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.

When returning your new patient paperwork to our office, it is important to include a copy of the front and back of your insurance card file if you plan to use insurance to cover your visit fees.

Please send/bring a copy of any recent lab work you have in your possession. A medical records release request will be sent to your other practitioners for any other information we need after your appointment. Please bring any supplements or prescription medications that you are currently taking. If this is a telehealth appt, it will be important to have the supplements and medications nearby during our web-based appointment.

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.

All co-pays, 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 will bill insurance for your visit. Please be certain to 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 to make sure you gather all pertinent information about your coverage. For plans that require referrals, we must receive your referral prior to your first office visit for our office to bill insurance for you. Harvard Pilgrim requires a referral for all the HMO plans. There is a Patient Financial Responsibility Waiver included in this packet which needs to be completed as well. 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: _____ Sex: _____

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

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

E-mail: _____

Occupation: _____ Employer: _____

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: _____

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, biopuncture, 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. _____	_____	❑ Yes ❑ No Date: _____
2. _____	_____	❑ Yes ❑ No Date: _____
3. _____	_____	❑ Yes ❑ No Date: _____
4. _____	_____	❑ Yes ❑ No Date: _____
5. _____	_____	❑ Yes ❑ No Date: _____

Health Concern #1
Is this the first time you have had this problem? ❑ Yes ❑ No If "No", Date of last occurrence: _____
What makes the problem feel better? _____
What makes the problem feel worse? _____
Is the problem: ❑ Constant ❑ Occasional ❑ Worse in the Morning / Evening
Previous Treatment: _____ by Doctor:_____ Outcome: _____

Health Concern #2
Is this the first time you have had this problem? ❑ Yes ❑ No If "No", Date of last occurrence: _____
What makes the problem feel better? _____
What makes the problem feel worse? _____
Is the problem: ❑ Constant ❑ Occasional ❑ Worse in the Morning / Evening
Previous Treatment: _____ by Doctor:_____ Outcome: _____

Health Concern #3
Is this the first time you have had this problem? ❑ Yes ❑ No If "No", Date of last occurrence: _____
What makes the problem feel better? _____
What makes the problem feel worse? _____
Is the problem: ❑ Constant ❑ Occasional ❑ Worse in the Morning / Evening
Previous Treatment: _____ by Doctor:_____ Outcome: _____

Health Concern #4
Is this the first time you have had this problem? ❑ Yes ❑ No If "No", Date of last occurrence: _____
What makes the problem feel better? _____
What makes the problem feel worse? _____
Is the problem: ❑ Constant ❑ Occasional ❑ Worse in the Morning / Evening
Previous Treatment: _____ by Doctor:_____ Outcome: _____

Health Concern #5
Is this the first time you have had this problem? ❑ Yes ❑ No If "No", Date of last occurrence: _____
What makes the problem feel better? _____
What makes the problem feel worse? _____
Is the problem: ❑ Constant ❑ Occasional ❑ Worse in the Morning / Evening
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 **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.				
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?
_____

If you wake up frequently, for what reason?
_____
_____

Sleep Walk Y N P
Grind Teeth Y N P
Nightmares Y N P
Wake Refreshed Y N P
Must Nap Y N P

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? If so, what sort of pollution were you exposed to? _____

Have you had any job where you were exposed to solvents, heavy metals, fumes or other toxic materials? If yes, please list:
_____

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? ❑ Yes ❑ No _____

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

SOCIAL LIFE

Please rate your energy on a scale of 1-10 (1 = poor, 10 = excellent): 1 2 3 4 5 6 7 8 9 10

If you are troubled by daytime fatigue, at what time do you experience this? _____ AM / PM

Stress Level (1=best, 10=worst): 1 2 3 4 5 6 7 8 9 10

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:

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. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

1. It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any preauthorization requirements of your insurance company.
2. We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
3. If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), for the date of service and then bill you for any amount determined to be your responsibility. This process generally takes 30-60 days from the time the claim is received by the insurance company.
4. Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.
5. If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit that day. If you would like to attempt reimbursement on your own, we will provide you with a statement that you can submit to your insurance company.
6. Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company
7. 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 bill insurance for unattended appointments.

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 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.

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**	

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PATIENT CONSENT FOR APPOINTMENT REMINDS VIA TEXT

Summit Holistic Medicine uses text message reminders for appointments and for alerts to let you know any supplements you may be waiting for are ready for pick up. Text reminders go out the week before and the day before of each appointment from our scheduling system. The Telephone Consumer Protection Act (TCPA) requires medical practices to get each patient's consent to text or call with appointment reminders. This form is asking for that consent and confirming that you understand that all charges from those calls and texts are your responsibility and you accept them. Additionally, if you do NOT want either of these please indicate below so we can note that in your chart and make sure you do not receive these types of reminders. I, _____, (first and last name) would like to receive:

Text appointment reminders ____ (initial) For text: _____ (mobile phone number)

I understand the above and I accept all charges associated with text reminders if selected above.

Signature: _____ Date: _____

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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. PATIENT IS RESPONSIBLE TO ALERTING OFFICE TO ANY CHANGES TO INSURANCE PRIOR TO EACH VISIT, OTHERWISE WE CANNOT BILL INSURANCE CARRIER AND PATIENT WILL BE RESPONSIBLE.

Patient Name: _____ Patient Date of Birth:_____
Insurance Subscriber Name (if not self): _____ Subscriber's Date of Birth: _____
Insurance Company and Plan: _____ ID#: _____
Group #: _____
Referral needed: Yes No
If yes:
Referring provider: _____ Referring Provider's NPI:_____

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.

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