Center For Natural Medicine LLC

640 Main Street, Watertown, CT 06795 ~ phone 860-945-1004 ~ fax 860-945-9988

Today's Date_____

First Name_____M.I._____Last Name_____

Birth Date_____Age_____Social Security #_____

Email_____Phone (Home)_____(Cell)_____

Occupation_____Phone (Work)_____

Home address_____

City_____State_____Zip_____

Relationship Status: Married/Partnered Divorced/Separated Single/Widowed

Name of Spouse/Significant Other_____

Parent / Guardian (if patient is a Minor)_____

In Case of Emergency Contact_____

How did you hear about us?_____

Payment for Services:

**Please note that payment for any services that is not covered by insurance is the responsibility of the patient. Payment is due at the time of service.

Insurance Information

Primary Insurance Company:_____

Address:_____City:_____State_____Zip_____

Telephone (_____)_____ID#_____Group#_____

If you are not the policy holder, who is?_____

Relationship to you?_____

Policy holder SSN?_____Birth date:_____

Secondary Insurance Company:_____

Address:_____City:_____State_____Zip_____

Telephone (_____)_____ID#_____Group#_____

If you are not the policy holder, who is?_____

Relationship to you?_____

Policy holder SSN?_____Birth date:_____

Medical Information (additional space at the end of form)

Please list your reasons for coming in today?_____

_____

_____

_____

_____

Mo/Yr of last medical exam_____Last Blood Tests_____Blood Type____

Women: Last Pap_____Mammogram_____Menses_____

Describe any abnormal labs, x-rays, or other tests_____

_____

_____

List hospitalizations or surgeries:_____

_____

_____

_____

Do you use:	Y/N	AMOUNT		Y/N	AMOUNT
Alcohol			Coffee/Caffeine		
Pain Relievers			Tobacco Current/Past		
Antacids			Sleeping Aids		
Recreational Drugs			Appetite Suppressants		
Laxatives			Sugar		

Diet:
Please list typical food intake for a 24 hour period:

_____

_____

_____

_____

Bowels:
How many bowel movements do you have daily?_____. Do you take anything to help with your bowel movements?_____Do you have gas/bloating?_____
Circle any that apply:
Bowel movements are: Painful Difficult to pass Loose/watery Contain blood, mucous, undigested food Pellet-like _____

Exercise:
Please list any exercise you do. Please include frequency and duration.

_____

_____

_____

_____

Sleep:
How many hours do you sleep:_____ Do you struggle to fall or stay asleep:_____
How many times/night is your sleep interrupted and for how long?_____
Do you feel rested on waking?_____Rate daytime energy 1-10 scale (10 = best)_____

Personal and Family Health History

Other relevant health history information (additional space at end of form):

Disease	Self &/or name family member	Approx. date	Disease	Self &/or name family member	Approx Date
Measles			Cataracts		
German measles			Glaucoma		
Mumps			Thyroid disease		
Chicken pox			Gout		
Whooping cough			Depression		
Scarlet fever			Nervous Breakdown		
Rheumatic fever			Attempted suicide		
Tuberculosis			Obsessive compulsive		
Mononucleosis			Eating disorder		
Herpes			Substance abuse		
Arthritis			Chronic fatigue		
Bursitis/sciatica			Fibromyalgia		
Chronic back issues			ADD/ADHD		
Herniated/ruptured disc			Insomnia		
Bone or joint disease			Heart murmur		
Epilepsy/seizures			Heart disease		
Blood transfusions			Phlebitis		
Appendicitis			Cancer		
Anemia			High blood pressure		
Lymphatic condition			High cholesterol		
Gall Bladder Disease			Stroke/thrombosis		
Jaundice			Obesity		
Liver disease/hepatitis			Diabetes		
I.B.S (irritable bowel)			Autoimmune condition		
Inflammatory colitis			Osteoporosis/osteopenia		
Candida			Migraines/headaches		
Hemorrhoids			Chronic sinus infections		
Stomach ulcers			Chronic bronchitis		
Hiatal hernia/reflux			Chronic strep throat		
Diverticulosis/itis			Chronic ear infections		
Prostatitis/BPH			Frequent antibiotic use		
Kidney stones			Skin disease		
Kidney infections			Eczema/psoriasis/hives		
Urinary tract infections			Asthma		
Sexually transmitted inf.			Hayfever		
Herpes virus			Lyme disease		
Yeast infections			Shingles		
Infertility			Menstrual issues		
Erectile dysfunction			Endometriosis		
Parkinson's disease			Fibroids		

System Review (circle all that apply, and note date of onset)

CONSTITUTIONAL	URINARY	ABDOMINAL	RESPIRATORY
change in weight	urgency	appetite change	shortness of breath
decreased endurance	frequency	difficult swallowing	wheezing
fatigue	pain	heartburn	coughing
night sweats	blood	blood in stool	frequent colds
bone pain	penis discharge	nausea	frequent sneezing
mood swings	difficulty starting urine	vomiting	sinus infections
emotional stress	dribbling	gas/bloating	coughing blood
insomnia	incontinence	cramps	
hot flashes	decreased sex drive	diarrhea	**THROAT**
always hot	sexual difficulties	constipation	sore throat
always cold		mucous in stool	coughing
always thirsty	**SKIN**	tarry stool	sore tongue
drink coffee	rashes	clay colored stool	dry mouth
crave sweets	moles	belching	difficult chewing
	bruising	food craving	change in taste
	itching		change in smell
MUSCULOSKELETAL	dryness	**NOSE**	hoarseness
joint pain	hair change	runny nose	canker sores
muscle pain	dandruff	bleeding	enlarged glands
weakness		pain	voice change
leg pain/cramps	**CARDIO**	sneezing	
joint stiffness	chest pain		**EARS**
joint swelling	palpitations	**HEAD**	change in hearing
back pain	dizziness	headaches	discharge
muscle tightness	racing heart	injury	ear pain
	varicose veins	dental problems	infection
NEUROLOGIC	ankle swelling	jaw stiffness	ringing in ears
tremor		poor memory	
numbness	**EYES**		
seizure	vision change	**PSYCH**	
dizziness	eye discharge	change in memory	
fainting	eye pain	brain fog	
loss of taste	poor night vision	depression	
loss of smell	dry eyes	anxiety	
shooting pain		difficult concentration	

Please list all current medications and supplements.

Medication/Supplements	Dosage	For what Purpose?	How long have you taken it?	Prescribing physician name or self	Side Effects

Please list allergies (medication, food, environment)

Additional Information:

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General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

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I voluntarily request a physician or nurse perform reasonable and necessary medical examination, testing and treatment for the condition, which has brought me to seek care at this practice. I understand that if additional testing or procedures are recommended, I will be given the opportunity to consent prior to these tests or procedures.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Name of Patient (Please Print)

Signature of Patient (or Representative if underage)

Date

Representative for underage patient **Relationship to Patient**
~~~~~~

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Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appoint reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization, in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restriction on certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove.

- ❖ The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- ❖ The right to inspect and copy your protected health information.
- ❖ The right to amend your protected health information.
- ❖ The right to receive an accounting of disclosures of protected health information.
- ❖ The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of you protected health information and to provide you with notice of our legal duties and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provision effective for all protected health information that we maintain. We will post and you may request a written copy of revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil
Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

The Center for Natural Medicine reserves the right to modify the privacy practice outlines in this notice.

I have received a copy of the notice of Privacy Practice for the Center for Natural Medicine.

_____

Name of Patient (Please Print)

_____

Signature of Patient (or Representative if underage)

_____

Date

_____ _____

Representative for underage patient **Relationship to Patient**

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Laboratory and Imaging:

Insurance plans that cover naturopathic care typically will pay for medically necessary laboratory tests (blood tests drawn through Quest/Clinical Laboratory/ Hospital labs, imaging studies, and preventative screening exams). In the event that the doctors at the Center for Natural Medicine are not participating providers for the insurance company or the individual's insurance plan does not include naturopathic care, the cost of these tests becomes the patient's responsibility.

Due to the potential expense associated with this type of testing, we suggest that patients contact their insurance company to confirm coverage of labs to prevent unexpected bills. In the event your insurance does not cover the labs ordered by the naturopathic physician, patients can contact the laboratory or imaging facility to discuss costs. Sometimes it is possible to negotiate prices and payment plans. Some patients have had success having the same tests ordered through another doctor who is covered by their insurance plan.

Patients can also order some blood tests at a reduced rate through the following website:
https://www.Directlabs.com/ or
through Mercy Diagnostics Laboratory

The Center for Natural Medicine is not responsible for the cost of tests incurred by the patient, but will facilitate affordable testing options, when possible, without compromising quality of care.

Food Intolerance testing:

IgG food allergy testing is offered at the Center for Natural Medicine. Insurance does not cover IgG food allergy testing when run through private or conventional laboratories, including Quest. IgE food allergy testing is typically covered and this type of testing is available through conventional labs. Please discuss the difference in IgG and IgE food reactivity with your naturopathic physician. The Center for Natural Medicine uses Alletess Laboratory for IgG food sensitivity testing and the cost of this lab is the patient's responsibility.

Name of Patient (Please Print)

Signature of Patient (or Representative if underage)

Date

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Cancellation Policy

The Center for Natural Medicine practices patient centered medicine, which requires that we have scheduled adequate visit time with our patients. Due to the extensive length of your visit, we require 24-hour notification of your cancellation to allow us time to schedule another patient during that time. There is a $40.00 charge for missed visits, or visits that are cancelled with less than 24-hour notification.

I understand that I will be charged $40.00 for any visit that I cancel with less than 24-hour notification.

Name of Patient (Please Print)

Signature of Patient (or Representative if underage)

Date

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Return Policy

Supplements:

Unopened supplements that are in perfect and re-sellable condition may be returned within 30 days of purchase for credit on account only. No refunds will be applied to credit or debit cards.

Tinctures:

Tinctures are made specifically for each individual patient and cannot be returned.

Test Kits:

Unused test kits may be refunded within 30 days of purchase. Kits must be physically returned, with the test requisition, to our office for a refund to be applied to a credit or debit card.

_____

Name of Patient (Please Print)

_____

Signature of Patient (or Representative if underage)

_____

Date

_____ _____

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Understanding your Insurance

The Center for Natural Medicine is a preferred provider of Anthem Blue Cross-Blue Shield, Aetna, Cigna, Connecticare, United Healthcare and Husky members who are under 21 years of age.

We cannot accept Medicare or any insurance plan that is secondary to Medicare.

We are considered a specialist and cannot be a primary care provider.

Each insurance company has various plans and policies, therefore, not all policies cover Naturopathic physicians. It is recommended that you call your insurance provider to verify your coverage prior to your appointment. We suggest that you familiarize yourself with your insurance policy so you can better understand what is covered and what your financial responsibilities are. If you have a deductible you may have to pay up to 100% of your visits and/or lab work until your deductible is met. After you have seen one of our physicians, we will bill your insurance. If any co-pay or deductible, etc. is due we will bill you (either via the patient portal or by mail). Payment is due within 30 days.

The Center for Natural Medicine is not responsible for the costs of any tests, deductibles, co-insurance, or co-pays incurred by the patient.

Name of Patient (Please Print)

Signature of Patient (or Representative if underage)

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Acupuncture Policy

The Center for Natural Medicine, LLC provides acupuncture by licensed Naturopathic physicians. Our acupuncture services are an out-of-pocket cost. This means, acupuncture will not be submitted to your insurance and you are responsible for the fee at the time of service. Each insurance policy is different, and each insurance carrier has varying criteria for submitting this service. For these reasons we will not bill your insurance for acupuncture services.

The Center for Natural Medicine, LLC, and its licensed professionals, reserve the right to bill for this service based on the time and complexity spent with each individual patient, assessment of presenting complaint, review of health history, and acupuncture treatment.

_____

Name of Patient (Please Print)

_____

Signature of Patient (or Representative if underage)

_____

Date

_____ _____

Representative for underage patient **Relationship to Patient**