Welcome

Thank you for trusting Nature Cures Clinic with your health care. We take our commitment to you very seriously, and we look forward to working with you to enhance your health and well-being, both now and in the future.

We value your time, and realize that office visits may be an interruption in an otherwise very busy schedule for you. For this reason, we've taken steps to assure that your time in the clinic is as focused and efficient as it can be. Please note the following:

1) Enclosed you will find an extensive **New Patient Intake Form**; this form is our first introduction to you and your history. Your detailed and thoughtful responses will help us to use our time in the clinic more effectively.

2) If a **New Patient appointment is missed without 24 hours** notice we will ask that upon making a second New Patient appointment that you **provide us with a payment of $100 prior to your appointment**, which will be credited to your account and will be applied to your first visit. If you miss that second New Patient appointment without 24 hours notice, the $100 will be applied to a New Patient missed appointment fee.

3) If you have health insurance, Nature Cures Clinic will gladly assist with insurance billing. You must provide your insurance information **at the beginning of your scheduled visit.** Please bring your insurance card and the *How do I Check My Insurance Benefits* form (**filled out completely**) that was provided to you prior to your appointment, to the office with you at the time of your visit. **Please see the statement below regarding our Payment Policy.**

We look forward to seeing you in our clinic. Our goal is always to provide you with health care that exceeds your expectations.

Sincerely,

Nature Cures Clinic

Required Benefits Form for All Patients Using Insurance

Patient Name_____ Insurance ID#_____

Nature Cures Clinic is happy to bill your insurance for your visit; however, **it is the patient's responsibility** to be aware of her/his coverage and co-pay, as well as any deductible and maximums. Please follow steps 1-9 when calling to find out benefits and eligibility.

First**, *Call the number*** on your insurance card listed for customer service, benefits and eligibility, or subscriber services and ask the representative the following questions. Online benefits and insurance handbooks will not give the same information as a live representative.

1. When did my *coverage begin and when is it valid thru*?
   Beginning Date of Coverage_____ Ending Date of Coverage_____

   Does my insurance plan follow a **Fiscal** or **Calendar** year schedule? _____

2. Do I need *a referral from my primary care physician* (PCP) for alternative services?
   ___Yes ___No

3. Is the doctor I want to see (Dr. Greg Nigh, Dr. Greg Eckel, Dr. Rose Paisley, Dr. Erika Siegel, Dr. Hilary Costello, Dr. Arthur/Andy Swanson) ***In-Network*** *or* ***a preferred provider*** with my insurance?
   ___Yes ___No

4. What are my ***benefits*** for the following services? ***Be sure to find out the benefits that apply to the doctor you are seeing; there will be different benefits depending on whether the doctor is In or Out-of-Network with your insurance company and whether your plan includes Out-of-Network benefits*.

Specialties/Procedures:

Naturopathic: % Covered_____ ;Co-pay/ Co-Insurance_____; Year Max_____

Acupuncture: % Covered_____ ;Co-pay/ Co-Insurance_____; Year Max_____

Physical Therapy: % Covered_____; Co-pay/ Co-Insurance_____; Year Max_____

Chiropractic: % Covered_____ ;Co-pay/ Co-Insurance_____; Year Max _____

Labs/Imaging % Covered_____ when billed to an In-Network Lab.

B12Injections: (CPT- 96372) Amount or % Covered_____

5. Is there a Co-pay per **visit** or per **specialty**? Please circle which one.

6. What is my ***deductible for the year*** and has any or all of it been met?

   Deductible $_____ Amount of Deductible met so far $_____ Date____

   Are any of the specialties listed above **subject to this deductible**? **____Yes ____No**

   If so, **which specialties**? _____

8. Is My **Annual Gynecological Exam Covered by a Naturopathic Physician? _____**
   If so, what is the coverage?_____

9. What was the ***name of the representative*** I spoke with_____ **Date_____**

Please bring this form with you to your appointment. If you have trouble getting the information you need, please feel free to call the clinic for assistance. Thanks so much!

*Please be aware that this is not a guarantee of payment, if an insurance company gives you inaccurate information they may not honor the benefits that were quoted.

Consent Form

PLEASE READ CAREFULLY BEFORE INITIALING OR SIGNING.

Consent To Treatment

Naturopathic, chiropractic, and Chinese medicine therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to soreness, inflammation, soft tissue injury or bruising, dizziness, burns, temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain to your satisfaction, please ask for more information.

I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for a specific cure or result.

_____

Print Name Signature of Patient Date

Agreement to Payment Policy of Nature Cures Clinic

By signing below, I understand that full payment for all services and products I receive from Nature Cures Clinic and its practitioners is required at the time of service, except that portion billed to my insurance company. Further, I understand that Nature Cures Clinic may submit my bill to my insurance carrier, if I so request, and that I am responsible for any services not covered by my insurance company, as well as, any co-pay, coinsurance or deductible required by my insurance.

_____ Signature of Patient

Consent Regarding Use of Information – Please initial if you consent to the statement below, or leave blank if you do not consent.

_____ Some physicians at Nature Cures Clinic use email to correspond with patients as a convenience. However, these emails are not encrypted and could theoretically be read by a malicious outside party with the technical skills to intercept such correspondences. By initialing this line, you are consenting to allow Nature Cures Clinic and its physicians to correspond with you via email in spite of these potential risks.

_____ Nature Cures Clinic is engaging in research into the efficacy of the therapies used by physicians practicing here. To gather sufficient data it is necessary to collect information about conditions treated, therapies used and outcomes observed from patient charts. In this process, no information that could be used to specifically identify individuals is ever used; only general demographic information is attached to the clinical data. By initialing this line, you are consenting to allow Nature Cures Clinic to include this anonymous data from your chart to conduct research to be published in the appropriate medical literature.

_____ Some physicians at Nature Cures Clinic have an interest in writing about alternative medicine and health care for the general public, either as fiction or nonfiction. By initializing this line, you are consenting to allow your medical history and care in our clinic to be used as an example or case history in such writing, with the understanding that all identifying information would be altered.

Consent for Purposes of Treatment, Payment and Healthcare Operations for Patients of Nature Cures Clinic, LLC.

I consent to the use or disclosure of my protected health information by Nature Cures Clinic, LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Nature Cures Clinic, LLC. I understand that diagnosis or treatment of me by my physician(s) at Nature Cures Clinic, LLC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Nature Cures Clinic, LLC is not required to agree to the restrictions that I may request. However, if Nature Cures Clinic, LLC agrees to a restriction that I request, the restriction is binding on Nature Cures Clinic, LLC and my physician(s) at Nature Cures Clinic, LLC.

I have the right to revoke this consent, in writing, at any time, except to the extent that my physician(s) at Nature Cures Clinic, LLC or Nature Cures Clinic, LLC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Nature Cures Clinic, LLC uses Quality Medical Billing Service as its insurance billing service; I understand this and do hereby give my consent to have my insurance information processed by this company.

I understand I have a right to review Nature Cures Clinic, LLC's Notice of Privacy Practices prior to signing this document. The Nature Cures Clinic, LLC 's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Nature Cures Clinic, LLC. This Notice of Privacy Practices also describes my rights and Nature Cures Clinic, LLC's duties with respect to my protected health information.

Nature Cures Clinic, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative’s Authority

Nature Cures Clinic Policies

Name:_____

***Please read carefully and initial by each policy. If you do not initial all policies we will be unable to treat you.*

____ Cancellations and Missed Appointments

If you are unable to make your scheduled appointment, please call the clinic at least 24 hours in advance of your scheduled time. You will be charged a $50 missed appointment fee if you miss a scheduled appointment or fail to cancel at least 24 hours in advance. If you miss your first appointment without giving 24 hours notice, you will be asked to put down a deposit of $100 to reschedule; this deposit will apply towards your first visit.

____ Product Returns

We are unable to give refunds or credits on any supplements, opened or unopened. We cannot re-sell supplements that have left the office; we cannot guarantee that these items were protected from conditions that might affect their quality or integrity.

____ Payment Agreement

If you are not billing insurance then you are responsible for your balance at the time of your visit. You will receive the time of service (TOS) discount on these visits.

In addition, all supplements, labs (except for Quest Labs), and uninsured procedures (explained by your doctor) require payment at the time of service.

If you would like us to bill your insurance, then you are responsible for your co-pay or co-insurance at the time of service. If your insurance has a deductible, you must pay the full amount at the time of service until the deductible is met. We will bill towards this deductible if you wish, or you may choose to receive the time of service discount and submit the claims yourself (we will provide the necessary forms).

Your insurance might pay only a portion of the charge for your treatment; you are responsible to pay for any balance on your account. We will bill you for the remainder once we have received the payment and explanation of benefits from your insurance.

____ Insurance Agreement

If you would like us to bill your insurance then you are responsible for determining the extent of your coverage prior to your first appointment. Nature Cures provides a "How to check your benefits" form, which guides patients through calling their insurance company to determine their coverage. This form must be filled out completely. Our clinic is happy to assist with this if you are unable to determine benefits on your own; however, you must call the clinic at least 24 hours prior to your appointment in order for us to help you. **If you do not check your benefits, we will not bill your insurance**.

____ Cell Phones

Nature Cures Clinic is a Cell Phone Free Zone. Please silence your cell phones and step outside the clinic door to place or take any calls. Thank you for your cooperation.

Nature Cures Clinic New Patient Intake Form

Please fill this out entirely and bring it with you to your first office visit.

Name _____ Date _____ Date of Birth_____
Home Phone_____ How were you referred to us?_____

Nature Cures Clinic or individual health care providers will call patients at times, and we wish to ensure your privacy regarding treatment at our clinic. In the event that we are unable to reach you by phone, please **indicate where it is appropriate to leave messages for you**:

☐ Home message machine ☐ With family members ☐ At work ☐ Never leave messages

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What are your primary health concerns? List as may as you can, in the order of their importance to you.

1) _____
2) _____
3) _____
4) _____
5) _____

What are the primary expectations you have for your visit today to our clinic?

1) _____
2) _____

Is this your first visit to a Naturopathic Physician? ____ Acupuncturist? _____

General Information:

Height _____ Weight _____ Weight 1 yr ago _____ Maximum weight _____ When _____

When during the day is your energy and alertness best? _____ Worst? _____ Blood type _____

Primary interests and hobbies _____

Primary form of exercise, if any _____

How often _____

Family History: Do you have a family history of any of the following diseases or conditions? When answering, include your parents, brother/sisters, and grandparents, if known. Check all that apply.

☐ Anemia	☐ Cancer	☐ Heart Disease	☐Mental Illness	☐Alzheimer's
☐Arthritis	☐ Diabetes	☐ Hypertension	☐ Multiple Sclerosis	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Parkinson's	☐ Other (list below)

Please list other significant family medical history not listed above:

_____
_____
_____

Are you currently receiving health care? If yes, where and from whom? Please provide contact information (phone and address) if available. If not, when was the last time you received medical care and why?

_____
_____
_____
_____

Which of the following childhood illnesses have you had?

☐ Diphtheria	☐ Measles	☐ Scarlet Fever	☐ German Measles
☐ Mumps	☐ Rheumatic Fever	☐ Chickenpox	☐ Other: _____

Which immunizations have you had. If you don't know if you've had one, place a question mark beside it.

☐ Diphtheria	☐Measles/Mumps/Rubella	☐ Meningitis	☐ Polio	☐ Tetanus
☐Chickenpox	☐ Hepatitis A/B/C	☐ Pertusis	☐ Flu	☐Other: _____

Which diagnostic studies have you had in the past year?

☐ Electrocardiogram (EKG)	☐ X-Ray	☐ Bone Density Scan (DEXA)	☐ CT Scan
☐ Electroencephalogram (EEG)	☐ Mammogram	☐MRI	☐ Other: _____

Are you aware of having allergies to any of the following? If so, describe your reaction to each one:

Drugs: _____
Foods: _____
Chemicals/Perfumes: _____
Animals: _____

Which medications, either by prescription or over-the-counter, are you taking or have you taken in the past 6 months?

☐ Laxatives ☐ Pain Relievers ☐ H2 Blockers/Ulcer Medication ☐ Antacids
☐ Cortisone/Predisone ☐ Appetite Suppressants ☐ Antidepressants ☐ Antibiotics
☐ Tranquilizers ☐ Thyroid medication ☐ Cholesterol-lowering medication
☐ Sleeping medication ☐ Other: _____

Please list, by name, any prescription medications you currently take, over-the-counter medications, and all vitamins/supplements/herbs you take regularly at this time. Include dosage, if known. ***Note: Please bring each of these with you to your first office visit.***

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

9) _____

(continue on back if necessary)

Assessing the Areas of Your Life

In assessing your health, it is helpful to have some sense of the degree of satisfaction you feel in various areas of your life. Using the scales below, please rate yourself in terms of satisfaction and dissatisfaction. Number 1 means you are very dissatisfied or stressed. Number 10 means you are very satisfied or comfortable.

Friends & Family
0 1 2 3 4 5 6 7 8 9 10

Physical Environment
0 1 2 3 4 5 6 7 8 9 10

Health
0 1 2 3 4 5 6 7 8 9 10

Career
0 1 2 3 4 5 6 7 8 9 10

Relationships/Romance
0 1 2 3 4 5 6 7 8 9 10

Recreation
0 1 2 3 4 5 6 7 8 9 10

Money
0 1 2 3 4 5 6 7 8 9 10

Personal Growth/Spirituality
0 1 2 3 4 5 6 7 8 9 10

Check the appropriate box:

	Yes	No
Get 6-8 hours of sleep nightly?		
Sleep Well		
Awaken Rested		
In a supportive relationship		
History of abuse		
Suffered recent (past 3 years) major life trauma		
Use recreational drugs		

	Yes	No
Treated for drug/alcohol dependence		
Drink alcohol?		
Use tobacco? If so, how many packs daily: ___ How many years: ____		
Enjoy your work?		
Take vacations?		
Spend time outside?		

	Yes	No
Watch TV? Hours daily ____		
Read? Hours daily ____		
Eat 3 meals daily?		
Eat out more than 3 times weekly?		
Go on diets more than twice yearly?		

	Yes	No
Drink tea?		
Drink coffee?		
Drink soda/cola?		
Use products with Nutrasweet or Splenda?		
Add sugar/salt to food?		

Review of Systems

In this section, check the box if you have the symptom currently or if you have experienced it in the past 6 months. Some questions are yes/no, in which case check the box to indicate "yes."

Mental/Emotional	
Treated for depression	
Mood swings	
Considered/Attempted suicide	
Poor concentration	
Depression	
Anxiety or nervousness	
Tension	
Memory problems	

Endocrine	
Hair loss	
Brittle nails	
Excessive thirst	
General fatigue	
Fatigue after meals	
Heat intolerance	
Cold intolerance	
Excessive hunger	
Seasonal depression	

Head	
Headaches	
Migraines	
Head injury	
Jaw pain/TMJ	

Immune	
Chronic fatigue symdrome	
Swollen glands	
Reaction to vaccines	
Ongoing infections	
Slow wound healing	
Colds/flu more than once yearly	

Neurological	
Seizures	
Muscle weakness	
Loss of memory	
Vertigo/dizziness	
Paralysis	
Numbness or tingling	
Easily stressed	
Involuntary shaking or unsteadiness in hands	

Ears	
Impaired hearing	
Earaches	
Ringing	
Itching inside or outside	
Frequent popping	

Nose and Sinuses	
Frequent head colds	

Stuffiness	
Sinus pain	
Nose bleeds	
Hay fever	
Loss of smell	

Eyes	
Spots in vision	
Blurriness	
Color blindness	
Double vision	
Cataracts	
Eye pain/strain	
Uncomfortable tearing or dryness	
Glaucoma	

Mouth and Throat	
Frequent sore throat	
Teeth grinding	
Gum bleeding/pain/disease	
Dental cavities	
Copious saliva	
Sore tongue/lips	
Hoarseness	
Jaw clicks	

Neck	
Lumps	
Goiter/enlargement in front of throat	
Pain or stiffness	

Skin	
Rashes	
Acne, boils	
Color changes	
Lumps	
Eczema	
Hives	
Generalized itching	
Night sweats	

Urinary	
Pain with urination	
Frequency at night; If so, how often do you wake to urinate each night __	
Frequent infections	
Unable to hold urine	
Kidney stones	
Splitting of stream	

Respiratory	
Cough	
Spitting of blood	
Asthma	
Pneumonia	
Emphysema	
Pain on breathing	
Shortness of breath at night	
Shortness of breath daily	
Shortness of breath lying down	
Lung congestion/sputum	
Wheezing	
Bronchitis	
Pleurisy	
Difficulty breathing	
Difficult taking a full deep breath	

Cardiovascular	
Heart disease	
High blood pressure	
Low blood pressure	
Blood clots	
Phlebitis	
Rheumatic fever	
Ankle swelling	
Angina/chest pain	
Heart murmurs	
Fainting	
Heart palpitations/fluttering	

Intestinal	
Trouble swallowing	
Change in thirst	
Change in appetite	
Nausea/vomiting	
Burning pain in stomach	
Jaundice	
Gallbladder disease	
Liver disease	
Hemorrhoids	

Heartburn	
Abdominal pain or cramps	
Excessive belching or excess gas	
Constipation	
Diarrhea	
Black stools	
Blood in stools	
Bowel movement (BM) daily How often are BMs: _____	

Musculoskeletal	
Joint pain or stiffness	
Broken bones	
Muscle spasms or cramps	
Arthritis	
Weakness	
Sciatica	

Blood/Peripheral Vascular	
Easy bleeding/bruising	
Deep leg pain	
Varicose veins	
Anemia	
Cold hands	
Cold feet	

Male Reproduction (questions apply to lifetime, not just last 6 months)	
Hernias	
Prostate disease	
Are you sexually active?	
Impotence	
Premature ejaculation	
Use condoms	
Testicular masses or pain	
Discharge or sores on penis	
Chlamydia	
Gonorrhea	
Condyloma/genital warts	
Genital herpes	
Syphilis	

Female Reproduction/Breasts (questions apply to lifetime, not just last 6 months)	
Age at first menses (first period) _____	
Age of last menses (if menopausal) ____	
Usual length of cycle (blood flow to next blood flow): _____	
Duration of menstruation (days of bleeding) ____	
Irregular cycles	
Painful menses	
Heavy flow	
Light flow	
Bleeding/spotting between periods	
Clotting	
Discharge	
PMS	
Menopausal symptoms	
Endometriosis	
Ovarian cysts	
Date of last annual exam/Pap _____	
Sexually active	
Pain during intercourse	
Use of birth control; if so, what type _____	
Difficulty conceiving	
Cervical dysplasia	
Sexual difficulties	
Gonorrhea	
Genital herpes	
Chlamydia	
Condyloma/genital warts	
Syphilis	
Regular self breast exams	
Breast pain/tenderness	
Breast lumps	
Nipple discharge	
Number of pregnancies _____ Number of live births _____ Number of miscarriages _____	

Are there any other health concerns that you have which have not been covered in this questionnaire?

_____
_____
_____
_____

_____

Signature Date