The Denver Center for Anthropsophic 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.(optional) Last

Date of Birth: / /

☐Male ☐Female

Social Security Number (optional):

Address:

Street: Apt:

City State Zip

Home phone number:

Daytime/cell phone:

Email (if you would like to get our newsletter):

Parent/Guardian Name: First M.I. (optional) Last

(for patients under 18yrs)

Address: (□ check if all information same as above)

Street:

City State Zip

Home phone number:

Daytime/cell phone number:

Emergency Contact Information:

Name: Relation: Phone number(s):

Allergies

Please list any allergies you have to medication:

Please list any environmental or food allergies:

Medication List: Please list the names and dosages of any medications or supplements you are currently taking

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(Please turn over and complete the Consent for Treatment on the back side)

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NEW PATIENT INFORMATION:

FIDUCIARY* CONSENT FOR TREATMENT

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.
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 the Denver Center for Anthroposophic Therapies will use and disclose my information for the purposes of treatment, payment, and healthcare operations. 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.* A photocopy of this consent shall be considered as valid as the original.

Date: ___________ Name:_____________________________Signature:____________________________

Relationship (if signing for the patient):_______________________

I acknowledge that I have been given a copy of the Denver Center for Anthroposophic Therapies' *Notice of Privacy Policies.* I understand that if I have questions or complaints I should contact the privacy officer.
Patient Initial: __________________

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

Thank you for completing the form.