The Denver Center for Anthroposophic Therapies

A professional LLC

NEW PATIENT INFORMATION

Please provide us with the following information so we know how best to contact you.

Patient Name: _____ _____ _____
First M.I. Last

Date of Birth: _____ Age: _____ Gender: _____
MM/DD/YYYY

Cell: _____ Home: _____ Work: _____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian Information (*for patients under 18 years of age*) ☐ Demographic info is the same as above.

Name: _____

Cell: _____ Home: _____ Work: _____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact (for adult patients)

Name: _____ Phone: _____ Relation: _____

Allergies *Please list specific allergies:*

Medication:	Environmental or food allergies:

Medications *Please list the names and dosages of any medications/supplements you are currently taking:*

1 _____ 6 _____

2 _____ 7 _____

3 _____ 8 _____

4 _____ 9 _____

5 _____ 10 _____

What are you goals for treatment?

Continue with the *Fiduciary Consent for Treatment* ▶

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FIDUCIARY* CONSENT FOR TREATMENT

Fiduciary comes from the Latin word* **fides *(trust), therefore it means:* **consent based on trust**.*

Please initial:

_____ I hereby consent to a comprehensive medical treatment. This means that I am seeking treatment beyond conventional therapy. Conventional or allopathic medicine is based on physical findings and diagnosis, and uses chemical substances (pharmaceutical drugs), surgery, and radiation therapy for treatment.

I am responsible for the choice to seek a therapeutic regimen that is individualized and may include physical, physiological, environmental, emotional, mental, and spiritual aspects.

I recognize the possibility that this treatment may not prove effective.

I am fully informed that this therapy differs from and may not be recognized by present medical standards. I recognize that this treatment—like any other medical treatment—can have side effects such as homeopathic aggravations in sensitive patients.

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis had been made and treatment recommended. The consent will remain in full force until revoked in writing.

_____ I understand that Dr. Blanning also travels to do teaching and consulting work, and does not provide 24-hour/7-day medical coverage.

_____ I understand that the Denver Center for Anthroposophic Therapies will use and disclose my information for the purposes of treatment, payment, and healthcare operations as necessary. I understand that the ways in which my personal health information (PHI) may be used are described in detail in the Denver Center for Anthroposophic Therapies' *Notice of Privacy Policies*.

_____ I acknowledge that I have been provided a copy of the Denver Center for Anthroposophic Therapies' *Notice of Privacy Policies*, and that I can review it any time on the practice website, DenverTherapies.com. I understand that if I have questions or complaints I should contact the privacy officer.

A photocopy of this consent shall be considered as valid as the original.

Date: _____ Name: _____

Signature: _____

Relationship (if signing for the patient): _____

Thank you for completing the form.

We look forward to working together to find the right path to better health and healing.