____

When during the day is your energy the Best: _____ Worst:_____

Please list any allergies to medications, food or environment:

_____

_____

Current Medications please list:

1)_____ 2)_____

3)_____ 4)_____

5)_____ 6)_____

Supplements: _____

_____

_____

Habits:

Main interests and hobbies_____

Do you exercise _____ How often _____

And what forms_____

How many hours do you sleep_____ Do you sleep well? _____

Any major traumas_____ History of abuse _____

Currently smoke _____ Past smoker _____

If so how many years _____

Weight lbs _____ Weight one year ago _____ Max weight_____

When _____ Height feet _____ inches_____

Please put an **X** next to any that apply

Mental/Emotional:

Depression	☐	Memory Problems	☐	Poor Concentration	☐
Anxiety	☐	Considered/ Attempted Suicide	☐		

Other: _____

Endocrine:

Fatigue	☐	Graves	☐	Hypothyroid Hashimoto	☐
Diabetes	☐	Hypoglycemia	☐	Excessive thirst or hunger	☐

Other Autoimmune_____

Immune:

Vaccinations/Covid Vaccine which one:_____

Date:_____ Any reactions;_____

Swollen glands ☐	Chronic fatigue syndrome ☐	Chronic Infections ☐

Neurological:

Seizure ☐	Paralysis ☐	Easily stressed ☐
Muscle weakness ☐	Loss of memory ☐	Tingling/numbness ☐
Headache ☐	Loss of balance ☐	Vertigo/dizziness ☐
Migraines ☐		

Respiratory/Cardiovascular:

Cough ☐	Emphysema ☐	Chronic Bronchitis ☐
Palpitations ☐	Fluttering ☐	Fainting ☐

Skin:

Cancer ☐	Stroke ☐	Kidney Disease ☐
Diabetes ☐	Mental Illness ☐	Glaucoma ☐
Heart Disease ☐	Allergies ☐	Autoimmune ☐
Blood Pressure ☐	Anemia ☐	Chronic Infections ☐
Epilepsy ☐	Rashes ☐	Eczema ☐
Psoriasis ☐	Hives ☐	Acne ☐
Hair loss ☐		

Gastrointestinal:

Heartburn ☐	Constipation ☐	Change in appetite ☐
Nausea ☐	Pancreatic ☐	Gallbladder Disease ☐
Diarrhea ☐	How many bowel movements per day ☐	

Urinary:

Infections ☐	Kidney stones ☐	Painful urination ☐
Frequency at night ☐	Increased frequency ☐	

Musculoskeletal:

Arthritis ☐	Broken bones ☐	Joint pain or stiffness ☐
Weakness ☐	Spasm ☐	Sciatica ☐

Vascular:

Easy bruising ☐	Bleeding ☐	Deep leg pain ☐
Anemia ☐	Varicose veins ☐	Cold hands/feet ☐
Swelling in legs ☐		

For Women:

Menses

Age of onset ☐ LastMenses ☐

Flow Heavy Y/N ☐ Painful Y/N ☐

Cycles Regular Y/N ☐ How long does cycles last? ☐

Other mark with X

Fibroids ☐	Ovarian cysts ☐	Any STD ☐
Abnormal Pap ☐		

Birth control? - if so how long and type_____

# of Pregnancies: _____ Miscarriage: _____

Problems conceiving_____

Any additional information_____

For Men:

Hernia ☐ Pain ☐ Prostrate Disease ☐

STD ☐ Testicular Mass ☐

Any other information_____

We look forward to helping you reach optimal health and wellness in your life!

If you have any questions please do not hesitate to ask.
Your family at Freeze Wellness

Terms of Agreement

Patient Name: Last: _____

First: _____ Age:_____

Date of Birth: _____Tel:_____

Welcome to Freeze Wellness and thank you for selecting us for your healthcare needs. We look forward to helping you along the way to great health.

Cancellation & Rescheduling Policy:

Your appointments are very important to us! They are reserved specifically for you. We respectfully request at least 48 hour notice for cancellations or rescheduling of your appointments.

Please understand that appointments that are missed, cancelled or changed without giving us enough notice, are missed opportunities for us to fill the apt time with clients that are on our waiting list.

Any appointment missed, cancelled or changed without 48 hour notice will result in a charge of 100% of your appointment fee. Please note you will receive several reminders via email and text prior to your apt date.

Please understand it is your responsibility to remember you appointment dates and times to prevent any missed appointment which result in the cancellation fee. Not receiving an electronic notification of your apt from us is not sufficient reason to miss an apt.

If you do need to cancel please either call the office at 623-824-9600 and leave a message if it goes to voice mail, or email us at admin@mydrfreeze.com

All appointments must be held with a valid credit card at the time of booking. Your credit card information is stored with full encryption.

We do understand that emergencies can occur beyond your control. Please contact us and we will reschedule your existing appointment and no charges will apply.

Fees: Payment of all fees are due at time of the visit.

Insurance billing: We do NOT bill insurance, nor do we take any insurance plans. If you wish to submit a HICFFA form for possible reimbursement to your insurance carrier please let us know at the time of your visit.

This form can be sent in to the address on the back of your insurance card. Please note we do NOT give forms for Medicare.

Terms: All of our fees are subject to change without prior notice. Past due balances are subject to a 2% fee per month (18% annum) service charge, plus a monthly billing of $20.

Statement: I have read and understand the above policies of Freeze Wellness and agree with them. I consent to the treatment with Dr. Karen Freeze and accept full responsibilities for all expenses incurred on my account for visits, tests, or supplements, medications, etc.

In the event of non-payment, I will bear the cost of collection and/or all court costs and legal fees should it be required.

I authorize the release of any medical information necessary to process an insurance claim and authorize payment directly to the signed physician. Due to the new privacy policies this form must be signed to disclose your private health information. A copy will be provided to you on request.

_____

Signature of patient and/or guardian_____

Date:_____

Summary of Notice of Privacy Practices

We strongly believe in maintaining the confidentiality of personal information we possess and/or receive about you and are committed to protecting your privacy.

We do not disclose any non-public information about you to anyone, except as permitted or required by law.

We do not sell or otherwise disclose personal information for purposes unrelated to our health practice.

We maintain physical and procedural safeguards that comply with federal and state regulations to protect information about you and from unauthorized disclosure.

We may disclose information we believe necessary to conduct our business as is legally required. You have the right to access, review, and correct all personal information collected.

Acknowledgment of Receipt of Notice Privacy Practices Summary

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Freeze Wellness will provide me with a copy if requested, of the Notice of Privacy Practice Summary that states how medical information may be used and disclosed.

Signature of Patient/Guardian:_____

Date:_____