Summit
HOLISTIC MEDICINE

Our Journey To Good Health Begins With A Single Step

Dear Future Patient,

Welcome to Summit Holistic Medicine. We look forward to meeting with you at your first office visit.

Enclosed you will find new patient paperwork. Please take some time before your visit with us to fill it out to the best of your ability and be sure to return the paperwork to Summit Holistic Medicine prior to your first appointment. We will use the intake form as a guide throughout your first office visit.

In addition, please bring a copy of any recent lab work you have in your possession. We will send out a medical records release request to your other practitioners for any other information we need after your appointment. We would also like you to bring any supplements or prescription medications that you are currently taking or have taken within the past 6 months.

It is important to note that we have a "no scents" policy at the office. Some of our patients suffer from chemical sensitivities. Perfumes, strongly scented lotions, cigarette smoke or hair products may set off their symptoms should their visit follow yours.

Please be aware all office visit, lab and supplement fees are due at the time of service and/or pick up. If you have health insurance that covers Naturopathic Specialist services we are happy to provide you with a reimbursement form for your visit. To verify coverage please call your insurance company and confirm benefits prior to your first appointment. We have included an Insurance Benefits Checklist for you to use while speaking to your insurance company in order to make sure you gather all pertinent information about your coverage. Some plans require prior authorization through a referral. For those plans that require referrals, we must receive your referral prior to your first office visit in order for reimbursement to be processed. Also included in this packet, is a Patient Financial Responsibility Waiver that needs to be completed. As the form states, you will be responsible for any service or lab fees that insurance does not cover. **These forms need to be completed and returned to us by fax, mail or email prior to your appointment.**

Should you need to cancel this appointment or any future appointments, please be aware of our **48-hour notice cancellation policy.** We request you call the office at least 48 hours prior to your scheduled appointment time if you are unable to make your appointment. As you can imagine, "no shows" or last minute cancellations can be very burdensome to our practice. If you know you cannot make an upcoming appointment, the office encourages you to call as soon as possible so that we may use your appointment slot for another patient who may be waiting to get in to see us. All patients who do not show up for a scheduled appointment or do not cancel outside of this 48 hour window will be charged the scheduled visit fee.

Please feel free to reach us at the office if you have any questions prior to your visit. We look forward to working with you on your path to greater health!

The Practitioners and Staff at Summit Holistic Medicine

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Today's Date: _____

CONFIDENTIAL PATIENT INFORMATION

Patient's Name: _____ Birth Date: ____-____-____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Social Security #: _____

Mother's Name: _____ Birth Date: ____-____-____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

E-mail Address: _____

Social Security #: _____ Driver's License #: _____

Occupation: _____ Employer: _____

Number of hours worked per week: _____

Father's Name: _____ Birth Date: ____-____-____ Age: _____

❑ **Address same as Mother's Address and Contact Information**

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

E-mail Address: _____

Social Security #: _____ Driver's License #: _____

Occupation: _____ Employer: _____

Number of hours worked per week: _____

Name & Number of Emergency Contact: _____ Relationship: _____

Were you referred by another physician: ❑ Yes ❑ No

Referring Physician's Name: _____ Phone: _____

Address, City, State, Zip: _____

Do you have Insurance: ❑ Yes ❑ No

Insurance Company: _____ Phone: _____

Name of Insured: _____ Relationship to the Insured: _____

Insured Date of Birth: _____ Policy #: _____ Group #: _____

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Today's Date: _____

Patient's Name: _____ Date of Birth:_____

FINANCIAL POLICY

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. I hereby authorize the undersigned physician to furnish medical information to my insurance carriers concerning this illness or accident. I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Clinic Policy requires payment at time of services.

_____ _____ _____

Parent or Guardian's Signature **Please Print Name** **Date**

CONSENT TO TREAT

I voluntarily consent to outpatient care at Summit Holistic Medicine, encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), body work, acupuncture, administration of supplements and medications prescribed by the practitioner.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including their designees as is necessary in the medical staff's judgment.
I understand that not ALL of the treatment suggestions provided are accepted by the United States FDA and therefore should not be taken as such.

I understand that this consent form will be valid and remain in effect as long as I receive medical care at Summit Holistic Medicine.

This form has been explained to me and I fully understand this *Consent To Treatment* and agree to its contents.

Comments:

_____

_____

❑ **Patient is a minor and is _____ years of age**

Name of Father _____

Name of Mother _____

_____ _____ _____

Parent or Legal Guardian's Signature **Please Print Name** **Date**

_____ _____

Relationship **Witness to Signature**

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PEDIATRIC INTAKE FORM

Name: _____ Birth Date: ____-____-____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Grad of School: _____

Mother's Name: _____ **Father's Name:** _____

Parent's are: ☐ Married ☐ Separated ☐ Divorced ☐ Living Together ☐ Other: _____

Referred by another physician: ☐ Yes ☐ No

Referring Physician's Name: _____ Phone: _____

Address, City, State, Zip: _____

Name of Other Physician: _____ Specialty: _____ Phone: _____

List your health concerns in order of importance:	How long has he/she had it?	Seen another doctor for this complaint?
1. _____	_____	☐ Yes ☐ No Date: _____
2. _____	_____	☐ Yes ☐ No Date: _____
3. _____	_____	☐ Yes ☐ No Date: _____
4. _____	_____	☐ Yes ☐ No Date: _____
5. _____	_____	☐ Yes ☐ No Date: _____

Other Complaints:

Ear Infections? ☐ Currently ☐ Never ☐ Past, **how many total?** _____
Colds? ☐ Currently ☐ Never ☐ Past, **how many total?** _____
Strep Throat? ☐ Currently ☐ Never ☐ Past, **how many total?** _____
Hearing Deficit? ☐ Currently ☐ Never ☐ Past, **how many total?** _____
Vision Deficit? ☐ Currently ☐ Never ☐ Past, **how many total?** _____

Any speech impediments: ☐ Currently ☐ Never ☐ Past

Learning impediments: ☐ Currently ☐ Never ☐ Past

Typical Day's Diet:

Breakfast: _____
Snack: _____
Lunch: _____
Snack: _____
Supper: _____
Snack: _____

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Developmental Milestones

Gross Motor Skills; is the child able to:

Hold head up momentarily	❑ **Yes**	❑ No	If yes, at what age?_____
Control head movement	❑ **Yes**	❑ No	If yes, at what age?_____
Sit unsupported	❑ **Yes**	❑ No	If yes, at what age?_____
Roll from a face down to face up position	❑ **Yes**	❑ No	If yes, at what age?_____
Crawl, cuise	❑ **Yes**	❑ No	If yes, at what age?_____
Walk with assistance	❑ **Yes**	❑ No	If yes, at what age?_____
Walk unassisted	❑ **Yes**	❑ No	If yes, at what age?_____
Runs	❑ **Yes**	❑ No	If yes, at what age?_____
Climbs stairs	❑ **Yes**	❑ No	If yes, at what age?_____

Social Skills; does the child:

Smiles	❑ **Yes**	❑ No	If yes, at what age?_____
Reaches for familiar objects	❑ **Yes**	❑ No	If yes, at what age?_____
Plays with hands	❑ **Yes**	❑ No	If yes, at what age?_____
Plays with feet	❑ **Yes**	❑ No	If yes, at what age?_____
Clearly shows joy and pleasure	❑ **Yes**	❑ No	If yes, at what age?_____
Feeds self with fingers	❑ **Yes**	❑ No	If yes, at what age?_____
Plays peek a boo	❑ **Yes**	❑ No	If yes, at what age?_____
Understands yes and no	❑ **Yes**	❑ No	If yes, at what age?_____

Fine Motor Skills; does the child:

Have a grasp reflex	❑ **Yes**	❑ No	If yes, at what age?_____
Hold rattle in hand	❑ **Yes**	❑ No	If yes, at what age?_____
Grasp object independently	❑ **Yes**	❑ No	If yes, at what age?_____
Moves object from on hand to other	❑ **Yes**	❑ No	If yes, at what age?_____
Self feed	❑ **Yes**	❑ No	If yes, at what age?_____
Turns 2-3 book pages	❑ **Yes**	❑ No	If yes, at what age?_____
Turns page one at a time	❑ **Yes**	❑ No	If yes, at what age?_____
Builds tower of 5 blocks	❑ **Yes**	❑ No	If yes, at what age?_____
Builds tower of 10 blocks	❑ **Yes**	❑ No	If yes, at what age?_____

Communication Skills; does the child:

Make cooing sounds	❑ **Yes**	❑ No	If yes, at what age?_____
Laugh	❑ **Yes**	❑ No	If yes, at what age?_____
Uses 1 syllable words	❑ **Yes**	❑ No	If yes, at what age?_____
Uses 2-3 words	❑ **Yes**	❑ No	If yes, at what age?_____
Uses 2-3 word phrases	❑ **Yes**	❑ No	If yes, at what age?_____

Adaptive Skills; does the child:

Feeds from cup unassisted	❑ **Yes**	❑ No	If yes, at what age?_____
Holds own bottle	❑ **Yes**	❑ No	If yes, at what age?_____
Feeds self with utensils	❑ **Yes**	❑ No	If yes, at what age?_____
Identify and match some colors	❑ **Yes**	❑ No	If yes, at what age?_____
Copies a circle	❑ **Yes**	❑ No	If yes, at what age?_____

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PAST HISTORY

Pregnancy:

Mother's age at conception: _____ Did she have other children already? ❑ Yes ❑ No

Duration of Pregnancy: (weeks) _____ Length of Labor: _____ hours

Mother's Health During Pregnancy

Smoking: ❑ Yes ❑ No ❑ Some

Diabetes: ❑ No ❑ Gestational ❑ Type I ❑ Type II ❑ Type III

Coffee: ❑ Yes ❑ No ❑ Some

Nausea : ❑ Yes ❑ No ❑ Some

Vomiting: ❑ Yes ❑ No ❑ Some

Preeclampsia: ❑ Yes ❑ No

Birth:

Was the birth: ❑ Vaginal ❑ Cesarean Section ❑ Forceps ❑ Suction

Length of Labor: _____ hours

Traumatic birth: ❑ Yes ❑ No

Complications during your birth: ❑ Yes ❑ No If "yes" please explain:_____

_____

_____

APGAR Score: 1 minute _____ 5 minute _____

Infancy:

Was the baby breastfed? ❑ Yes ❑ No For how long: _____

Was the baby put on formula: ❑ Yes ❑ No What formula was used: _____

When was child put on solid food: _____

Vaccination:

(Yes, has had; No, has not; Some, did not finish all shots)

MMR:	❑ Yes	❑ No	❑ Some	DPT:	❑ Yes	❑ No	❑ Some
Hep B:	❑ Yes	❑ No	❑ Some	Hib:	❑ Yes	❑ No	❑ Some
Chickenpox:	❑ Yes	❑ No	❑ Some	Polio:	❑ Yes	❑ No	❑ Some

Any reactions to vaccinations? ❑ Yes ❑ No ❑ Unknown

Please explain: _____

_____

_____

Childhood:

What was your health like as a child? _____

_____

Did you receive the normal series of childhood vaccinations? ❑ Yes ❑ No

Did you have any vaccination reactions or other notes on vaccination history: _____

_____

_____

Adolescence:

What was your health like as a teen/adolescent? _____

_____

Estimated number of rounds of antibiotics:

As a Child: _____

As an Adult: _____

In the Last Year: _____

Have you ever taken probiotics? (L. acidophilus, B. bifidum)

❑ Yes ❑ No

If "Yes", please list: _____

_____

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KNOWN STRESSORS

(Any particular household stressors child has witnessed or gone through)

1. _____ Last Date Occurred: _____ Severity: _____
2. _____ Last Date Occurred: _____ Severity: _____
3. _____ Last Date Occurred: _____ Severity: _____
4. _____ Last Date Occurred: _____ Severity: _____

PREVIOUS SURGERIES AND HOSPITALIZATIONS

1. _____ Date Occurred: _____ Outcome: _____
2. _____ Date Occurred: _____ Outcome: _____
3. _____ Date Occurred: _____ Outcome: _____
4. _____ Date Occurred: _____ Outcome: _____

KNOWN ALLERGIES

(medications, environment, foods)

1. _____ Last Date Occurred: _____ Severity: _____
2. _____ Last Date Occurred: _____ Severity: _____
3. _____ Last Date Occurred: _____ Severity: _____
4. _____ Last Date Occurred: _____ Severity: _____

LAB TESTS AND IMAGING

Most Recent Procedures:

Bloodwork Assessment:	❑ Never	_____, 20____	Results: _____
Physical Exam:	❑ Never	_____, 20____	Results: _____
X-Rays/MRI/CT	❑ Never	_____, 20____	Results: _____
Ultrasound	❑ Never	_____, 20____	Results: _____
HIV Test	❑ Never	_____, 20____	Results: _____
Dental Visit	❑ Never	_____, 20____	Results: _____
Eye Exam	❑ Never	_____, 20____	Results: _____

MEDICATIONS

Antacids ❑ Yes ❑ No ❑ Previously

Steroids ❑ Yes ❑ No ❑ Previously

Over-the-Counter Pain Meds. ❑ Yes ❑ No ❑ Previously

Current prescription or over the counter medications (please attach additional paper if needed)

Medication and Dose	Reason Prescribed	Prescriber	Length of Time Taking This Medication	Side Effects Experienced
1.				
2.				
3.				
4.				

Current supplements with brands and dosages

Supplement and Brand	Dose	Reason Prescribed	Prescriber	Length of Time Taking This Supplement	Side Effects Experienced
1.					
2.					
3.					
4.					

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FAMILY HISTORY

	Father	Mother	Siblings	Paternal Grandparents	Maternal Grandparents	Children
Age if living	_____	_____	_____	_____	_____	_____
Age when died	_____	_____	_____	_____	_____	_____
Reason for death	_____	_____	_____	_____	_____	_____
High Blood Pressure	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack / Stroke	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease	Y N	Y N	Y N	Y N	Y N	Y N
Asthma / Allergies	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness	Y N	Y N	Y N	Y N	Y N	Y N
TB	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis	Y N	Y N	Y N	Y N	Y N	Y N

EXERCISE

How often do he/she exercise: _____
What types of exercise? _____
For how long? _____
Hobbies: _____

Present Weight: _____
Maximum Weight and When: _____

SLEEP

How long per night? _____

If the child wakes up frequently, for what reason?
_____
_____

Sleep Walk	❑ Yes	❑ No	❑ Previously
Grind Teeth	❑ Yes	❑ No	❑ Previously
Nightmares	❑ Yes	❑ No	❑ Previously
Wake Refreshed	❑ Yes	❑ No	❑ Previously
Must Nap	❑ Yes	❑ No	❑ Previously

DIET

What special diet does the child follow, if any?
❑ Vegetarian ❑ Vegan ❑ Food Allergy ❑ Atkins
❑ Other: _____

What does the child drink during the day, how much?
❑ Coffee _____ ❑ Soda _____ ❑ Juice _____
❑ Tea _____ ❑ Water _____ ❑ Other _____

Eating Habits (check any that apply):
❑ Skip Breakfast ❑ Crave sweet
❑ 3 meals per day ❑ Crave salt
❑ 2 meals per day
❑ Graze (small, frequent meals)
❑ Eat constantly whether hungry or not
❑ Generally eat on the run

TOXIN EXPOSURE

Has the child ever lived near any refinery, polluted area? ❑ Yes ❑ No

Has the child ever lived in a home with lead paint? ❑ Yes ❑ No

Has the child ever lived in a home that had new carpeting, paint, new cabinets or did other refurbishing? ❑ Yes ❑ No
_____

Does the child seem particularly sensitive to perfumes, gasoline or other vapors? ❑ Yes ❑ No _____

Do you use pesticides, herbicides or other chemicals around your home? ❑ Yes ❑ No _____

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Regarding the next section, **please circle Yes (Y), No (N) or Past (P)** regarding the following:

EYES

Dry/Watery	Y	N	P
Double Vision	Y	N	P
Glaucoma	Y	N	P
Dark Under Eyelids	Y	N	P
Cataracts	Y	N	P
Styes	Y	N	P

HEAD

Headache	Y	N	P
Migraine	Y	N	P
Past Head Injury	Y	N	P
Hair Loss	Y	N	P
Dandruff	Y	N	P
Oil/Dry Hair	Y	N	P

NOSE

Frequent Colds	Y	N	P
Chronic Congestion	Y	N	P
Polyps	Y	N	P
Nosebleeds	Y	N	P
Post Nasal Drip	Y	N	P
Seasonal Allergies	Y	N	P

SKIN

Rash	Y	N	P
Hives	Y	N	P
Psoriasis/eczema	Y	N	P
Dry	Y	N	P
Skin Cancer	Y	N	P
Abnormal Perspiration	Y	N	P
Itchy	Y	N	P
Warts/Moles	Y	N	P

MOUTH/ THROAT

Canker Sores	Y	N	P
Sore Throat	Y	N	P
Dentures	Y	N	P
Odd Taste	Y	N	P
Chronic Dry Mouth	Y	N	P
Cold Sores	Y	N	P
Gum Disease	Y	N	P
Cavities	Y	N	P
Hoarseness	Y	N	P
Swollen Glands	Y	N	P

RESPIRATORY

Cough	Y	N	P
Wheezing	Y	N	P
TB	Y	N	P
Bronchitis	Y	N	P
Pneumonia	Y	N	P
Asthma	Y	N	P
Shortness of Breath:			
with exertion	Y	N	P
at rest	Y	N	P

URINARY TRACT

Incontinence	Y	N	P
Frequent Infections	Y	N	P
Urgency	Y	N	P
Discharge / Blood	Y	N	P
Kidney Stones	Y	N	P

Do you get up to urinate at night? 1x 2x 3x more

GASTROINESTINAL

Heartburn	Y	N	P
Indigestion	Y	N	P
Bloating	Y	N	P
Nausea	Y	N	P
Vomiting	Y	N	P
Recent BM Change	Y	N	P
Diarrhea / Constipation	Y	N	P
Hemorrhoids	Y	N	P
Gall Bladder Disease	Y	N	P

CARDIOVASCULAR

High Blood Pressure	Y	N	P
Low Blood Pressure	Y	N	P
Arrhythmias	Y	N	P
Edema (swelling)	Y	N	P
High Cholesterol	Y	N	P
Murmurs	Y	N	P
Palpitations	Y	N	P
Chest Pain	Y	N	P

MUSCULOSKELETAL

Weakness	Y	N	P
Stiffness	Y	N	P
Tremors	Y	N	P
Arthritis	Y	N	P
Leg Cramps	Y	N	P
Pain	Y	N	P

NERVOUS SYSTEM

Paralysis	Y	N	P
Tingling/Numbness	Y	N	P
Seizures	Y	N	P
Sciatica	Y	N	P
Carpal Tunnel Syndrome	Y	N	P
Fainting	Y	N	P

EMOTIONAL HEALTH

Depression	Y	N	P
Suicidal	Y	N	P
Anxiety	Y	N	P
Eating Disorder	Y	N	P
Anger/Irritability	Y	N	P
High-Strung/Tense	Y	N	P
Fear/Panic	Y	N	P
Psychiatric Hospitalization	Y	N	P

MALE GENETALIA

Testicular Pain/Swelling	Y	N	P
Discharge	Y	N	P
Impotency	Y	N	P
Healthy Libido	Y	N	P
Sexually Active	Y	N	P
Prostate Disease	Y	N	P

FEMALE GENETALIA

Age Periods Began	_____		
How long Period Lasts	_____		
Menstrual Cramping	Y	N	P
PMS	Y	N	P
How Often Period Occurs	_____		
Heavy Menstrual Bleeding	Y	N	P
Menopausal?	Y	N	P
At what age?	_____		
Last Pap Smear	Y	N	P
Any Abnormal Paps	Y	N	P
Times Pregnant	_____		
How many births	_____		
Miscarriages	Y	N	P
Food Cravings	_____		
	_____		
Sexually Active	Y	N	P
Vaginal Dryness	Y	N	P
Vaginal Itching/Irritation	Y	N	P
STD	Y	N	P
Vaginitis	Y	N	P
	Y	N	P
Mammography			
Bone Density Test	Y	N	P
	Y	N	P

Current Method of Birth Control: _____

Hormonal Birth Control Used in the Past and How Old You Were: _____

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PATIENT FINANCIAL RESPONSIBILITY WAIVER

This form needs to be returned to your office via email, fax or USPS prior to you first visit.
Fax: 603-294-1130 Email: Info@SummitHolisticMedicine.com

Today's Date: _____

Patient's Name: _____ Date of Birth:_____

We are pleased to assist with your insurance. As advocates for our patients, we will make every effort to access the maximum benefits allowed under your third party payer contract ("insurance"). As a patient of **Summit Holistic Medicine, LLC** you will receive treatment that is specific to the problems that are noted during your initial visit. We will assist you in obtaining reimbursement from your third party benefits payer ("insurance" and/or other entities involved in your financial health services) for part of this responsibility. If you do not have third party coverage we will gladly discuss other available options.

1. FINANCIAL RESPONSIBILITY: I understand that I am personally responsible for any medical fees I incur at **Summit Holistic Medicine, LLC**. I also understand that I will be responsible for any charges incurred by not providing the most current, correct insurance information to **Summit Holistic Medicine, LLC.**
2. I understand that **Summit Holistic Medicine, LLC** has a 48-hour cancellation policy. If I do not cancel my appointment within 48 hours of the scheduled time, I understand that I will be responsible for the full scheduled visit fee. **Summit Holistic Medicine, LLC** cannot provide a reimbursement form for unattended appointments.

I understand that my insurance benefits may have an "allowed amount" for each visit, which is determined by the benefit contract I have with my insurance company and does NOT always equal the doctor's fee. While I am responsible for the fees associated with my medical care at Summit Holistic Medicine, I understand that my insurance may pay a percentage of the "allowable," and may not cover the entire fee accrued at each office visit. All fees are due at the time of service. Insurance reimbursement forms will be provided at the conclusion of each visit with Summit Holistic Medicine.

I understand I am financially responsible for services received from Summit Holistic Medicine, LLC.

_____	_____	_____
Patient or Legal Guardian's Signature	**Please Print Name**	**Date**
_____	_____	
Relationship	**Witness to Signature**	

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NOTICE OF PRIVACY PRACTICE

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following information:

Use and disclosure of your health information in certain special circumstances:

The following circumstances may require us to disclose your health information:
1. To public health authorities and health oversight agencies that are authorized by law to collect information
2. Lawsuits and similar proceedings in response to a court administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent this threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information
1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may as that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Summit Holistic Medicine, 1 Hampton Road Suite 301, Exeter, NH 03833.

Note: We must respond to this request within 30 days.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Summit Holistic Medicine, 1 Hampton Road Suite 301, Exeter, NH 03833. You must provide us with a reason that supports your request for amendment.

Note: We must respond within 60 days. The Privacy Officer or the patient's doctor will usually do this. If the doctor believes the information is complete and accurate, the doctor can refuse to make any changes.

5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the front desk receptionist/office manager.

6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our medical director, Dr. Hilary Trojano, at Summit Holistic Medicine. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

Shared information within Summit Holistic Medicine.

In order to provide you with the best quality health care we do at times consult with our colleagues. Information regarding your medical history or current treatment plan may be shared with the other doctors at Summit Holistic Medicine.

If you have any questions regarding this notice or our health information privacy policies, please contact our medical director, Dr. Hilary Trojano, at Summit Holistic Medicine.

Summit
HOLISTIC MEDICINE

Our Journey To Good Health Begins With A Single Step

PRIVACY PRACTICES ACKKNOWLEDGEMENT

I have received a Notice of Privacy Practices and I have been provided an opportunity to view it.

Patient or Legal Guardian's Signature	**Please Print Name**	**Date**
Relationship	**Witness to Signature**	

Summit
HOLISTIC MEDICINE

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INSURANCE BENEFITS CHECKLIST

This form needs to be returned to our office via email, fax or USPS prior to your first visit.
Fax: 603.294.1130, Email: info@SummitHolisticMedicine.com

Patient Name: _____
Insurance Company: _____
Insurance ID# _____

Our office will happily provide you with a reimbursement form to submit to your insurance carrier. It is the patient's responsibility to be aware of his/her coverage as well as any deductible and maximums. Please follow steps 1-5 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:

1. When did my coverage begin and when is it valid through?
   Beginning date of coverage:_____ Ending date of coverage:_____

2. Do I need a referral from my primary care physician (PCP) for naturopathic services?
   (Naturopathic services may be included within or listed as "alternative services")
   ___Yes ___No

3. What are my benefits for **naturopathic services**?
   Covered %: _____ CoPay: $_____ or CoInsurance %:_____ Year Max:_____

   What are my benefits for **acupuncture services**? (if applicable)
   Covered %: _____ CoPay: $_____ or CoInsurance %:_____ Year Max_____

   What are my benefits for **therapy services**? (if applicable)
   Covered %: _____ CoPay: $_____ or CoInsurance %:_____ Year Max:_____

   *** Note: Please make sure to ask "Are there any exclusions under my plan and if so, what are these exclusions?" ***

4. What is my deductible for the year and has any or all of it been met?
   Deductible $ _____ Deductible met so far $ _____ Date:_____

5. What was the name of the representative I spoke with: _____ Date: _____

I _____ filled out the above with the help of an insurance professional and the information is accurate the best of my ability:

_____	_____	_____
Patient or Legal Guardian's Signature	**Please Print Name**	**Date**

*Please send in this COMPLETED form prior to your first appointment.
If you have trouble getting this information please contact us at Summit Holistic Medicine, (603) 499-4598