WELCOME TO THE CENTER OF NATURAL MEDICINE, INC

Welcome to our office. We would like to thank you for selecting Center for Natural Medicine, Inc. We are dedicated to helping you restore, achieve and maintain your overall health naturally. For your information, driving directions are provided on the reverse of this letter.

Enclosed you will find your Intake Registration Forms. Please fill out these forms prior to your arrival and bring them with you. If you should have any questions regarding the enclosed information, please call us.

If you have not already pre-certified your insurance coverage, please call our office and we will be happy to do so for you. Completing this paperwork ahead of time will allow us to apply your coverage on your initial visit. Once your insurance has been verified, we require payment of all deductibles and/or co-payments, as defined by your primary carrier.

Because the providers at Center for Natural Medicine, Inc. are very busy, it is absolutely necessary for you to give at least 24 hours notice if an appointment needs to be rescheduled or canceled.

We look forward to meeting and helping you reach your health goals.

CLIENT INFORMATION

Today's Date: ______________________ WORK RELATED VISIT? **YES** **NO**

Client Name: ______________________ DOB: ____________ SSN: ______________

Mailing Address: ____
Street City State Zip

Home Phone: ________________ Work Phone: ________________

Parent/Legal Guardian (if different from client): ______________________
(person responsible for bill if patient is under 18)

Emergency Contact: ____________Phone: ________ Relationship: ______

Responsible Party Employer: ______________________________

Referral Source: ______________________________

Method of Payment Today: ___ Cash/Check ___ Credit Card ___ Money Order

Cancellation Policy: ***There is a fee charged for appointments not cancelled 24 hours prior to the scheduled appointment which is 50% of the scheduled visit charge.***

CLIENT PAYMENT AGREEMENT

I understand that I am responsible for any charges NOT COVERED AND PAID by my insurance company or other third party resources.

ASSIGNMENT OF INSURANCE/BENEFITS: **By signing below, I authorize THE CENTER FOR NATURAL MEDICINE to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the doctor all payments for medical services rendered to myself or my dependents. This authorization shall be valid only for the period of time necessary to actually process payment claim pertaining to the client but in any case shall cease to be valid one (1) year from this date.**

THIS FACILITY IS NOT ENROLLED IN FEDERAL OR STATE PROGRAMS, AND THEREFORE DOES NOT ACCEPT ASSIGNMENT OF BENEFITS FOR FINANCIAL PROGRAMS OF THIS NATURE.

SIGNATURE:______________________________**DATE:** ____________________

WITNESS:______________________________**DATE:**____________________

INSURANCE INFORMATION

Client Name: ____

***Primary Insurance Company Name*:** ____

Claim Office Address: ____

Claim Office Phone #: ____

Subscriber Name: _____________________________________ DOB: _________________

Policy/Group Number: __________________________________ SSN: _________________

***Secondary Insurance Company Name*:** ____

Claim Office Address: ____

Claim Office Phone #: ____

Subscriber Name: _____________________________________ DOB: _________________

***Liability Insurance Company Name*:** ____

Claim Office Address: ____

Claim Office Phone #: ____________________ Date of Injury: ___________________________

Insured's Name: ____________________________________ Policy #: __________________

Name of Adjustor: ___________________________________ SSN: _________________

Work Comp Insurance Name: ____

Claim Office Address: ____

Claim Office Phone #: ________________________________ Date of Injury: ______________

Name of Adjustor: _________________________ Claim #: _____________________________

Name of employer at time of injury: ____________________ Contact person: __________________

Is this claim in dispute? YES NO Are you being represented by legal council? YES NO

Name of Attorney: ____

Address: ____ Phone: ______________________

SIGNATURE:____________________________________DATE: _____________________

WITNESS:______________________________________DATE:_____________________

MEDICAL HEALTH HISTORY QUESTIONNAIRE

Other doctors you see: ____

____

Please list the most important reason you came in today: ______________________________

____

____

What other health concerns do you have at this time? ______________________________

____

Medical History (Please include dates):

Major illnesses: ____

____

Surgeries: ____

____

List prescription medicine you now take (include dosage, reason you take it):

____

____

List over-the-counter medicines, vitamins, and food supplements you take:

____

____

Allergies: ____

Sensitivities: ____

List conditions that run in your family:

____

____

How tall are you? ________ What do you weigh? ________ How much would you like to weigh? ________

Has anyone in your family had?

☐ Alcoholism	☐ Cancer: type ____________	☐ Glaucoma	☐ Stomach problems
☐ Arthritis	☐ Diabetes	☐ Heart disease	☐ Thyroid disease
☐ Asthma	☐ Genetic disorder	☐ Mental illness	☐ Tuberculosis

Please mark "**N**" for problems that you **NOW** have and "**P**" for any **PAST** problems:

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding problems
- ☐ Blood clots
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive problems
- ☐ Drug addiction
- ☐ Ear infections
- ☐ Eczema
- ☐ Frequent colds
- ☐ Frequent headaches
- ☐ Gallstones
- ☐ Gout
- ☐ Hearing trouble
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Other _______________________
- ☐ Herpes
- ☐ Hypertension
- ☐ Hypoglycemia
- ☐ Kidney problems
- ☐ Memory trouble
- ☐ Mental illness
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Neurosis/psychosis
- ☐ Psoriasis
- ☐ Seizures
- ☐ STDs
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Trauma, major
- ☐ Tuberculosis
- ☐ Urinary infections
- ☐ Venereal disease
- ☐ Vision trouble
- ☐ Ulcer

Medical Care:

Where did you last receive medical care? ____

For what reason(s)?____

Date of last physical exam:_____________________ Date of last lab work:__________________________

Date of last EKG: ____________________________ Date of last tetanus shot: _____________________

Date of last TB test: ___________________________ Date of last chest x-ray: ______________________

Date of last rectal exam: _______________________

Men:

Date of last prostate exam: ________________________ Have you had a vasectomy? ________________

Women:

Age of 1st period _____________ First day of last normal period_________ # of pregnancies ______

# of live births ____ # of children living with you ____ Birth control method __________________

Date of last pap ____________________ Done where ____

Date of last mammogram ___________ Done where ____

Date of last bone densitometry (dexa)? ____

Do/did you have?

- ☐ Abnormal mammogram
- ☐ Abnormal pap smear
- ☐ Bad menstrual cramps
- ☐ Breast problems
- ☐ Heavy periods
- ☐ Hot flashes
- ☐ Infertility
- ☐ Irregular periods
- ☐ Menopause
- ☐ Pelvic pain
- ☐ PMS
- ☐ Vaginal dryness
- ☐ Vaginal discharge
- ☐ Vaginal itching
- ☐ Vaginal odor

Health Habits:

Hobbies: ____

Exercise: What, and how often?____

Sleep: How many hours? _________ Light _______ Sound ____ Insomnia ______

Do/did you smoke? ☐ yes ☐ no How much? ___ packs/day ___# years___ year you quit?__

Do/did you consume alcohol? ☐ yes ☐ no How much? _______ Do you want to quit? _____

Do/did you use: ☐ Caffeine ☐ Nutrasweet ☐ margarine ☐ marijuana ☐ cocaine ☐ chewing tobacco ☐ diet pills

Diet:

☐ Junk food ☐ Standard American (meat, potatoes, desert) ☐ Wholesome ☐ Raw foods ☐ Vegetarian

What do you typically eat for breakfast?

____

What do you typically eat for lunch?

____

What do you typically eat for dinner?

____

What do you typically drink during the day?

____

Do you have any skin problems? If so, please describe them: ______________________________

____

Do you have any lung and/or breathing problems? If so, please describe them: _______________

____

Do you have any urinary problems? If so, please describe them: ___________________________

____

Do you have any sexual concerns? If so, please describe them: ____________________________

____

Do you have any digestion problems, or any concerns with your stomach, intestines, colon, or bowel movements? If so, please describe them: ____

____

Do you have any bone, muscle, or joint problems? If so, please describe them: ______________

____

Do you have any hormone problems? If so, please describe them: ______________________________

____

Do you have any problems with thinking, concentration, mood, energy level, or interest in life? If so, please describe them: ____

____

Do you have any strength, sensation, coordination, or neurological function problems? If so, please describe them:

____

____

Anything else? ____

____

Patient signature ____ Date _________________

Thank you for taking the time to provide this information so that we may provide you with more effective care.

CONSENT FOR TREATMENT

General Information: Due to the diversity of modalities offered at the Center for Natural Medicine, Inc., your treatment may include any or all of the following general modalities: Acupuncture and Oriental Medicine, Naturopathic Medicine, Physical Medicine, Homeopathy, Psychological Counseling and Nutritional Counseling.

Methods, Procedures and Therapeutic Approaches: Clinicians may perform any of the following procedures as necessary to give proper assessments, determine treatment approaches, treat or otherwise address your health concerns.

General Diagnostic Procedures (including but not limited to venipuncture, pap smears, radiography, and blood and urine labwork, general physical exams, neurological and musculoskeletal assessments).
Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions
Acupuncture: Insertion of special sterilized needles at specific points on the body.
Electroacupuncture: Using very small amounts of electricity to stimulate specific acupuncture points.
Acupressure: Traditional Chinese medical massage and manual therapy.
Infrared Heat: Applying heat generated by an infrared lamp over a specific area of the body.
Dermal-friction Technique: Friction is applied topically to the skin using a smooth object to relieve symptoms.
Cupping: Glass cups are placed on the skin with a vacuum created by heat or suction device.
Dietary Advice: Suggestions for nutrition and herbal food products.
Liniments, Oils, Plasters: Herbal formulas applied topically to the skin.
Moxa: A soft woolly mass prepared from ground young leaves, typically in the form of sticks or cones which are ignited and placed on or close to the skin or used to heat acupuncture needles.
Topical Treatments and Prepping (includes cupping --a technique using glass cups on the surface of the skin with usually a heat-created vacuum; and Gua Sha--rubbing on an area of the body with a blunt, round instrument)
Herbs/Natural Medicines (prescribing of various therapeutic substance including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical cremes, pastes, plasters washes; suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.)
Dietary Advice and Therapeutic Nutrition (use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections).
Soft Tissue and Osseous Manipulation (use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy)
Electromagnetic and Thermal Therapies (includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and infrared and ultraviolet therapies or moxa—warming or indirect burning of an acupuncture point and hydrotherapies.)
Minor Surgery and IV Therapies: As deemed appropriate by clinicians.

Potential Risks These include, but are not limited to: pain, discomfort, blistering, bruising, discolorations, infection, burns, dizziness, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; broken needle; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms., possible aggravation of symptoms existing prior to the acupuncture treatment, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax).

Patients with bleeding disorders or pacemakers as well as pregnant patients should inform the practitioner prior to receiving treatment

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. We do not use labor-stimulating acupuncture points or any labor-inducing substances unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Center for Natural Medicine, Inc., or any of its personnel regarding cure or improvement of my condition. I hereby release Center for Natural Medicine, Inc. from any and all liability, which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or otherwise permitted or required by law.

______________________________	______________________________
Guardian/Personal Representative's Name (PRINT)	Patient's Name (PRINT)
______________________________	______________________________
Guardian/Personal Representative's Signature	Patient's Signature
______________________________	______________
Relationship/Representative's Authority	Date

____

Date

NOTICE OF PRIVACY PRACTICES

I consent to the use of disclosure of my identifiable health information by the Center for Natural Medicine, for the purpose of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that my diagnosis or treatment by the practitioners at Center for Natural Medicine may be conditioned upon my consent as by my signature on this document.

Practitioner means a Naturopathic Doctor, Acupuncturist, Massage Therapist or other health care worker employed by or under contract with the Center for Natural Medicine.

Patient means any person seeking health care advice and/or treatment of a practitioner at the Center for Natural Medicine, through consultation by phone or in person.

My *identifiable health information* means information collected from me and created or received by my practitioner, another health care provider, a health plan, any my employer. This *identifiable health information* results to my past, present, or future, physical or mental health condition and identifies me, or there is a reasonable basis to believe that the information may identify me.

I understand that I have the right to request a restriction as to how my health care information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Center for Natural Medicine is not required to agree to the restrictions that I may request. However, if the Center for Natural Medicine agrees to a restriction that I request, the restriction is binding on the Center for Natural Medicine.

I have the right to revoke this consent, in writing; at any time except to the extent the Center for Natural Medicine has taken action in reliance of the consent.

I understand that I have the right to review the Center for Natural Medicine, Inc. Notice of Privacy Practices prior to signing this document. This notice describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills, or in the performance of health care operation of Center for Natural Medicine, Inc.

Center for Natural Medicine, Inc. reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices at any time by requesting the most current notice in writing or in person at the time of my office visit. By my signature below I acknowledge receipt of the Notice of Privacy Practices.

____
Patient's Name (PRINT)

____
Guardian/Personal Representative's Name (PRINT)

____
Patient's Signature

____
Guardian/Personal Representative's Signature

____
Date

____
Relationship/Representative's Authority