



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
Control head movement
Sit unsupported
Roll from a face down to face up position
Crawl, cruise
Walk with assistance
Walk unassisted
Runs
Climbs stairs

Social Skills; does the child:

- Smiles
Reaches for familiar objects
Plays with hands
Plays with feet
Clearly shows joy and pleasure
Feeds self with fingers
Plays peek a boo
Understands yes and no

Fine Motor Skills; does the child:

- Have a grasp reflex
Hold rattle in hand
Grasp object independently
Moves object from one hand to other
Self feed
Turns 2-3 book pages
Turns page one at a time
Builds tower of 5 blocks
Builds tower of 10 blocks

Communication Skills; does the child:

- Make cooing sounds
Laugh
Uses 1 syllable words
Uses 2-3 words
Uses 2-3 word phrases

Adaptive Skills; does the child:

- Feeds from cup unassisted
Holds own bottle
Feeds self with utensils
Identify and match some colors
Copies a circle



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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 **Over-the-Counter Pain Meds.** Yes No Previously
- Steroids** 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: _____ Present Weight: _____
 What types of exercise? _____ Maximum Weight and When: _____
 For how long? _____
 Hobbies: _____

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		HEAD		NOSE	
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
SKIN		MOUTH/ THROAT		RESPIRATORY	
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		
URINARY TRACT		GASTROINTESTINAL		CARDIOVASCULAR	
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		
MUSCULOSKELETAL		NERVOUS SYSTEM		EMOTIONAL HEALTH	
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
		MALE GENETALIA			
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
		FEMALE GENETALIA			
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 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