Good Life Health Center

501 S 11th St.
Show Low, AZ 85901
Phone: 928-537-4242
Fax: 928-496-0282

Informed Consent for Treatment

Notice as to the Nature of Services

I hereby request the expertise and medical services of Dr. Manrique and his staff. I understand that Dr. Manrique is a Naturopathic Physician licensed in the state of Arizona and that the advice, diagnostic techniques, and treatments that Dr. Manrique provides to his patients are based on the "Naturopathic standard of care." I understand that, since many of his treatment modalities, diagnostic techniques, and definitions of "health" and "disease" have yet to be accepted as "standard" by the mainstream medicals system, these methods may be considered by some to be "holistic", "alternative", "innovative" or "unconventional". Initials ( )

I understand that, when possible, Dr. Manrique would like to prevent disease rather than treat it and that his goal is to help me achieve my personal state of optimum health. Dr. Manrique is an expert at interpreting lab results, patient histories, and physical exam finding. He can often identify the subtle signs of imbalance before they become a "diagnosable" disease. Therefore, his interpretation of my lab-work may differ from that of my other physicians who are using standard lab reference ranges to determine whether or not I have a nameable "disease". Initials ( )

Notice that services are not primary care

I understand that Dr. Manrique does not practice primary care medicine and will not act as my primary care physician. Initials ( )

I understand that Dr. Manrique requires that all of his patients maintain a relationship with a primary care physician. Initials ( )

Your primary care physician is responsible for:

- Making sure that all routine health screenings are performed
- Billing routine health screenings to your insurance plan.
- Providing medical care and advice at times when Dr. Manrique is not available for consultation.

I understand that all of the medical care provided at the Good Life Health Center is office based and is not covered by insurance. Dr. Manrique is not affiliated with any hospital and **does not provide emergency medical care**. He recommends that his patients choose a primary care physician who has access to hospital facilities and is a provider for their insurance plan. Initials ( )

I understand that I am responsible for informing Dr. Manrique who my primary care and specialists are and to let him know of any diagnoses or treatments that I receive from the other physicians involved in my care. Initials ( )

No Guarantees

I understand that Dr. Manrique and the Good Life Health Center do not make any representations, claims, or guarantees that I will be helped with my medical conditions by undergoing treatment at the Good Life Health Center. Dr. Manrique will do his best to help me accomplish my health goals and to guide me in the healing process. However, ultimately my success **depends on me**, and **my commitment to healing**. Initials ( )

I understand that **I am responsible for my own health and healing**. Dr. Manrique cannot and will not "heal" me. His job is to assist my body's innate ability to heal itself and to guide me in the healing process. Initials ( )

I understand that my diet, exercise patterns, sleep habits, and life stressors all directly contribute to the development/maintenance of my current state of health. Initials ( )

I, _____, hereby authorize medical treatment for myself, or my minor child by Dr. Manrique and the staff of the Good Life Health Center. I have read and understand the above Notice as to the Nature of Services and agree that there are no implied or expressed guarantees as to what results I will achieve.

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Signature of Patient or Guardian: _____ Date:_____

Financial policies

Insurance coverage: Good Life Health Center is a cash pay clinic, completely outside of the insurance system. This is what allows Dr. Manrique to provide personalized medicine which goes above and beyond the standard of care that insurance covers.

- The clinic does not submit insurance claims, collect from, negotiate with, or respond to requests for information from any insurance company.
- **Lab testing:** Dr. Manrique does not code lab orders for insurance claims, therefore labs and imaging ordered by Dr. Manrique will not be paid for by your insurance.
    - Dr. Manrique has negotiated special self-pay prices for our patients through LabCorp. This is the most affordable option for self-pay lab testing.
    - You can ask your insurance contracted primary care physician to order your labs so that they can be billed to insurance. However, it is your responsibility to make sure that the correct tests are run and that Dr. Manrique gets your results prior to your appointment.
- **Specialty medications:** Specialty medications are medications that Dr. Manrique prescribes as part of a non-standard treatment protocol. Dr. Manrique does not write regular send out prescriptions for non-standard treatments that require close monitoring. Prescriptions for specialty medications will be filled either by our in office dispensary or a specialty pharmacy depending on the medication.
    - **Medications that will not be covered by insurance include but are not limited to:** Natural desiccated thyroid, adrenal hormones, testosterone, ovarian hormones, and treatments for chronic microbial infection.

I agree that I am financially responsible for all charges incurred for office visits, treatments, medicines, or other services received. **Payment is due in full at the time of service.** Charges for office visits are based on the amount of time spent in consultation with Dr. Manrique as well as the complexity of the case, which may require additional research and consultation with other doctors or health professionals. Your initial office visit will take approximately 1 hour and cost $300. **Payment can be made with a check, cash or debit card.**

Missed Appointments I understand that Dr. Manrique sets aside 1 hour for each new patient visit. There will be a $200 charge if I do not show up to my new patient appointment. For other missed appointments the fee is $65. These fees can be avoided by notifying us at least 48 hours in advance if you will not be able to make your appointment.

I understand and agree to the financial policies of the Good Life Health Center stated above.

Signature of Patient or Responsible Party _____

Patient Name _____Date: _____

Patient Information/Intake Forms

Confidential Patient Information

Patient Name:_____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Age:_____Height:_____ Weight:_____

Address:_____

City:_____ State:_____ Zip:_____

Primary phone number:_____ Cell Home Work (circle)

Alternate phone number:_____ Cell Home Work (circle)

Emergency contact: _____

Emergency contact's Phone Number:_____

Allergies to medication:_____

E-mail:_____

Employer:_____Occupation:_____

Employer's address:_____Phone#:_____

How did you hear about the Good Life Health Center?

_____

_____

Have you seen our website? ☐ Yes ☐ No *GoodLifeHealthCenter.com*

How committed are you to improving your health?
☐ A little ☐ Moderately ☐ Very ☐ Interested in prevention

Physician Contact information

1. Primary Care Provider Name:_____

Phone number:_____ Fax number:_____

Date last seen:_____ Date of next appointment:_____

2. Specialist name and medical specialty:_____

Phone number:_____ Fax number:_____

Date last seen:_____ Date of next appointment:_____

3. Specialist name and medical specialty:_____

Phone number:_____ Fax number:_____

Date last seen:_____ Date of next appointment:_____

Please List Your Health Concerns In order of importance

1_____

- When did it start:_____
- What types of treatments have you tried? How helpful were they?

_____

_____

2_____

- When did it start:_____
- What types of treatments have you tried? How helpful were they?

_____

_____

3_____

- When did it start:_____
- What types of treatments have you tried? How helpful were they?

_____

_____

Please list any medical conditions that you have been diagnosed with:

1. _____

- Diagnosis _____ Date of diagnosis _____
- Treatment received _____

2. _____

- Diagnosis _____ Date of diagnosis _____
- Treatment received _____

3. _____

- Diagnosis _____ Date of diagnosis _____

  Treatment received _____

Have you ever had an allergic reaction to any Medication, Supplement or Food? ☐ Yes ☐ No

- Medication/Supplement/Food: _____
- Reaction: _____

Are you currently taking any medications/supplements?

1. _____
   Medication Dose/Frequency Reason for taking
2. _____
   Medication Dose/Frequency Reason for taking
3. _____
   Medication Dose/Frequency Reason for taking
4. _____
   Medication Dose/Frequency Reason for taking
5. _____
   Medication Dose/Frequency Reason for taking
6. _____
   Medication Dose/Frequency Reason for taking

Please list all surgeries, hospitalizations, accidents and when they occurred:

_____

_____

Family History

Health Info	Relative			
	Father	Mother	Siblings	Grandparents
Cancer				
Autoimmunity				
Arthritis				
High Blood pressure				
Diabetes				
Mental Illness				
Thyroid disorder				
Osteoporosis				

Social History/Lifestyle

Have you ever been physically, or emotionally abused? ☐ Yes ☐ No
If yes how old were you and by whom?_____

Work

What is your present or former occupation? _____

How many hours do you work per week?_____

Shift work? ☐ Yes ☐ No

How stressful is your job? **Circle one**

0 1 2 3 4 5 6 7 8 9 10
Fun relaxed environment *Draining and anxiety producing*

Are you satisfied with your job? ☐ Yes ☐ No

Family

Marital status: ☐ Married ☐ Divorced ☐ Single

Spouse's occupation:_____

Level of stress at home: **Circle one**

0 1 2 3 4 5 6 7 8 9 10
Sanctuary fun with family *War zone*

Personal Interests

What are your Hobbies/Interests? _____

How often do you get to do the activities that you enjoy? _____

Diet and Lifestyle

How many cups of water do you drink per day?_____

How do you drink it? ☐ warm ☐ room-temperature ☐ cool ☐ ice cold

How often do you drink soda? (**Fill in one)** ☐ Diet ☐ Regular

_____ per year _____ per month _____ per week _____ per day

How many cups coffee do you drink? (**Fill in one)**

_____ per year _____ per month _____ per week _____ per day

How many alcoholic drinks do you consume (**Fill in one)**
_____ per year _____ per month _____ per week _____ per day

Have you ever used tobacco? Yes___ No____ Smoke/chew (**Circle one)**

If Yes, how much per day and for how long? _____

If you currently use tobacco, how much and how often?_____

Do you notice any symptoms after eating any particular food or type of food?
(example: "meat sits like a rock in my stomach")
☐ N ☐ Y _____

What type of oil do you cook with? _____

Please describe your typical meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Sleep

How many hours do you sleep per night?_____ _

Do you feel rested and energetic when you wake up in the morning? ☐ N ☐ Y

How many times to you wake in the night?_____ What time?_____

Why? (to urinate, pain, don't know why, etc)_____

Do you have trouble falling asleep? ☐ N ☐ Y

Exercise:

Describe your exercise schedule and type of exercise:_____

_____

_____

Please answer the following questions by checking the Past or Now box if applicable:

Past	*Now*	
☐	☐	Energy drinks
☐	☐	Recreational drugs
☐	☐	Pain medicine Y N P
☐	☐	Antidepressant medication
☐	☐	Sleep medication
☐	☐	Anti anxiety medication (Xanax, valium, etc.)
☐	☐	Laxatives
☐	☐	Steroids (Prednisone, dexamethasone, fluticasone, etc.)
☐	☐	Birth control medications

Review of Systems:

Weight one year ago: _____Maximum weight and when:_____

Minimum weight as adult & when:_____

Ideal Weight:_____ Do you feel tired on a regular basis: ☐ N ☐ Y

Skin

Past	*Now*	
☐	☐	Rash
☐	☐	Color Change
☐	☐	Hives
☐	☐	Psoriasis/eczema
☐	☐	Dry
☐	☐	Cancer

MUSCULOSKELETAL

Past	*Now*	
☐	☐	Weakness
☐	☐	Stiffness
☐	☐	Tremors
☐	☐	Pain
☐	☐	Leg Cramps
☐	☐	Arthritis

Head

Past	*Now*	
☐	☐	Headache
☐	☐	Head Injury
☐	☐	Oily/dry hair
☐	☐	Hair loss:

MENTAL/EMOTIONAL

☐	☐	Depression
☐	☐	Suicidal
☐	☐	Anxiety
☐	☐	Eating disorder
☐	☐	History of drug abuse
☐	☐	Anger/irritability
☐	☐	High-strung/tense
☐	☐	Fear/Panic
☐	☐	Psych Hospitalization

NERVOUS SYSTEM

Past	*Now*	
☐	☐	Paralysis
☐	☐	Tingling/numbness
☐	☐	Seizures
☐	☐	Fainting
☐	☐	Sciatica
☐	☐	Nerve pain

GENERAL

Past	*Now*	
☐	☐	Fatigue
☐	☐	Weight loss/gain
☐	☐	Fever/chills
☐	☐	Cold hands/feet
☐	☐	Varicose veins
☐	☐	Leg swelling
☐	☐	Decreased memory or mental clarity

ABDOMINAL

Past	*Now*	
☐	☐	Pain
☐	☐	Heart Burn
☐	☐	Constipation

How many bowel movements do you have each day?_____

EARS/NOSE/THROAT

Past	*Now*	
☐	☐	Vertigo
☐	☐	Sore Throat
☐	☐	Hoarseness/coughing
☐	☐	Sinus infections
☐	☐	Swollen glands
☐	☐	Difficulty hearing

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to?

_____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials?_____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing?_____

Do you have mercury amalgam dental fillings? ☐ N ☐ Y If yes, how many and at what age where they put in?_____

Are you particularly sensitive to perfumes, gasoline or other vapors? ☐ N ☐ Y

Do you use pesticides, herbicides or other chemicals around your home? ☐ N ☐ Y

FEMALE SPECIFIC QUESTIONS

Age Period Began:_____ How Often Period Occurs_____
How long period lasts: _____

Times Pregnant:_____

How many births:_____

Miscarriages:_____

Abortions:_____

Past	*Now*	
☐	☐	Heavy menstrual bleeding
☐	☐	Menstrual cramping
☐	☐	Menstrual Pain
☐	☐	PMS
☐	☐	Food cravings

Last Pap Smear:_____ Normal? ☐ N ☐ Y
Abnormal paps: ☐ N ☐ Y

Menopausal since what age:_____
Hormone replacement: ☐ N ☐ Y Type of hormones used:_____
Osteoporosis/osteopenia: ☐ N ☐ Y
Dry vagina: ☐ N ☐ Y
Difficulty sleeping: ☐ N ☐ Y
Irritability or depression: ☐ N ☐ Y
Hair loss: ☐ N ☐ Y
Hot Flashes/Night sweats: ☐ N ☐ Y
Loss of muscle tone: ☐ N ☐ Y
Sexually Active: ☐ N ☐ Y
Pain w/ Intercourse: ☐ N ☐ Y
Healthy libido? ☐ N ☐ Y

Past	*Now*	
☐	☐	Vaginitis
☐	☐	S.T.D.

Date of last clinical breast exam:_____ Date of last pelvic exam:_____

Date of last bone density scan:_____ Results of last bone density scan:_____

Please list any birth control used and ages used:

_____

Have any of your family members been diagnosed with breast or ovarian cancer?_____ If yes, who and around what age?_____

Have you ever been diagnosed with breast or ovarian cancer?_____

Have you ever had an abnormal breast exam or mammogram?_____

Have you ever had any breast surgeries:

Biopsy ☐ N ☐ Y date(s)_____ Implants ☐ N ☐ Y date

Mastectomy ☐ N ☐ Y date(s) Lumpectomy ☐ N ☐ Y

MALE SPECIFIC QUESTIONS

Date of last prostate exam? _____

Have you ever been diagnosed with prostate cancer?_____

Have you ever had an abnormal prostate exam? _____

Have you ever had a prostate biopsy?_____ What was the result?_____

How many times per night do you wake to urinate? _____

Decreased quality of erections: ☐ N ☐ Y

Decreased ability to maintain erections: ☐ N ☐ Y

Decreased libido: ☐ N ☐ Y

Decreased muscle tone: ☐ N ☐ Y

Irritability/depression: ☐ N ☐ Y

Hot Flashes/Night sweats: ☐ N ☐ Y

Difficulty urinating: ☐ N ☐ Y

Pain or blood in the urine: ☐ N ☐ Y

Genital rash/STD: ☐ N ☐ Y

Diet Diary Instructions

Please record all food and drinks on the following chart that you consume for 1 week. Include everything, snacks and liquids. Don't try to alter your diet while recording your diet diary. The purpose of the diet diary is to give me an accurate idea of what your normal diet actually is.

Meals: Homemade foods: please try to give me an idea of ingredients and quantity. For example: 3 egg omelet, 2 whole wheat toast and strawberry jam. Please include brand names for processed ingredients.

Processed ingredients are foods that come in a package and contain more than one basic ingredient, such as: Peter Pan peanut butter or Hamburger Helper.

Meals at restaurants: Please give me the restaurant name and try to accurately describe your meal.

Snacks: Please include all snacks, including candy, breath mints, etc.

Water: Please record you daily water consumption in ounces or in number of 8 ounce cups. Also, please tell me the temperature that you drink your water and whether or not you add ice.

Non-Water Drinks: Please record all drinks other than water along with number of ounces of each, and brand if applicable.

Meal	Date						
Breakfast							
Lunch							
Dinner							
Snacks							
Water							
Drinks other than water							

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Office Policies and Procedures

New Patient Appointments

- Your initial visit is an in depth consultation with Dr. Manrique that lasts 45 minutes to 1 hour. During this visit, Dr. Manrique takes a detailed medical history, conducts physical exams, and orders any necessary lab work or imaging studies. In addition, he listens to your whole story with special emphasis on what you want to accomplish from your treatment and what type of changes you are willing to make.
- During your second visit you and the doctor will discuss your lab results, his assessment of your case, and your personalized written treatment plan. Please make sure to ask all of your questions and voice any concerns you may have about your treatment plan during this appointment.

Follow up appointments

- Your first follow up appointment is usually scheduled 6 weeks after starting your treatment. Most cases are complex and may initially require frequent follow up. Follow up appointments are usually scheduled every 6 weeks for the first 3-6 months of treatment.
- Please arrive 15 minutes before your scheduled appointment.
- **No results will be discussed over the phone. An office appointment or phone appointment must be scheduled to discuss lab results.**

Late Arrivals

- If you arrive more than 10 minutes after your scheduled appointment time, it may be necessary to reschedule. The missed appointment fee will apply.
- If you choose to keep your appointment, your visit time will be shortened accordingly.
- Please call us if you are running late.

Telephone Appointments

- As a courtesy to patients who are not able to come in to the office in person we offer phone appointments that are billed at the same rate as a regular office visit.

Initials ( )

Clinic Hours

- We are open Tuesday, Wednesday, and Thursday 9:00AM - 4:00PM and take a lunch break from 12:00 - 1:00PM
- The clinic is located on our family's private property. We are only open to the public during our regular office hours. Please respect our privacy and do not stop by the clinic except during office hours.
- **Dr. Manrique does not practice emergency medicine and does not act as a primary care provider. If you have a medical emergency please call 911. If you have another medical concern that occurs while we are closed, please leave us a message and we will get back to you as soon as possible on the next business day. If you have an urgent medical concern that requires immediate attention, please contact your primary care physician or an urgent care facility.**

Communication and Phone Policies

- **We don't answer questions via email.** Please be sure to call our office with any questions.
- Phone calls pertaining directly to your recent visit, and which require 1-2 minutes will be answered. Phone calls will be answered as soon as possible, within 24 hours or the next business day.
- More complex discussions will require a follow up appointment with the doctor. If needed, a phone appointment will be scheduled and will be billed at the same rate as an office visit.

Prescription refills

- During your office visit, the doctor will give you prescriptions with the appropriate number of refills to last until your next follow up visit.
- Please make sure you have all of the prescriptions you need before you leave the office.
- An office visit is required at minimum every 6 months, or as specified by the doctor to evaluate your care, order labs, and approve additional refills.
- Failure to make and keep scheduled appointments will make it difficult to continue your care and will result in having refills denied.
- **To avoid waiting, please call before picking up refills from our dispensary.**

Nutritional supplements

- Nutritional supplements are an important part of your treatment. Please continue to take them as prescribed unless you are directed to discontinue or change dosage by the doctor.
- Please be aware that since nutritional supplements are not regulated and standardized in the same way as prescription medications, different brands are not equivalent.
- Dr. Manrique spends a great deal of time researching nutritional supplements to determine which ones will be best for his patients. For best results take the exact supplements that Dr. Manrique has prescribed for you, at the doses specified in your treatment plan.

Initials ( )

Lab Procedures and Results

- It is imperative that all necessary labwork be completed on time so that your results are available for discussion during your next scheduled appointment.
- **Our office staff is not authorized to discuss your lab results with you over the phone.**
- If you elect to have your primary care physician order your labwork so that it can be billed to insurance, it is your responsibility to make sure that the correct labs are ordered and that we receive the results at least 48 hours before your appointment. **If you have labs ordered by your PCP we strongly suggest that you make sure that the correct Labcorp test codes be included on the order and that you get the labs run through Labcorp.** Since most general practitioners are not familiar with some of the tests commonly ordered by Dr. Manrique, these steps help avoid getting the wrong tests run.

Fasting and Bloodwork

- Fasting bloodwork requires that you have nothing by mouth, other than water after 10pm the night before your blood draw appointment.
- Please drink plenty of water prior to your blood draw.
- Please ask about how to take your medications the morning of your draw.

Medical Records Release

- A signed release is required before any information in your chart can be mailed or faxed to you, another physician, or a third party.
- Records are sent to your physician at no charge.
- Copies of your labs are given to you at your follow up visit. Additional copies will be billed at $1 per page.

I have read and understand the office policies

Patient or Guardian signature:_____Date:_____

Patient Name_____

Office Personnel Signature:_____