Health For Life Naturopathic Medicine

Confidential Patient Information

Patient Contact Information

Today's Date: _____/_____/_____

Name:_____ _____ _____/_____/_____
(Last) (First) (Sex) (Date of Birth)

Permanent Address: _____ City: _____ State: _____ Zip: _____

Temporary Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Phone Work: _____

Email Address: _____ Preferred mode of contact: _____

May we send you emails regarding updated office information and events : _____Yes _____No

Name of nearest relative not living with you: _____ Relation:_____

Phone: _____

Additional Patient Information

Employer:_____ Occupation: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Marital Status (circle): Single Married Separated Divorced With Partner Widow(er)

Whom may we contact in case of an emergency: _____ Relationship to you: _____

Emergency Contact Phone #: _____

How did you hear of us? _____

Were you referred by another physician: ❑ Yes ❑ No
If "Yes" please provide us with as much information as possible for the Referring Physician?

Referring Physician's Name:_____

Address, City, State, Zip: _____

Telephone Number: _____

Insurance Information

Insurance Company: _____ Phone: _____

Name of Insured: _____ Relationship to the Insured: _____

Policy #: _____ Group #: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. I hereby authorize the undersigned physician to furnish medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment at the time of service. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Furthermore, in the event that payment is not made on this account and it is place with a licensed collection agency, I/we agree to pay the fees of the collection agency. Should legal action also be necessary to collect the account, I/we agree to pay attorney's fees and court costs incurred for the collection.

Releases may be requested prior to specific procedures being performed (i.e., minor surgery, etc.)

Clinic Policy requires payment at time of services.

Signatures

_____ _____ ____/____/____

Patient's Signature **Parent or Guardian's Signature** **Date**

Health For Life Naturopathic Medicine

Health History Summary

Patient Name: _____ DOB: _____ Date: _____

List in Order of Importance what your concerns are:

1. _____
2. _____
3. _____
4. _____
5. _____

Last time you had blood work done and with what physician: _____

_____

Do you currently have a primary care physician? _(yes or no)_ If Yes, Who? _____

Family History:

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if Living						
Reason for Death						
Cancer-Type?						
High Blood Pressure	Y N	Y N	Y N	Y N	Y N	Y N
Heart attack/stroke	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness	Y N	Y N	Y N	Y N	Y N	Y N
TB	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis	Y N	Y N	Y N	Y N	Y N	Y N
Obesity	Y N	Y N	Y N	Y N	Y N	Y N

What is your nationality? (Please give all backgrounds and approximate %)

_____

List All Surgeries & Hospitalizations, including date occurred:

1. _____
2. _____
3. _____
4. _____
5. _____

Please Note When & Why You Have Had Each of the Following:

Xrays:_____ MRI/Cat Scans:_____

Ultrasounds: _____ Accidents: _____

TB Test: _____ HCV: _____

HIV: _____ Last Dental Visit: _____

Last Eye Exam: _____ Other: _____

Did you have the following Disease (D), Get Immunized (I), or Neither (N):

Measles: D I N Chicken Pox: D I N Mumps: D I N Rubella: D I N

Tetanus: D I N Whooping Cough: D I N Hemophilus (Hib): D I N Hepatitis B: D I N

Rheumatic Fever: D I N HPV: D I N Polio: D I N Small Pox: D I N

Diptheria: D I N Scarlet Fever: D I N Typhoid Fever: D I N Other: _____

Any vaccination reactions: _____

List **Yes** (Y), **No** (N), or **Past** (P) regarding use of the following:

Antacids: Y N P Steroids: Y N P Smoking: Y N P Packs per day & # years: _____

Analgesics: Y N P Laxatives: Y N P Coffee: Y N P Cups per day: _____

Soda Pop: Y N P Ounces per day: _____

Alcohol: Y N P How often, type and how much? _____

Any Alcohol Addiction: Y N P Any Alcohol Treatment: Y N P

Recreational Drugs: Y N P Any Drug Addictions: Y N P Any Drug Treatment: Y N P

Medications (Please give full name, dosage, and how long you have been taking the medication)

Name	Dose	When/How Often	What Purpose

Supplements/Vitamins/Herbs

Name	Dose	When/How Often	What Purpose

Review of Systems:

Present Weight: _____ **Weight one year ago**:_____

Height:_____ **Maximum weight and when**: _____

Minimum weight as adult & when: _____ **Ideal Weight**: _____

Any Known Allergies to food, drugs, environment, animals: _____

_____

REGARDING THE NEXT LONG SECTION: Please circle (**Y)** if you have the problem **NOW**, (**N)** if you've **NEVER** had the problem, (**P)** if you had the problem in the **PAST**.

Good Energy: Y N P **Fatigue**: Y N P

If you have fatigue, when in morning, afternoon, evening is it the worst? _____
If you have fatigue, can you do what you need to during the day? Y N

SKIN			
Rash:	Y N P	**Color Change:**	Y N P
Hives:	Y N P	**Lump:**	Y N P
Psoriasis/eczema:	Y N P	**Itchy:**	Y N P
Dry:	Y N P	**Warts/moles:**	Y N P
Cancer:	Y N P	**Perspiration:**	Y N P

HEAD			
Headache:	Y N P	**Migraine:**	Y N P
Dandruff:	Y N P	**Head Injury:**	Y N P
Oil/dry hair:	Y N P	**Hair loss:**	Y N P
NOSE			
Frequent Colds:	Y N P	**Nosebleeds:**	Y N P
Congestion:	Y N P	**Post Nasal Drip:**	Y N P
Polyps:	Y N P	**Seasonal Allergies:**	Y N P
EYES			
Dry/Watery:	Y N P	**Blurry Vision:**	Y N P
Double Vision	Y N P	**Cataracts:**	Y N P
Glaucoma:	Y N P	**Styes:**	Y N P
Strain:	Y N P	**Discharge:**	Y N P
Itchy:	Y N P	**Dark under Eyelid:**	Y N P
Vision Tested	Y N		
EARS			
Frequent infections:	Y N P	**Loss of Hearing:**	Y N P
Ringing:	Y N P	**Vertigo:**	Y N P
Discharge:	Y N P	**Pain:**	Y N P
Hearing Tested	Y N		
MOUTH/THROAT			
Canker sores:	Y N P	**Cold sores:**	Y N P
Sore Throat:	Y N P	**Gum disease:**	Y N P
Dentures:	Y N P	**Cavities:**	Y N P
Loss of taste:	Y N P	**Hoarseness:**	Y N P
Strep throat	Y N P	**Speech Impediments**	Y N F
NECK			
Stiffness:	Y N P	**Swollen Glands:**	Y N P
Full movement:	Y N P	**Tension:**	Y N P
RESPIRATORY			
Cough:	Y N P	**TB:**	Y N P
Shortness of breath w/ exertion:	Y N P	**Bronchitis:**	Y N P
Shortness of breath sitting:	Y N P	**Pneumonia:**	Y N P
Shortness of breath lying down:	Y N P	**Asthma:**	Y N P
Wheezing:	Y N P	**Painful breathing:**	Y N P
CARDIOVASCULAR			
High Blood Pressure:	Y N P	**Rheumatic Fever:**	Y N P
Low Blood Pressure	Y N P	**Murmurs:**	Y N P
Arrhythmias:	Y N P	**Palpitations:**	Y N P
Edema:	Y N P	**Chest Pain:**	Y N P
URINARY TRACT			
Incontinence:	Y N P	**Pain w/ Urination**	Y N P
Frequent Infections:	Y N P	**Kidney Stones**	Y N P
Urgency:	Y N P	**Discharge/Blood:**	Y N P
GASTROINTESTINAL			
Heartburn:	Y N P	**Bowel Movement Frequency:**	

Indigestion:	Y N P	**Recent BM Change:**	Y N P
Bloating:	Y N P	**Diarrhea/Constipation:**	Y N P
Nausea:	Y N P	**Hemorrhoids:**	Y N P
Vomiting:	Y N P	**Gall Bladder Disease**	Y N P
Change in Appetite:	Y N P	**Liver Disease:**	Y N P
Pancreatitis:	Y N P	**Ulcer**	Y N P
MALE GENITALIA			
Testicular pain/swelling:	Y N P	**Sexually Active:**	Y N P
Hernia:	Y N P	**S.T.D.:**	Y N P
Discharge:	Y N P	**Prostate Disease/Symptoms:**	Y N P
Impotency:	Y N P	**Sexual Orientation:**	Hetero Homo Bi
FEMALE GENITALIA			
Age Period Began:		**How Often Period Occurs:**	
How long period lasts:		**Heavy menstrual bleeding:**	Y N P
Menstrual cramping:	Y N P	**Menstrual Pain:**	Y N P
PMS:	Y N P	**Food cravings:**	Y N P
Times Pregnant:		**How many births:**	
Miscarriages:		**Abortions:**	
Last Pap Smear:		**Diagnosis:**	
Any abnormal paps:	Y N P	**When was abnormal:**	
Menopausal since what age:		**Use of hormones:**	Y N P
Type of hormones used:		**Healthy libido:**	Y N P
Dry vagina:	Y N P	**Sexually Active:**	Y N P
Pain w/ Intercourse:	Y N P	**Vaginitis:**	Y N P
S.T.D.:	Y N P	**Mammography:**	Y N P
Dexa Scan:	Y N P	**If Yes, what were results:**	

Please list any birth control used and ages used: _____

_____

_____

MUSCULOSKELETAL			
Weakness:	Y N P	**Arthritis:**	Y N P
Stiffness:	Y N P	**Leg Cramps:**	Y N P
Tremors:	Y N P	**Pain:**	Y N P
NERVOUS			
Paralysis:	Y N P	**Sciatica:**	Y N P
Tingling/numbness:	Y N P	**Carpal tunnel syndrome:**	Y N P
Seizures:	Y N P	**Fainting:**	Y N P
Mental/Emotional			
Depression:	Y N P	**Anger/irritability:**	Y N P
Suicidal:	Y N P	**High-strung/tense:**	Y N P
Anxiety:	Y N P	**Fear/Panic**	Y N P
Eating disorder:	Y N P	**Psych Hospitalization:**	Y N P

Exercise :

How often do you exercise? _____ What type of exercise? _____

For how long? _____ Hobbies: _____

Sleep :

How long per night? _____If you wake up frequently, what is the reason? _____

Nightmares: Y N P Wake Refreshed: Y N P Must nap during the day: Y N P

Sleep walk: Y N P Grind teeth: Y N P Snore: Y N P

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?

_____

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

_____

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

_____

Social Life :

Enjoy job: Y N P Hours worked per week:_____ Highest Level of Education: _____

Active spiritual practice: Y N P Quality of significant relationship: _____

History of sexual, mental/emotional, physical abuse: Y N P If so, at what age and by whom:

_____

What is your greatest health concern:

_____

How does it limit you the most:

_____

Please list the 5 most significant, stressful events in your life, from the most recent to the most distant. Please circle the most significant one.

1. _____
2. _____
3. _____
4. _____
5. _____

How committed are you towards making valuable changes: Little Moderately Very

Health For Life Naturopathic Medicine

Payment Agreement & Cancellation Policy

Please read the following agreement. It explains your financial obligations while under our care and our policies regarding cancellations.

- Payment is always due at the time of service.
- We accept the following forms of payment: Cash, Check, Debit Card, Visa, MasterCard, and American Express
- We do not accept insurance, however:
- If you have a PPO-style plan (these are plans that allow you to see doctors who are not part of your insurance company's provider network), we can do the following.
  - Prepare a health insurance claim form and give it to you to submit to your insurance company to request reimbursement of your visit charges.
  - Bill your insurance company for labs and imaging studies.
  - We can never guarantee that your insurance company will reimburse you for your visits or cover the cost of your labs and imaging studies. You are ultimately responsible for the cost of your care at our office.
  - All new patients are required to provide a valid credit card number, including expiration date and billing zip code, in order to schedule a new patient appointment.

New Patient Appointments:
- If you cancel your appointment with less than 24 hours notice, or fail to show for your appointment without notification, your credit card will be charged $100.
- New patient visits require the doctor to block out large time slots, making last-minute cancellations and rescheduling of visits very problematic. We spend an inordinate amount of time and energy with each and every one of our new patients because we are committed to providing the highest quality care to be found anywhere.

Follow-Up Visits:
- If you cancel a follow-up visit within 24 hours of your scheduled appointment, or fail to show for your appointment without notification, your credit card will be charged $100.
- Assuring that all our established patients have access to their doctor when necessary is a constant challenge. When you cancel or reschedule with adequate notice, it is more likely that another patient in need will be able to use your time-slot. When you cancel or reschedule at the last minute, or fail to show for your appointment, you are depriving another patient of the care they need.

Phone Consultations:
- We bill for phone consultations. They require the same time and expertise as office visits.
- Billing for phone consultations is, however, at the doctor's discretion. Your doctor may choose not to bill you if the nature of the phone consultation is uncomplicated, such as taking a minute to address a quick question. If the number of questions needing to be addressed is greater or takes more time, it is likely your doctor will bill for the phone consultation. Phone consult fees are the same as our in office fees (see Fee Schedule for cost)

There are no refunds on any labs or services.

By signing this payment agreement & cancellation policy, you are indicating that you understand and agree to the terms of service explained above. You are also indicating that you have given your permission to us to charge your credit card for missed appointments, phone consultations, or any of the above stipulations that may apply to you. **We will only automatically charge this card as described by the terms above.** If you request, phone consults or other services may be paid with another card or account at the time of service. Your card on file can also serve as a convenient way to pay for supplements or services without having to wait in line at check out. As a courtesy, the front desk staff will call two work days prior to your appointment to remind you of your scheduled time.

Signature:_____ Date:_____

Type of Card: Visa MC AmEx Card Number:_____

Expiration Date:_____ Security Code:_____ Billing Zip Code:_____

Health For Life Naturopathic Medicine

Confidentiality Statement

Your privacy is important to us. All medical records and interactions between doctor and patient are entirely confidential.

Outlined below is a brief summary of your rights and protections under the Health Insurance Portability and Accountability Act (HIPAA). You can learn more about your rights from the website at http://www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

You have the right to:

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used or shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Request where you would like to be contacted.
- Ask that your information not be shared. For example, you could ask your doctor not to share your medical record with other doctors in the office.

If you believe your rights are being denied or your health information isn't being protected, you can

- File a complaint with your doctor
- File a complaint with the U.S. Government.

If it is necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or the public, your doctor has the obligation to disclose any relevant information.

You are authorized to discuss my personal medical information with the following people or medical practices:

1) _____

2) _____

3) _____

4) _____

Name of Patient or Legal Guardian:_____

Signature:_____ Date:_____

Health For Life Naturopathic Medicine

Fee Schedule, Labs & Other Diagnostic Testing

o Initial Visit Adult or Pediatric	$325
o Follow-up Visits: (for in office or phone consultations)	
• 15 minute	$75
• 30 minutes	$150
• 45 minutes	$225
• 60 minutes	$300
o Labor Support Package	$1,500
o Home Birth Package	$4,600
o Acupuncture Initial	$150
o Acupuncture Follow-up	$75
o Acupuncture Packages available	Prices vary; inquire with front desk
o IV Therapy	Prices vary depending on treatment given
o Injections	$20-150
o Child Wellness Visit	$150
o After hours Phone Consult (Urgent Medical Matters)	
▪ Under 15 min	$45
▪ 15 min	$75
▪ 30 min	$150

The purpose of this document is to help you make an informed choice when your doctor recommends lab tests, imaging studies (x-rays, MRI, etc.) or other diagnostic procedures.

You should be aware that **Medicare and private insurance companies may not pay for all diagnostic tests ordered by your doctor**, even those your doctor considers absolutely necessary. If you agree to any testing recommended by your doctor and your insurance company refuses to pay for the testing, you are responsible for the cost of the ordered tests. **Medicare does NOT cover any testing ordered by non-Medicare providers. Currently**, **naturopathic physicians are NOT Medicare providers.**
As a general rule, many specialty lab tests are not covered by private insurance companies or Medicare, though there are exceptions. Your doctor will be happy to tell you whether the tests being recommended are specialty labs.

Once ordered, there will be NO REFUNDS on labs or any other diagnostic testing.
Several things to keep in mind when your doctor recommends diagnostic testing:

1) Your doctor will be happy to explain any testing to you and why they believe it is necessary.
2) You always have the right to refuse any testing recommended, though your doctor also has the right to discharge you from their care if they believe the testing is mandatory.
3) Our front desk staff will be happy to inform you of the cost of the recommended tests.
4) Even if you have insurance, you may opt to pay for tests out-of-pocket at the discounted cash price in order to avoid any possibility that your insurance company will refuse to pay. You may be able to pay for diagnostic testing not covered by your insurance company using a Health Savings Account or Flex Spending Account.
5) If your insurance company does refuse to pay, the lab or imaging center will usually charge you the full retail price of the tests.

Please choose one option below:

- **Yes,** I am open to receiving laboratory testing as recommended at this office. All of the testing options and prices can be discussed before making any decisions to run labs. I understand that Medicare or my private insurance company may not pay for these tests, and I will be responsible for any lab charges not covered by insurance.

- **No,** I have decided not to receive any laboratory tests at this office. I understand that by not having tests done, my doctor may not be able to properly diagnose and treat me, and has the right to discharge me from care. I also understand that if my insurance company covers testing when ordered by my primary care physician or another doctor, I can request tests through my other doctor's office and authorize for a copy of the results to be sent here.

Patient Name: _____

_____ _____
Signature of Patient/Responsible Party Date

Health For Life Naturopathic Medicine

Informed Consent Regarding
Nutritional and Herbal Supplements

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201(g) (1), the term drug is defined as an "article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." Technically vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effect on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding the use of these substances in order to upgrade the quality of foods in a patient's diet and supplement nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

Sale of Nutritional Supplements at Health for Life Naturopathic Medicine

You are under no obligation to purchase nutritional supplements at our office
As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering (1) the quality of science behind the product and (2) the quality of the product components. The brands of supplements that we carry in our center are those that meet our high standards and tend to produce predictable results. While these supplements may come at higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body) and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality with over the counter. There is a lack of stringent testing requirements for dietary supplements over the counter, therefore, product quality varies widely. If you have concerns about this issue, please discuss them with our staff.

By signing this form, I acknowledge receiving this:

_____ _____

Patient or Authorized Representative Date