Today's date: **PLEASE COMPLETE AND SIGN** New Patient ☐ Updated info: ☐

## ACCOUNT# PATIENT INFORMATION FCOF RCOF

Last name: First name: Middle Initial: Marital status: Single ☐ Mar ☐ Partner ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No If not, what is your legal name? Social Security no.: Birth date: Age: Sex: ☐ M ☐ F

Street address (Mailing address for statements) City: State: Zip:

Email address: Evening phone no: ( )

Prefer to receive messages: Day# ☐ Evening# ☐ Email ☐ None ☐

Employer Daytime phone no.: ( )

Chose clinic because/referred to clinic by: ☐ Location ☐ Family ☐ Friend ☐ Insurance plan ☐ Physician ☐ Seminar or event ☐ Yellow Pages ☐ Other

NAME OF PERSON WHO REFERRED YOU (if applicable):

If you are interested in our Limited Income Discount please **contact the clinic prior to your appointment**.

For Office Use Only: **Income Verified** [ ] **Date**: **Date to be Re-Verified:**

## PRIVATE HEALTH INSURANCE INFORMATION

**(If you are using Insurance, fill out this box and give your insurance card to the receptionist**.)

Name of primary insurance plan: Address: City: State: ZIP Code:

Subscriber's name: Subscriber's S.S. no.: Birth date: Group no.: Policy/ID no.: Copay/insurance:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

***IF YOU HAVE A SECONDARY INSURANCE YOU WOULD LIKE US TO BILL PLEASE NOTIFY THE RECEPTIONIST.***

## MOTOR VEHICLE ACCIDENT OR WORKER'S COMPENSATION INSURANCE INFORMATION

☐Work comp ☐ MVA (Please give your insurance card to the receptionist.)

Name of insurance plan: Address: City: State: ZIP Code:

Claim representative's name: Phone no.: ( ) Attorney's name: Phone no.: ( )

Date of injury: Claim number: Injured body part:

Employer at time of injury name:

## IN CASE OF EMERGENCY

Name of local friend or relative: Relationship to patient: Phone no.: ( )

## SIGNATURE

**The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance per the credit policies of Nature Cures Clinic. I also authorize Nature Cures Clinic or insurance company to release any information required to process my claims.**

**Patient or Guardian signature**: Date:

Name:-

# CONSENT & ACKNOWLEDGMENT FOR TREATMENT and SERVICES

______________________________________________ Date:______________________

Completion of this informed consent form is necessary to offer services to all patients. By signing this document you are providing informed consent, understanding and agreement to the content. Some items may not apply to your current situation; however, in order to provide comprehensive care during this and future visits, we request that you complete this consent in its entirety. Failure to do so will result in our inability to treat you. You have the privilege of revoking this consent, by providing written notice, at any time.

## CONSENT FOR TREATMENT

____________ (Initials) I hereby grant my permission and informed consent to Nature Cures Clinic to perform such tests, treatments and procedures as ordered by the medical staff (including naturopathic physicians, nurse practitioners, certified nurse midwives, acupuncturists), for diagnostic and/or therapeutic purposes. Including, but not limited to, physical evaluation and assessment, blood draws, lab work, STD testing, naturopathic methods of care and Chinese medicine.

____________ (Initials) I understand that my care and treatment may include a variety of disease-specific prevention, procedures, education, risk-reduction services, nutritional recommendations, botanical medications, acupuncture, prescription medications, dietary supplements, homeopathic remedies, Chinese herbal blends, and/or physical medicine techniques in accordance with the respective scope of practice of the provider(s) seen at Nature Cures Clinic.

____________ (Initials) I acknowledge that I have the right to ask questions and discuss to my satisfaction:
1) my suspected diagnosis(es) or condition(s)
2) the nature, purpose, goals, and potential benefits of proposed care
3) the inherent risks, complications, potential hazards or side effects of a treatment or procedure.
4) the probability or likelihood of success
5) reasonable available alternatives to the proposed treatment or procedure
6) potential consequences if treatment or advice is not followed

____________ (Initials) By initialing, I authorize Nature Cures Clinic to communicate with the following individual about my health care which may include information about my medical diagnosis, eligibility status and appointments.

______________________________________________________________________

First Name Last Name Relationship

## FINANCIAL RESPONSIBILITY

____________ (Initials) I understand that payment-in-full, for all services and products I receive from Nature Cures Clinic and its practitioners, is required at the time of service.

____________ (Initials) I understand that Nature Cures Clinic may submit my bill to my insurance carrier and that I am responsible for all services not covered by my insurance company, as well as, any co-pay, coinsurance or deductible required by my insurance.

____________ (Initials) I understand that if I would like Nature Cures Clinic to bill my insurance then I am responsible for filling out completely the 'checking benefits' form available online, in the clinic or by email request, bringing it and my insurance card to Nature Cures Clinic. If I do not check my benefits, Nature Cures Clinic will not bill my insurance.

____________ (Initials) I understand that my insurance plan may pay only a portion of the charge for my care and treatment at Nature Cures Clinic and I understand that I am responsible to pay for any balance on my account.

_____________ (Initials) I understand that if there is a remainder on my account, Nature Cures Clinic will bill me after receiving payment and explanation of benefits from my insurance.

## CLINIC POLICIES

_____________ (Initials) I understand that I will be charged a $60 missed appointment fee if I do not cancel a scheduled appointment at least 24 hours in advance of the scheduled time. Recurrent late cancellations may result in discharge from this practice.

_____________ (Initials) I understand that if I fail to show up to an appointment ("No Show"), I will be asked to put down a deposit of $100 to reschedule. Further "no shows" will also result in $60 fee and may result in discharge from this practice.

_____________ (Initials) I understand that there are no refunds or credits on any supplements, opened or unopened.

_____________ (Initials) I understand that if I would like Nature Cures Clinic to bill my insurance then I am responsible for determining the extent of coverage prior to my first appointment. Nature Cures provides a 'checking benefits' form (available online, in clinic and by email request), which guides patients through calling their insurance company to determine their coverage. This form must be filled out completely prior to my first visit. If I need assistance, Nature Cures Clinic staff may assist me upon request, at least 24 hours prior to my appointment.

_____________ (Initials) I understand that I may be responsible for my co-pay to be paid prior to me being seen by a health care practitioner.

_____________ (Initials) I understand that Nature Cures Clinic is a Cell Phone Free Zone. I agree to silence my cell phone and step outside the clinic door to place or take any calls.

## RIGHTS AND RESPONSIBILITIES

We recognize that each patient has unique health care needs and we encourage a partnership between the patient and the health care team. We encourage patients or their legally designated representative to participate in discussions and decisions about their treatments, options, alternatives, risks and benefits.

**Rights**

_____________ (Initials) I understand that as a patient of Nature Cures Clinic, I have the right to expect:

•CARE that is safe, high quality, respectful and considerate of your personal, spiritual, cultural and religious beliefs and values.
•INFORMATION that is understandable and complete, including rights, health status, treatment and care options, and who is providing care.
•PARTICIPATION in the decisions about my care, treatment and services
•CONFIDENTIALITY and privacy
•COMMITMENT to safety and security in an environment that preserves dignity, including freedom from abuse and neglect, as well as my right to voice complaints and grievances without being subject to reprisal.
•PROMPT RESPONSE to requests for assistance, concerns and complaints.

**Responsibilities**

_____________ (Initials) As a patient of Nature Cures Clinic, I have a responsibility to:

•INFORM caregiver staff of my past and current medical history, including changes in condition, medications, or providers
•ASK questions about my care and treatment, particularly if instructions are not clear
•PARTICIPATE in my plan of care by cooperating with care
•RESPECT others by adhering to clinic policies regarding safety and comfort.
•NOTIFY staff if I am unable to keep a scheduled appointment.
•PROVIDE INFORMATION regarding insurance coverage and payment plans.
•TELL US how we can provide better care or service to you and your family.

## AGREEMENT FOR ELECTRONIC CORRESPONDENCE

Patients may want to use email or other electronic formats to facilitate communication. Federal regulations impose a "duty to warn" patients of risks associated with unencrypted email. Nature Cures Clinic wants to ensure patients have been advised that email communications could potentially be read by a third party. **Upon receipt and documentation of this notification, the patient has the right to request communication via email.**

**Risks of using email:**

____________ (Initials) I understand clearly that the following risks of using email include, but are not limited, to:
•Email may be forwarded, printed, and stored in numerous paper and electronic forms.
•Email may be sent to the wrong address by either party.
•Email may be easier to forge than handwritten or signed papers.
•Copies of email may exist even after the sender or the receiver has deleted his or her copy.
•Email service providers have a right to archive and inspect emails.
•Email may be intercepted, altered, or used without detection or authorization.
•Email may spread computer viruses.
•Email delivery is not guaranteed.

**Patient Agreement & Guidelines for use of email:**
____________ (Initials) I understand and agree to:
**•not use email for medical emergencies or in sending time-sensitive information to providers.**
•to follow up with my healthcare provider(s) or staff if I have not received a response to an email within a reasonable time period.
•Inform Nature Cures Clinic office staff of any changes to my email address.
•inform my healthcare provider or staff in writing if I decide to discontinue using email communications.
____________ (Initials) Patients who send email messages agree to follow these guidelines:
•A subject line that describes the question or concern
•Clearly state a question or concern briefly
•Clear patient identification, including patient name, telephone number and how/when best to reach you, in the body of the message.

## ACKNOWLEDGMENT OF RECEIPT

____________ (Initials) By initialing, I acknowledge receipt of the Notice of Privacy Practices from Nature Cures Clinic. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. It is available in our clinic and on the website under "Privacy Policy". The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy by visiting our website at www.NatureCuresClinic.com or on request from our staff.

## TERMS OF CONSENT

By signing below, I agree to the terms and information above. I am giving this informed consent of my own free will. I fully release Nature Cures Clinic, LLC, as well as their Members, Providers, employees, and agents (i.e.: volunteers, students) harmless from any and all damages, losses, liabilities (joint or several), payments, obligations, penalties, claims, litigation, demands, defenses, judgments, suits, proceedings, costs, disbursements or expenses (including without limitation, fees, disbursements and expenses of attorney, and other professional advisors and of expert witnesses and costs of investigation and preparation) of any kind or nature whatsoever resulting from, relating to or arising out of my receipt of services.

I have had the opportunity to ask any questions and have had them answered in a language that I understand. I further agree to abide by the terms of this consent. I understand that this document remains in effect until I revoke my consent in writing. I also understand that I am free to revoke my consent at any time.

______________________________________________________________________
Signature of Client or Parent / Guardian or Power of Attorney Date

______________________________________________________________________
Witness Signature Date

# NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

## Nature Cures Clinic New Patient Intake Form

Name____________________________________ Date ___________________

Home Phone____________________ DOB _________________

What are the primary health concerns? List as many as you can and in order of importance.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

What are the primary expectations you have for your visit today at our Clinic?

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Is this your first visit to a Naturopathic Physician?_____ or Acupuncturist?_____
Who referred you?__________________________________________________

General Information:
Height _________
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_________________________________________________________

# NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

**Dear New Patient:**

a. Please **read** and **fill in** all of the information that pertains to you.
b. On pages 2 through 11, under each category, **check all** symptoms that you experience either *acutely or chronically*. Use the column on the left side of the page. The columns to the right of the page will be used by your physician at re-exam.
c. **Add** and **total** all of the boxes you checked.
d. **Date** today's day.

| | *TEST* | *DATE* | *TEST RESULTS* |
|---|---|---|---|
| ☐ | Physical | ______ | ______ |
| ☐ | Cholesterol | ______ | ______ |
| ☐ | Prostate | ______ | ______ |
| ☐ | Mammography | ______ | ______ |
| ☐ | Pap Smear | ______ | ______ |
| ☐ | Blood (which test?) | ______ | ______ |
| ☐ | HIV/STD | ______ | ______ |
| ☐ | Other | ______ | ______ |

***Please indicate if you have (or have been tested for) any of the following:***

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | Diabetes | ☐ | Allergies | ☐ | Rheumatic fever | ☐ | Vein condition |
| ☐ | Heart disease | ☐ | CVA (stroke) | ☐ | Thyroid disorder | ☐ | Tuberculosis |
| ☐ | Asthma | ☐ | Pneumonia | ☐ | Emphysema | ☐ | Chicken pox |
| ☐ | High blood pressure | ☐ | Gonnorhea | ☐ | Bleeding tendency | ☐ | Polio |
| ☐ | Syphilis | ☐ | Measles | ☐ | Nervous disorder | ☐ | Migraines |
| ☐ | Meningitis | ☐ | HIV | ☐ | Monoucleosis | ☐ | Other liver illnesses |
| ☐ | Epilepsy | ☐ | High fever | ☐ | Multiple Sclerosis | ☐ | Other heart illnesses |
| ☐ | Paralysis | ☐ | Cancer | ☐ | Jaundice | ☐ | Other kidney illnesses |
| ☐ | Glaucoma | ☐ | Mumps | ☐ | Hepatitis | ☐ | Other lung illnesses |

**IMMUNIZATIONS?**

______
______
______
______
______

**SURGERIES?**

______
______
______
______
______



Nature Cures Clinic ~ *1020 SW Taylor St. Suite 330 ~ Portland, OR 97205 ~ 503-287-4970*

# NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

## *1. Pain:*

| ☐ | **What makes the pain better?** |
|---|---|
| ☐ | Soft pressure |
| ☐ | Hard pressure |
| ☐ | Cold |
| ☐ | Heat |
| ☐ | Exercise |
| ☐ | Rest |
| ☐ | Other |

| ☐ | **What makes the pain worse?** |
|---|---|
| ☐ | Soft pressure |
| ☐ | Hard pressure |
| ☐ | Cold |
| ☐ | Heat |
| ☐ | Exercise |
| ☐ | Other |

**On the figures below, please mark clearly any areas of pain and indicate any scars.**

R

L

## *2. Describe your pain:*

- ☐ Sharp
- ☐ Fixed
- ☐ Burning
- ☐ Moving
- ☐ Cramping
- ☐ Aching
- ☐ Dull
- ☐ Other:________________________

☐ ***Total Boxes Checked:***

Date:____________

**FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, check the box if a symptom is 90% improved or better. Put a circle in the box for any new symptoms.**

| Re-Exam 1 | Re-Exam 2 | Re-Exam 3 | Re-Exam 4 | Re-Exam 5 | Re-Exam 6 |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Total | ☐ Total | ☐ Total | ☐ Total | ☐ Total | ☐ Total |
| Date:______ | Date:______ | Date:______ | Date:______ | Date:______ | Date:______ |



Nature Cures Clinic ~ *1020 SW Taylor St. Suite 330 ~ Portland, OR 97205 ~ 503-287-4970*

## 3. *Kidney Function:*
***(Overall temperature)***

- ☐ Cold hands
- ☐ Cold fingers
- ☐ Cold toes
- ☐ Cold feet
- ☐ Sweaty hands
- ☐ Sweaty feet
- ☐ Hot body temperature sensation
- ☐ Cold body temperature sensation
- ☐ Afternoon flushes
- ☐ Night sweats
- ☐ Heat in the hands, feet & chest
- ☐ Hot flashes any time of the day
- ☐ Thirsty
- ☐ Perspire easily
- ☐ Lack of perspiration
- ☐ Taking water to bed

☐ ***Total Boxes Checked:***
Date:____________

**FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, check the box if a symptom is 90% improved or better. Put a circle in the box for any new symptoms.**

| Re-Exam 1 | Re-Exam 2 | Re-Exam 3 | Re-Exam 4 | Re-Exam 5 | Re-Exam 6 |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** |
| **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ |

## 4. *Lung, Kidney Function:*
***(Overall energy)***

- ☐ Shortness of breath
- ☐ Difficulty keeping eyes open (day time)
- ☐ General weakness
- ☐ Easily catch colds
- ☐ Low energy
- ☐ Feel worse after exercise
- ☐ Daily chronic fatigue & malaise

☐ ***Total Boxes Checked:***
Date:____________

**FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, check the box if a symptom is 90% improved or better. Put a circle in the box for any new symptoms.**

| Re-Exam 1 | Re-Exam 2 | Re-Exam 3 | Re-Exam 4 | Re-Exam 5 | Re-Exam 6 |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** |
| **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ |

# NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

## *5. Liver, Spleen, Heart Function:*

- ☐ Dizziness
- ☐ See floating black spots

☐ ***Total Boxes Checked:***
Date:____________

**FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, check the box if a symptom is 90% improved or better. Put a circle in the box for any new symptoms.**

| Re-Exam 1 | Re-Exam 2 | Re-Exam 3 | Re-Exam 4 | Re-Exam 5 | Re-Exam 6 |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** |
| **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ |

## *6. Heart Function:*

- ☐ Anxiety
- ☐ Sores on tip of tongue
- ☐ Restlessness
- ☐ Mental confusion
- ☐ Alternating chest to shoulder pain
- ☐ Frequent dreams
- ☐ Wake up feeling tired
- ☐ Coffee? How much per week?_______

☐ ***Total Boxes Checked:***
Date:____________

**FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, check the box if a symptom is 90% improved or better. Put a circle in the box for any new symptoms.**

| Re-Exam 1 | Re-Exam 2 | Re-Exam 3 | Re-Exam 4 | Re-Exam 5 | Re-Exam 6 |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** |
| **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ |

## *7. Spleen Function:*

- ☐ Low appetite
- ☐ Abrupt weight gain
- ☐ Abrupt weight loss
- ☐ Abdominal bloating
- ☐ Abdominal gas

***spleen function continued next page...***

**FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, check the box if a symptom is 90% improved or better. Put a circle in the box for any new symptoms.**

| Re-Exam 1 | Re-Exam 2 | Re-Exam 3 | Re-Exam 4 | Re-Exam 5 | Re-Exam 6 |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

# NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

## *7. Spleen Function, continued…*

| Symptom | Re-Exam 1 | Re-Exam 2 | Re-Exam 3 | Re-Exam 4 | Re-Exam 5 | Re-Exam 6 |
|---|---|---|---|---|---|---|
| ☐ Gurgling noise in stomach | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Fatigue after eating | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Prolapsed organs? Which?_________ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Bruise easily? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Over-thinking | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Worry | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ ***Total Boxes Checked:*** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** |
| Date:____________ | **Date:______** | **Date:______** | **Date:______** | **Date:______** | **Date:______** | **Date:______** |

## *8. Lung Function:*

**FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, check the box if a symptom is 90% improved or better. Put a circle in the box for any new symptoms.**

| Symptom | Re-Exam 1 | Re-Exam 2 | Re-Exam 3 | Re-Exam 4 | Re-Exam 5 | Re-Exam 6 |
|---|---|---|---|---|---|---|
| ☐ Nasal discharge (color___________) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Cough | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Nose bleeds | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Sinus congestion | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Dry mouth | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Dry throat | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Dry nose | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Dry skin | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Allergies (which?_________________) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Alternating chills/fever | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Sneezing | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Headache (location______________) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Overall aches in body | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Stiff neck | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Stiff shoulders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Sore throat | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Difficulty breathing | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Smoke cigarettes (amount_______) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Sadness | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Melancholy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ ***Total Boxes Checked:*** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** |
| Date:____________ | **Date:______** | **Date:______** | **Date:______** | **Date:______** | **Date:______** | **Date:______** |

# NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

## 9. *Spleen, Stomach, Small/Large Intestine Function*

☐ Loose stools
☐ Constipation
☐ Incomplete stools
☐ Diarrhea
☐ Blood in stools
☐ Mucous in stools
☐ Undigested food in the stools

☐ ***Total Boxes Checked:***
Date:____________

**FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, check the box if a symptom is 90% improved or better. Put a circle in the box for any new symptoms.**

| Re-Exam 1 | Re-Exam 2 | Re-Exam 3 | Re-Exam 4 | Re-Exam 5 | Re-Exam 6 |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** |
| **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ |

## 10. *Stomach Function:*

☐ Burning sensation after eating
☐ Large appetite
☐ Bad breath
☐ Canker sores (mouth)
☐ Bleeding, swollen or painful gums
☐ Heartburn
☐ Acid regurgitation
☐ Ulcer (diagnosed?)
☐ Belching
☐ Hiccoughs
☐ Stomach pain
☐ Vomiting

☐ ***Total Boxes Checked:***
Date:____________

**FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, check the box if a symptom is 90% improved or better. Put a circle in the box for any new symptoms.**

| Re-Exam 1 | Re-Exam 2 | Re-Exam 3 | Re-Exam 4 | Re-Exam 5 | Re-Exam 6 |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** |
| **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ |



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# NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

## *11. Dampness trapped in the Body:*

- ☐ Bodily sensation of heaviness
- ☐ Mental heaviness
- ☐ Mental sluggishness
- ☐ Mental fogginess
- ☐ Swollen hands
- ☐ Swollen feet
- ☐ Swollen joints
- ☐ Chest congestion
- ☐ Nausea
- ☐ Snoring

☐ ***Total Boxes Checked:***

Date:____________

**FOR LONG TERM-CARE PATIENTS ONLY:** On the day of your re-exam, check the box if a symptom is 90% improved or better. Put a circle in the box for any new symptoms.

| Re-Exam 1 | Re-Exam 2 | Re-Exam 3 | Re-Exam 4 | Re-Exam 5 | Re-Exam 6 |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** |
| **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ |

## *12. Liver Function (eyes):*

- ☐ Itchy
- ☐ Bloodshot
- ☐ Hot
- ☐ Dry
- ☐ Watery
- ☐ Gritty
- ☐ Blurry vision
- ☐ Decreased night vision
- ☐ Near-sighted
- ☐ Far-sighted

☐ ***Total Boxes Checked:***

Date:____________

**FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, check the box if a symptom is 90% improved or better. Put a circle in the box for any new symptoms.**

| Re-Exam 1 | Re-Exam 2 | Re-Exam 3 | Re-Exam 4 | Re-Exam 5 | Re-Exam 6 |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** |
| **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ | **Date:**______ |

# NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

## *13. Liver, Gall Bladder Function:*

**FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, check the box if a symptom is 90% improved or better. Put a circle in the box for any new symptoms.**

| Symptom | Re-Exam 1 | Re-Exam 2 | Re-Exam 3 | Re-Exam 4 | Re-Exam 5 | Re-Exam 6 |
|---|---|---|---|---|---|---|
| ☐ Alternating diarrhea & constipation | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Chest pain | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Tight sensation in the chest | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Bitter taste in the mouth | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Anger easily | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Depression | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Frustration | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Irritability | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Skin rashes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Headache at the top of the head | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Tingling sensation | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Numbness | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Muscle twitching | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Muscle cramping | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Muscle spasms | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Seizures | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Convulsions | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Lump in the throat | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Neck tension | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Shoulder tension | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Limited range-of-motion (neck) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Limited range-of-motion (shoulder) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ How much alcohol / day?_________ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Recreational drugs (which?_________) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ High-pitched ringing in ears | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Gall stones (history or current) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ STD's (which?_________________) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Unable to adapt to stress | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ ***Total Boxes Checked:*** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** |
| Date:____________ | **Date:______** | **Date:______** | **Date:______** | **Date:______** | **Date:______** | **Date:______** |



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### 14. Kidney, Urinary Bladder Function:

| Symptom | Re-Exam 1 | Re-Exam 2 | Re-Exam 3 | Re-Exam 4 | Re-Exam 5 | Re-Exam 6 |
|---|---|---|---|---|---|---|
| ☐ Frequent cavities, teeth problems | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Easily broken bones | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Sore knees | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Weak knees | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Cold sensation in the knees | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Low back pain | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Memory problems | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Excessive hair loss | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Low-pitched ringing in the ears | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Kidney stones | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Bladder infections | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Lack of bladder control | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Wake during the night 2 (or more ) times to urinate? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Fear | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Easily startled | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ ***Total Boxes Checked:*** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** |
| Date:____________ | **Date:______** | **Date:______** | **Date:______** | **Date:______** | **Date:______** | **Date:______** |

**FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, check the box if a symptom is 90% improved or better. Put a circle in the box for any new symptoms.**

### 15. Libido:

| Symptom | Re-Exam 1 | Re-Exam 2 | Re-Exam 3 | Re-Exam 4 | Re-Exam 5 | Re-Exam 6 |
|---|---|---|---|---|---|---|
| ☐ Normal | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ High | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Low | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ ***Total Boxes Checked:*** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** |
| Date:____________ | **Date:______** | **Date:______** | **Date:______** | **Date:______** | **Date:______** | **Date:______** |

**FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, check the box if a symptom is 90% improved or better. Put a circle in the box for any new symptoms.**



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## *16. Urination (Bladder Function):*

**FFOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, check the box if a symptom is 90% improved or better. Put a circle in the box for any new symptoms.**

| Symptom | Re-Exam 1 | Re-Exam 2 | Re-Exam 3 | Re-Exam 4 | Re-Exam 5 | Re-Exam 6 |
|---|---|---|---|---|---|---|
| Color (please check): | | | | | | |
| ☐ Pale____; Dk Yellow____; Clear____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Reddish | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Cloudy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Scanty | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Profuse | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Strong odor | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Burning | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Painful | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Discharge | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Difficult | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Urgent | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Frequent | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ ***Total Boxes Checked:*** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** |
| Date:____________ | **Date:______** | **Date:______** | **Date:______** | **Date:______** | **Date:______** | **Date:______** |

## WOMEN ONLY

- ☐ Yes ☐ No Do you have a regular menstrual cycle?
- ☐ Yes ☐ No Are you pregnant?
- ☐ Yes ☐ No Do you have bleeding beetween periods?
- ☐ Yes ☐ No Do you have a vaginal discharge?

- _______ Age of first menstruation
- _______ Average number of days in flow
- _______ Average number of days in entire cycle
- _______ Number of children
- _______ Number of pregnancies
- _______ Age of menopause (if applicable)

| **Please fill in the menstrual chart:** | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
|---|---|---|---|---|---|---|---|
| **Color (choose one):** normal, pale, bright red, brown rust, dark purple, other | ________ | ________ | ________ | ________ | ________ | ________ | ________ |
| **Amount of flow (choose one):** normal, heavy, light | ________ | ________ | ________ | ________ | ________ | ________ | ________ |
| **Pain/Cramps (choose one):** dull, sharp, other | ________ | ________ | ________ | ________ | ________ | ________ | ________ |
| **Vomiting (check if yes):** | ________ | ________ | ________ | ________ | ________ | ________ | ________ |
| **Nausea (check if yes):** | ________ | ________ | ________ | ________ | ________ | ________ | ________ |



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# NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

**Women Only:**

**FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, check the box if a symptom is 90% improved or better. Put a circle in the box for any new symptoms.**

| | Re-Exam 1 | Re-Exam 2 | Re-Exam 3 | Re-Exam 4 | Re-Exam 5 | Re-Exam 6 |
|---|---|---|---|---|---|---|
| ☐ Nausea | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Vomiting | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Food cravings | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Water retention | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Breast swelling | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Breast tenderness | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Headaches | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Migraines | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Dull pain (where?__________) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Sharp pain (where?___________) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Depression | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Irritability | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Anxiety | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Other (explain_____________) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ ***Total Boxes Checked:*** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** |
| Date:_____________ | **Date:______** | **Date:______** | **Date:______** | **Date:______** | **Date:______** | **Date:______** |

**Men Only:**

**FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, check the box if a symptom is 90% improved or better. Put a circle in the box for any new symptoms.**

| | Re-Exam 1 | Re-Exam 2 | Re-Exam 3 | Re-Exam 4 | Re-Exam 5 | Re-Exam 6 |
|---|---|---|---|---|---|---|
| ☐ Swollen testes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Testicular pain | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Impotence | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Premature ejaculation | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Feeling of coldness or Numbnesss in external genitalia | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ Other? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ ***Total Boxes Checked:*** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** | ☐ **Total** |
| Date:_____________ | **Date:______** | **Date:______** | **Date:______** | **Date:______** | **Date:______** | **Date:______** |

# 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 1-8 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 **Calenda**r year schedule? ___________

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

**3.** Is the naturopathic doctor or acupuncturist I want to see ***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 provider 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______**

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

**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.** 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.

Revised 4/2014

**Nature Cures Clinic, LLC**
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**Portland, OR 97205**
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