NEW PATIENT INTAKE FORM

Patient Name: Date of Birth: Today's Date:

Age: Female ❒ Male ❒ Last 4 of SS# E-mail:

Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Okay to Leave Detailed or Text Message at: Home ❒ Work ❒ On my Cell ❒

Emergency Contact Name & Phone Number:

Single ❒ Married ❒ Separated ❒ Other ❒

Occupation: Religious Affiliation (Optional):

Hobbies:

Primary Care Physician: Okay to contact: Yes ❒ No ❒

Referred by:

HEALTH INSURANCE INFORMATION

Primary Insurance: Naturopathic Coverage?

Policy Holder's Name: Policy Holder's Date of Birth:

Policy Holder's Employer: Co-payment for Office Visits:

OFFICE POLICIES

PAYMENT POLICY: 100% of all doctor visits, other treatments, and supplements fees are due at the time of services. We accept cash, checks, debit and credit cards as payment. All sales are final. We cannot provide refunds or exchanges. We charge $35.00 for any returned check. If you have insurance coverage for Naturopathic care, we are happy to bill your primary insurance for you.

CANCELATION POLICY: Last minute cancellations of scheduled appointments are challenging to fill, wasteful of an opportunity for another patient, and costly for the clinic. **We therefore require changes or cancellations to be made at least 24 hours prior to your scheduled appointment.** Otherwise, you will be charged $35.00 for the 1st missed visit, and $100.00 for any subsequent missed visits.

I, the patient, understand that I am financially responsible for all charges regardless of insurance coverage and/or treatment outcome. I understand that 100% of fees are due at the time service is rendered, and that all sales are final. I authorize Baker Family Naturopathic to bill my health insurance for services rendered. I understand that I will be charged for any appointment missed or cancelled less than 24 hours in advance. I hereby agree to pay any and all charges.

Signature: Date:

Relationship to the Patient:

PATIENT HEALTH HISTORY Patient Name:

Allergies to Medications:

Current Medications:

Current Supplements:

Most Important Health Concerns:

Reason for Today's Visit:

FAMILY HISTORY

Disease	*Yes*	*No*	*Which Relative(s)*	*Deceased/Living*
Breast Cancer	Y ❒	N ❒		
Other Cancer	Y ❒	N ❒		
Diabetes	Y ❒	N ❒		
High Blood Pressure	Y ❒	N ❒		
Heart Disease/Stroke	Y ❒	N ❒		
Kidney Disease	Y ❒	N ❒		
Liver Disease	Y ❒	N ❒		
Blood Disorder	Y ❒	N ❒		
Mental Illness	Y ❒	N ❒		
Alcoholism/Drug Abuse	Y ❒	N ❒		
Thyroid Issues	Y ❒	N ❒		
Cataracts/Glaucoma	Y ❒	N ❒		
Osteoporosis	Y ❒	N ❒		
Other:				

PERSONAL HISTORY:

Major Illnesses (type & when):

Surgeries/Hospitalizations/Accidents (type & date):

Major Toxic Exposure: pesticides/chemicals Heavy Metals

Have *YOU* Ever Experienced: Check for yes or no. ***Please underline which condition***

Y ❒	N ❒	Measles/Mumps/Rubella/Chicken Pox/Mono/Strep	Y ❒	N ❒	Headaches/Numbness/Sensory Change/Head Injury
Y ❒	N ❒	Liver Disease/Hepatitis/Jaundice	Y ❒	N ❒	Epilepsy/Loss of Consciousness
Y ❒	N ❒	Gallbladder Disease/Gallbladder Stones	Y ❒	N ❒	Fatigue/Insomnia/Waking Not Rested
Y ❒	N ❒	Kidney Disease/Urinary Problems/Bladder Infections	Y ❒	N ❒	Poor Memory/Confusion/Foggy Mind
Y ❒	N ❒	Gonorrhea/Chlamydia/Herpes/ Genital Warts/Other Sexually Transmitted Disease	Y ❒	N ❒	Anemia/Nose Bleeds/Easy Bruising
Y ❒	N ❒	Pain/Impotence/Problems with Sexual Intercourse	Y ❒	N ❒	Hot Flashes/Night Sweats
Y ❒	N ❒	Ovarian/Uterine/Testicular Pain, Problems, or Masses	Y ❒	N ❒	Thyroid/Pituitary/Adrenal Problems
Y ❒	N ❒	Lung Disease/Shortness of Breath/Asthma/Tuberculosis	Y ❒	N ❒	Weight Loss/Gain (>10 Lbs.)

Patient Name: _____

Y ❒	N ❒	Racing Heart/Chest Pain/High Cholesterol/Hypertension	Y ❒	N ❒	Sinus Problems/Runny Nose/Allergies
Y ❒	N ❒	Muscle Cramps/Tightness/Aches	Y ❒	N ❒	Recurrent Colds/Flues/Infections
Y ❒	N ❒	Visual Changes/Eye Pain Infections/Cataracts	Y ❒	N ❒	Cancer/Pre-Cancer of Any Kind
Y ❒	N ❒	Ear Pain/Ear Infections/Decreased Hearing/Ringing	Y ❒	N ❒	Skip Meals/Dieting/Binge Eating
Y ❒	N ❒	Joint Pain/Arthritis/Bone Loss/Bone Pain	Y ❒	N ❒	Diabetes/Hypoglycemia/Sugar Craving
Y ❒	N ❒	Digestive Troubles/Pain/Gas/ Bloating/Constipation/Diarrhea	Y ❒	N ❒	Depression/Anxiety/Irritability/ Weepiness
Y ❒	N ❒	Itching/Rashes/Eczema/Psoriasis/ Mole Changes	Y ❒	N ❒	Dry Skin/Excessive Sweating/ Hair loss

Other Health Problems/Concerns: _____

_____

SOCIAL HISTORY:

Exercise # of days/week: _____ type(s): _____

Caffeine (# cups/day): Coffee _____ Tea _____ Soft Drinks _____

Tobacco Use: Y ❒ N ❒ In the past ❒ # of cigarettes/day: _____ total years smoking: _____

Alcohol Use: Y ❒ N ❒ In the past ❒ # of drinks _____ per day ❒ week ❒ month ❒

Drug Use: Y ❒ N ❒ In the past ❒ Type(s): _____

Use: daily ❒ weekly ❒ monthly ❒ almost never ❒

Sexually Active: Y ❒ N ❒ Prefer: Men ❒ Women ❒ Both ❒ Practice Safe Sex? Y ❒ N ❒

History of Sexual/Physical/Emotional Abuse: Y ❒ N❒ _____

Currently Live With: _____

OB/GYN HISTORY (*Women Only*):

Age at 1st menses: _____ First day of Last Period: _____ Periods Regular: Y ❒ N ❒

Currently pregnant: Yes ❒ No ❒ Maybe ❒ Are you trying to get pregnant: Y ❒ N ❒

Birth Control Method: _____ Are you satisfied with this method: Y ❒ N ❒

Last Annual Exam: _____ Abnormal Pap Smear Ever: Y ❒ N ❒

Total Number of Pregnancies: _____ # Births: _____ # Miscarriages: _____ # Abortions: _____

Number of Children Breast Fed: _____ Total # Years on Hormones (including birth control): _____

Last Mammogram: _____ Abnormal Mammogram Ever: Y ❒ N ❒ _____

Gyn and/or Breast Surgeries & Dates: _____

Question/Concerns: _____

I look forward to assisting you with your health!

INFORMED CONSENT TO TREATMENT

Patient Name:_____ Date of Birth: _____ /_____ /_____

This is to acknowledge that I have been informed and understand that:

1. As a Naturopathic Physicians, Dr. Emma Baker and Dr. Emily Livengood do not have hospital privileges and can only prescribe certain drugs. Therefore, I, the patient, will maintain an on-going relationship with a local primary care M.D. or D.O. physician of my choosing.

2. **In the case of a medical emergency, I, the patient, am to call 911 or proceed to the nearest emergency room.**

3. I, the patient, understand that Dr. Emma Baker and Dr. Emily Livengood offer **adjunctive care only to cancer patients**, and I will therefore maintain care with an M.D. or D.O. oncologist of my choosing should I be diagnosed with cancer.

4. Any treatment or advice provided to me as a patient of Dr. Emma Baker N.D. or Dr. Emily Livengood is not mutually exclusive from any other treatment or advice that I maybe receiving now or in the future from another healthcare provider.

5. I, the patient, am at liberty to seek or continue medical care from any physician, surgeon, or other healthcare provider.

6. The treatment and therapies provided or recommended by this health center may be different than those usually offered by other licensed healthcare providers.

7. There have not been any representations made regarding the likelihood of success of any recommendation(s) or treatment(s) offered.

8. I understand that I am responsible for all fees regardless of insurance coverage and/or treatment outcome. I further understand that 100% of these fees are due at the time service is rendered.

I hereby authorize and consent to treatment.

Signature: _____ Today's Date: _____ /_____ /_____

Relationship to Patient: _____

Witness Signature: _____ Today's Date: _____ /_____ /_____

NOTICE OF PRIVACY PRACTICES AKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____

ADVANCED BENEFICIARY NOTICE (ABN)

Patient Name:_____ Date of Birth: _____ /_____ /_____

The purpose of this notice is to help you make an informed decision about whether or not you want to receive these items and/or services, fully knowledgeable that you might have to pay for them out of pocket.

I, the patient, accept that my insurance company may or may not pay for the items and/or services that are described below:

1. Naturopathic Office Visits and Exams
2. Bowen Therapy
3. Massage
4. Nutritional and/or herbal supplements
5. Injectables and Injections
6. Any service ordered by a Naturopathic physician (including labs, imaging or any other service(s))

Before you make a decision about your options, you should read this entire notice carefully. If you do not understand why your insurance may not pay ask us to explain. Ask us how much the items and/or services will cost you, in case you have to pay for them out of pocket.

Please choose **ONE** of the following options:

☐ Option 1: **YES**, I want to receive these items and/or services

I, the patient, understand that my insurance will not decide whether to pay unless I receive these items and/or services and have a claim submitted. I understand you may bill me for these items and/or services in full if my insurance denies my claim and refuses to pay within **60 days** of the submitted claim. I agree to be personally and 100% fully financially responsible for payment.

☐ Option 2: **NO**, I do not want to receive these items and/or services

I will not receive these items or services. I understand that you will not be able to send a claim to my insurance.

Signature: _____ Today's Date: _____ /_____ /_____

Relationship to Patient: _____

ACKNOWLEDGEMENT OF DISCLOSURE AND ACCEPTANCE OF PATIENT FINANCIAL RESPONSIBILITY

Patient Name:_____ Date of Birth: _____ /_____ /_____

Initial the following

_____ I, the patient, understand that I am 100% financially responsible of all doctor visits, other treatments, and supplements, regardless of insurance coverage and/or treatment outcome. I understand that not all services rendered may not be covered by insurance and that I, the patient, am financially responsible for the balance.

_____ I, the patient, understand that my copay and/or deductible is due at the time of services rendered.

_____ I, the patient, understand that all fees are due at the time service is rendered, that all sales are final, and that Baker Family Naturopathic cannot provide refunds or exchanges.

_____ I, the patient, authorize Baker Family Naturopathic to bill my health insurance, if applicable, for services rendered.

_____ I, the patient, understand if my insurance company does not pay my claim within **30 days**, and we are not notified by insurance company of late payment, then it is my responsibility as the patient to contact them and expedite payment. I understand that if my insurance company refuses to pay I then am 100% financially responsible for payment.

_____ I, the patient, understand if my insurance company does not pay within **60 days**, then I the patient am required to pay the balance on my account in the form: cash, check, Visa, or MasterCard.

_____ I, the patient, understand that there is a $35 returned check fee, when applicable.

_____ I, the patient, understand that I personally, not my insurance company, will be charged for any appointments missed or cancelled less than **24 hours in advance**.

I, the patient or the patient's legal representative, hereby agrees to pay any and all charges.

Signature: _____ Today's Date: _____ /_____ /_____

Relationship to Patient: _____