Dr.
Laura Lambert Rampe

Naturopathic Physician
4525 S Lakeshore Dr Ste 101
Tempe, AZ 85282
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P: 602-688-4325 F: 602-680-5778

Date: _____

Name: _____**Age:**_____**Date of Birth:**_____**Gender: M F**

Address:_____

City_____ **State**_____ **Zip Code**_____

Phone: _____ **Is it ok to leave a message at this number? Y N**

Email Address:_____

Emergency Contact: _____

Relationship:_____ **Phone:**_____

Are you currently receiving healthcare? Y N

If yes, where and from whom? _____

Allergies: Please list and drug allergies and reaction:

_____

_____

Medications & Supplements: Please list all medication and/or supplements you are taking:

_____

_____

Do you have any major Medical/Health Events in your history, if so, please list?

_____

_____

HIPAA and "Privacy Rule"

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health information in protected for privacy. The Privacy Rule was also created in order to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment and health care operations.

Dr. Laura Lambert Rampe respects the privacy of your personal medical records. She will do all we can to secure and protect that privacy. In some cases, she will be asked to submit sections of your medical chart to your health insurance plan (if applicable) or to another practitioner (with a "Release of Records" form signed by you.) If at any point you do not want us to share your personal health information, please submit to us a written request. If we need to request your records from another practitioner, we will ask you to sign a "Release of Records" form before doing so.

Please speak with us or with a HIPAA Compliance Officer if you need more information.

I have read and understand the above statement regarding the "privacy rule".

Signature of Patient: Date:

Print Name:

Dr. Lambert Rampe Consent for Treatment Form

I, (or the patient named below for whom I am legally responsible), hereby request and consent to receive naturopathic medical care by the above named Arizona licensed Naturopathic Doctor. I understand that the methods of treatment are permitted under the Naturopathic Licensure in the state of Arizona, which may include but are not limited to nutritional counseling, acupuncture, botanical medicine, homeopathy, nutritional supplements, oral chelation, hydrotherapy, naturopathic manipulation, intramuscular and intradermal injections, pharmaceutical prescriptions, scar therapy and IV therapy.

I have had the opportunity to discuss with the Naturopathic Doctor the nature and purpose of Naturopathic treatments and procedures. I am aware that all existing methods of diagnosis and treatment, including Naturopathic healthcare, pose some level of risk. Within the general healthcare setting, the possible outcomes of these practices by a Naturopathic Doctor range from minor to fatal.

The herbs, homeopathic medicines and nutritional supplements (which are from plant, animal, mineral and other sources) that have been recommended, are considered safe when taken as instructed in the practice of naturopathic medicine. It is extremely important that you follow the prescribed recommendations when taking herbs, homeopathic medicines and nutritional supplements because they may be toxic when taken in large doses. I understand that some herbs and supplements may be inappropriate during pregnancy, and I will immediately notify the doctor if I become aware that I am pregnant. I have also been made aware that B12 injection or IV can make urine red colored for a few hours and that this is a normal occurrence that is not detrimental to my health.

I will immediately inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. In order to properly treat your medical condition, the doctor must be contacted promptly if an adverse reaction or condition occurs. In any event, if an emergency medical condition arises, please seek treatment immediately from a trauma center or call 9-1-1.

I understand that it is my right to refuse recommendations and seek out an alternative medical opinion elsewhere without negative consequences on my healthcare as provided by Dr. Lambert Rampe.

I acknowledge that Dr. Lambert Rampe is **not** **my primary care provider.**

I have read, or have had read to me, the above information and consent. I have also had an opportunity to ask questions about its content, and by voluntarily signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

_____	_____
Patient (18 years or older)	Date
_____	_____
Parent, Guardian, Responsible Party	Date

I agree to provide a 24 hour notice of cancellation for all follow-up appointments. $50 will be charged for if cancellations are made with less than a 24 hour notice. Initial: _____

I agree to accept email from Dr. Lambert as an acceptable form of communication in regards to my healthcare. Email address: _____. Initial: _____