

WELCOME TO FREEZE WELLNESS

9221 S San Pablo Dr

Goodyear AZ 85338

Tel: 623-824-9600/ Email: freezewellness@gmail.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 you 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 | <input type="checkbox"/> | Memory Problems | <input type="checkbox"/> | Poor Concentration | <input type="checkbox"/> |
| Anxiety | <input type="checkbox"/> | Considered/
Attempted Suicide | <input type="checkbox"/> | | |

Other: _____

Endocrine:

- | | | | | | |
|----------|--------------------------|--------------|--------------------------|----------------------------|--------------------------|
| Fatigue | <input type="checkbox"/> | Graves | <input type="checkbox"/> | Hypothyroid Hashimoto | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Hypoglycemia | <input type="checkbox"/> | Excessive thirst or hunger | <input type="checkbox"/> |

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 | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Mental Illness | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | Allergies | <input type="checkbox"/> | Autoimmune | <input type="checkbox"/> |
| Blood Pressure | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | Chronic Infections | <input type="checkbox"/> |
| Epilepsy | <input type="checkbox"/> | Rashes | <input type="checkbox"/> | Eczema | <input type="checkbox"/> |
| Psoriasis | <input type="checkbox"/> | Hives | <input type="checkbox"/> | Acne | <input type="checkbox"/> |
| Hair loss | <input type="checkbox"/> | | | | |

Gastrointestinal:

- | | | | | | |
|-----------|--------------------------|----------------------------------|--------------------------|---------------------|--------------------------|
| Heartburn | <input type="checkbox"/> | Constipation | <input type="checkbox"/> | Change in appetite | <input type="checkbox"/> |
| Nausea | <input type="checkbox"/> | Pancreatic | <input type="checkbox"/> | Gallbladder Disease | <input type="checkbox"/> |
| Diarrhea | <input type="checkbox"/> | How many bowel movements per day | <input type="text"/> | | |

Urinary:

- | | | | | | |
|--------------------|--------------------------|---------------------|--------------------------|-------------------|--------------------------|
| Infections | <input type="checkbox"/> | Kidney stones | <input type="checkbox"/> | Painful urination | <input type="checkbox"/> |
| Frequency at night | <input type="checkbox"/> | Increased frequency | <input type="checkbox"/> | | |

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

(Oarian 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: For EXISTING PATIENTS ONLY: (For new patients please see below)

All cancellations and rescheduling must be made at least **THREE** (Open) business days prior to your appointment, no later than 4:30pm. Please note *Fridays, weekends as well as holidays* are **NOT** counted as business days.

For example, a Tuesday appointment **MUST** be cancelled by the preceding **WEDNESDAY before we close at 4:30pm**. All missed or cancelled appointments not adhering to this established guideline will result in **FULL CHARGE** to your credit card on file for your reserved one hour appointment with **NO** credit****

For NEW PATIENTS: **Cancellation/Rescheduling Policy:** *** All cancellations and rescheduling must be made at least **FIVE** (Open) business days prior to your appointment, no later than 4:30pm. Please note *Fridays, weekends as well as holidays* are **NOT** counted as business days.

For example, a Tuesday appointment **MUST** be cancelled by **MONDAY of the previous week** by 4:30pm. All missed or cancelled appointments not adhering to this established guideline will result in **FULL CHARGE** to your credit card on file for your reserved one hour appointment with **NO** credit****

We appreciate your understanding as this policy allows us to offer open slots to other clients on our waiting list who may be in urgent need of an appointment.

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 freezowellness@gmail.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: _____