



## 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

Name: \_\_\_\_\_ Birth Date: \_\_\_\_-\_\_\_\_-\_\_\_\_ Age: \_\_\_\_\_  Male  Female

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: \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced  With Partner  Widow(er)

Spouse's Name \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Number of children and Ages: \_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Were you referred by another physician:  Yes  No

Referring Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address, City, State, Zip: \_\_\_\_\_

Name of Current Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Other Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Other Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have Insurance:  Yes  No

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to the Insured: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

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.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Parent or Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Please Print Name



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Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Person Authorized to consent for Patient

\_\_\_\_\_  
Date

-----  
If the patient is a minor or is unable to consent, please complete the following:

Patient is a minor and is \_\_\_\_\_ years of age

Name of Father \_\_\_\_\_

Name of Mother \_\_\_\_\_

Patient is unable to consent because: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Parent or Legal Guardian's Signature

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Witness to Signature



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PATIENT INTAKE FORM

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

- List your health concerns in order of importance: How long have you had it? Is it the result of an accident/injury? 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_

Health Concern #1
Is this the first time you have had this problem?
What makes the problem feel better?
What makes the problem feel worse?
Is the problem:
Previous Treatment: by Doctor: Outcome:

Health Concern #2
Is this the first time you have had this problem?
What makes the problem feel better?
What makes the problem feel worse?
Is the problem:
Previous Treatment: by Doctor: Outcome:

Health Concern #3
Is this the first time you have had this problem?
What makes the problem feel better?
What makes the problem feel worse?
Is the problem:
Previous Treatment: by Doctor: Outcome:

Health Concern #4
Is this the first time you have had this problem?
What makes the problem feel better?
What makes the problem feel worse?
Is the problem:
Previous Treatment: by Doctor: Outcome:

Health Concern #5
Is this the first time you have had this problem?
What makes the problem feel better?
What makes the problem feel worse?
Is the problem:
Previous Treatment: by Doctor: Outcome:



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PAST HISTORY

Infancy: Was your birth: [ ] Vaginal [ ] Cesarean Section [ ] Forceps [ ] Suction
Complications during your birth: [ ] Yes [ ] No If "yes" please explain:
Were you breastfed as a baby? [ ] Yes [ ] No

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:

PREVIOUS SURGERIES AND HOSPITALIZATIONS

- 1. Date Occurred: Outcome:
2. Date Occurred: Outcome:
3. Date Occurred: Outcome:
4. Date Occurred: Outcome:
5. 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:
5. Last Date Occurred: Severity:

LAB TESTS AND IMAGING

Most Recent Procedures:
Bloodwork Assessment: [ ] Never, 20 Results:
Physical Exam: [ ] Never, 20 Results:
X-Rays: [ ] Never, 20 Results:
MRI/CT [ ] Never, 20 Results:
Ultrasound [ ] Never, 20 Results:
HIV Test [ ] Never, 20 Results:
Dental Visit [ ] Never, 20 Results:
Eye Exam [ ] Never, 20 Results:



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**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.				
5.				
6.				
7.				

**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.					
5.					
6.					
7.					

**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



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EXERCISE

How often do you exercise:
What types of exercise?
For how long?
Hobbies:
Present Weight:
Weight 1 Year Ago:
Maximum Weight and When:
Ideal Weight:

SLEEP

How long per night?
Sleep Walk
Grind Teeth
Nightmares
Wake Refreshed
Must Nap
If you wake up frequently, for what reason?

DIET

What special diet do you follow, if any?
Vegetarian
Vegan
Food Allergy
Atkins
Other:
What do you drink during the day, how much?
Coffee
Soda
Juice
Tea
Water
Other
How often do you eat at restaurants?

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

ALCOHOL

Do you drink alcohol?
Yes
No
Previously
How often and how much if "Yes" or "Previously":
Alcohol Use: drinks per day / week / month

TOBACCO

Do you smoke or chew tobacco?
Yes
No
Prev.
Number of Cigarettes
Per Day/Week/Month
Number of Cigars
Per Day/Week/Month
Amount of Chewing Tobacco
Per Day/Week/Month
Age When Started:
Does anyone in your workplace smoke?
Yes
No

TOXIN EXPOSURE

Did you grow up near any refinery, polluted area or in a home with lead paint?
Have you had any job where you were exposed to solvents, heavy metals, fumes or other toxic materials?
Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing?
Are you particularly sensitive to perfumes, gasoline or other vapors?
Do you use pesticides, herbicides or other chemicals around your home?

SOCIAL LIFE

Please rate your energy on a scale of 1-10
If you are troubled by daytime fatigue, at what time do you experience this?
Stress Level (1=best, 10=worst)
What are your major sources of stress?
If you have a partner, what is the quality of your relationship?



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

<b>EYES</b>		<b>HEAD</b>		<b>NOSE</b>	
Dry/Watery	Y N P	Headache	Y N P	Frequent Colds	Y N P
Double Vision	Y N P	Migraine	Y N P	Chronic Congestion	Y N P
Glaucoma	Y N P	Past Head Injury	Y N P	Polyps	Y N P
Dark Under Eyelids	Y N P	Hair Loss	Y N P	Nosebleeds	Y N P
Cataracts	Y N P	Dandruff	Y N P	Post Nasal Drip	Y N P
Styes	Y N P	Oil/Dry Hair	Y N P	Seasonal Allergies	Y N P
<b>SKIN</b>		<b>MOUTH/ THROAT</b>		<b>RESPIRATORY</b>	
Rash	Y N P	Canker Sores	Y N P	Cough	Y N P
Hives	Y N P	Sore Throat	Y N P	Wheezing	Y N P
Psoriasis/eczema	Y N P	Dentures	Y N P	TB	Y N P
Dry	Y N P	Odd Taste	Y N P	Bronchitis	Y N P
Skin Cancer	Y N P	Chronic Dry Mouth	Y N P	Pneumonia	Y N P
Abnormal Perspiration	Y N P	Cold Sores	Y N P	Asthma	Y N P
Itchy	Y N P	Gum Disease	Y N P	Shortness of Breath:	
Warts/Moles	Y N P	Cavities	Y N P	with exertion	Y N P
		Hoarseness	Y N P	at rest	Y N P
		Swollen Glands	Y N P		
<b>URINARY TRACT</b>		<b>GASTROINTESTINAL</b>		<b>CARDIOVASCULAR</b>	
Incontinence	Y N P	Heartburn	Y N P	High Blood Pressure	Y N P
Frequent Infections	Y N P	Indigestion	Y N P	Low Blood Pressure	Y N P
Urgency	Y N P	Bloating	Y N P	Arrhythmias	Y N P
Discharge / Blood	Y N P	Nausea	Y N P	Edema (swelling)	Y N P
Kidney Stones	Y N P	Vomiting	Y N P	High Cholesterol	Y N P
		Recent BM Change	Y N P	Murmurs	Y N P
Do you get up to urinate at night?	1x 2x 3x more	Diarrhea / Constipation	Y N P	Palpitations	Y N P
		Hemorrhoids	Y N P	Chest Pain	Y N P
		Gall Bladder Disease	Y N P		
<b>MUSCULOSKELETAL</b>		<b>NERVOUS SYSTEM</b>		<b>EMOTIONAL HEALTH</b>	
Weakness	Y N P	Paralysis	Y N P	Depression	Y N P
Stiffness	Y N P	Tingling/Numbness	Y N P	Suicidal	Y N P
Tremors	Y N P	Seizures	Y N P	Anxiety	Y N P
Arthritis	Y N P	Sciatica	Y N P	Eating Disorder	Y N P
Leg Cramps	Y N P	Carpal Tunnel Syndrome	Y N P	Anger/Irritability	Y N P
Pain	Y N P	Fainting	Y N P	High-Strung/Tense	Y N P
				Fear/Panic	Y N P
				Psychiatric Hospitalization	Y N P
		<b>MALE GENETALIA</b>			
Testicular Pain/Swelling	Y N P	Impotency	Y N P	Sexually Active	Y N P
Discharge	Y N P	Healthy Libido	Y N P	Prostate Disease	Y N P
		<b>FEMALE GENETALIA</b>			
Age Periods Began	_____	Last Pap Smear	Y N P	Sexually Active	Y N P
How long Period Lasts	_____	Any Abnormal Paps	Y N P	Vaginal Dryness	Y N P
Menstrual Cramping	Y N P	Times Pregnant	_____	Vaginal Itching/Irritation	Y N P
PMS	Y N P	How many births	_____	STD	Y N P
How Often Period Occurs	_____	Miscarriages	Y N P	Vaginitis	Y N P
Heavy Menstrual Bleeding	Y N P				Y N P
Menopausal?	Y N P	Food Cravings	_____	Mammography	
At what age?	_____		_____	Bone Density Test	Y N P
Current Method of Birth Control:	_____		_____		Y N P
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 your 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 ask 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.



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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 or wellness coordinators 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.



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**PRIVACY PRACTICES ACKNOWLEDGEMENT**

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**



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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