All Around Health

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CLIENT INTAKE FORM

Name				Date of visit				
Address								
City			_State		ZíF	Code		
Primary Pho	ne			Alter	nate			
Is it okay to	leave a messag	ge? 🗌 Yes 🗌	No	Age	D	ate of Birth		
Email						_Mailing List	Yes No	
Gender				Pref	erence []He []Sh	ne 🗌 Other	
Single	Partnership	Married	2	Separ.	ated	Dívorced	Widowed	
Live with:	Spouse	Partner	Parent	5	Children	Friend	s Alone	
Occupation	:				_ Hours p	per week		
How did you	ı hear about u	5?						
C	contact							
)							

Terms and Conditions

Acknowledgement of Consent:	
I acknowledge that I have been informed of the procedure, alternative Naturopathic care and that my questions have been answered contract that neither claims of cure nor promises of outcome have been matherapies. I have both read and received information and consent at All Around Health.	npletely. I acknowledge de regarding any
Printed Name	
Signature	Date
Payment and Cancellation Policies:	
I understand and agree to the following:All payment is due at the time of service. Cash, check or Credit of the control of t	card is accepted.
 All Around Health is not credentialed with any insurance companinsurance. A superbill can be provided if I wish to seek insurance. 	•
 Anyone who cancels less than 24 hours prior to an appointment cancellation fee of \$45. 	
Signature	Date

Privacy Policy:

All information given from the client to All Around Health is considered confidential and in compliance with all current HIPAA laws.

Confidential information is defined as any information found in a client's medical record, personal information, and work-related information. All information relating to a client's care, recommendations, or anything contained in a client's chart constitutes confidential information.

Any questions regarding the above statement please speak to an employee of All Around Health.

Thank You! We look forward to working with you!