Pacific Bay Integrative Health Center

CONSENT FOR SERVICES & DEMOGRAPHIC INFORMATION

NAME: _____ DOB: _____/_____/_____ ❑ M ❑ F ❑ NB

ADDRESS: _____ CITY: _____

ZIP: _____ EMAIL: _____ PHONE: _____

RACE: _____ ETHNICITY: _____ ARE YOU PREGNANT? ❑ YES ❑ NO

EMERGENCY CONTACT NAME & PHONE: _____

PLEASE LIST ALL PRESCRIPTION MEDICATIONS/SUPPLEMENTS YOU CURRENTLY TAKE:

_____

PLEASE LIST ANY ALLERGIES YOU HAVE:

_____

MEDICAL HISTORY: Do you suffer from any of the following medical conditions?

HIGH BLOOD PRESSURE ❑ YES ❑ NO
KIDNEY DISEASE ❑ YES ❑ NO
ASTHMA ❑ YES ❑ NO
G6PD DEFICIENCY ❑ YES ❑ NO
LIVER DISEASE ❑ YES ❑ NO
HEART DISEASE ❑ YES ❑ NO
DEPRESSION/ANXIETY ❑ YES ❑ NO
SEIZURES ❑ YES ❑ NO
STROKE ❑ YES ❑ NO
CANCER ❑ YES ❑ NO

PLEASE LIST ANY OTHER ILLNESSES OR CHRONIC CONDITIONS:

_____

I certify that everything on this form is true and correct to the best of my knowledge. I voluntarily consent to treatment services and procedures as ordered by Nils Lambrecht, M.D. I have received and read the informed consent that outlines the risks, benefits of COVID testing, intramuscular (injection) and/or intravenous (drip) vitamin therapy and the treatment options with each. I hereby acknowledge that Pacific Bay Integrative Health Center has provided me a copy of its HIPAA Notice of Privacy Practices. I acknowledge that no guarantees or warranties have been made to me as to the result of treatments or examination. COVID nasal swab testing has been explained to me and I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks, ask that the testing or treatment be performed, and release Pacific Bay Integrative Health Center and its practitioners, providers and associates of all liability and agree to binding arbitration to settle any claim including, but not limited to, medical malpractice.

_____ _____ _____ _____

Patient Signature Date Provider Signature Date

Rev. 01/2023