WHOLE HEALTH CONCORD
Individualized Health Care, Naturally!

Dear Future Patient,

Welcome to Whole Health Concord. 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 Whole Health Concord 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 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 are happy to bill insurance for your visit however, 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. For plans that require referrals, we must receive your referral prior to your first office visit in order for our office to bill insurance for you. Also included in this packet, is a Patient Financial Responsibility Waiver which 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 4**8-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 the 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 Whole Health Concord

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CONFIDENTIAL PATIENT INFORMATION

Name:_____ Sex: _____ Date of Birth:_____

Perm. Address:_____City:_____State:_____Zip: _____

Phone Perm:_____Cell Phone:_____Work Phone: _____

Email: _____

Address:_____

Were you referred by another physician: Yes No

Referring Physician's Name:_____Phone: _____

Address, City, State, Zip: _____

Who is your current Physician:_____ Phone: _____

Employer:_____Occupation:_____ Phone: _____

Nearest relative not living with you: _____Relation: _____Phone:_____

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

Name of Spouse (or parent for minor child):_____

Emergency Contact:_____Relationship to you:_____ Phone: _____

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 me. I hereby authorize the undersigned physician to furnish medical information to my insurance carriers concerning this illness or accident. I clearly 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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CONSENT TO TREAT

Today's Date:_____

Patient Name:_____ Date of Birth:_____

I voluntarily consent to outpatient care at Whole Health Concord, 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, and administration of supplements, 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 Whole Health Concord.

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:_____

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_____

_____

_____ _____

Signature of Closest Relative or Legal Guardian Please Print Name

Relationship: _____

Witness to Signature: _____

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PEDIATRIC INTAKE FORM

Name Date of birth Age Sex: M or F

Grade of School:

Address:

City: State: Zip:

Mother's Name:

Father's Name:

Parents are (circle): Married Separated Divorced Living Together Other

Regular Pediatrician name and city located in:

Health Concerns in order of priority:

Has child been seen by any other doctor(s) for this complaint? Yes No Past

Has child had any blood work done? If yes, please list what:

Please list any surgeries or hospitalizations and year occurred:

1.

2.

3.

Please list all medicines (from drugstore or prescription) child is on now:

1.

2.

3.

4.

Please list all supplements child is taking:

1.

2.

3.

4.

Allergy information (mediations, environmental, foods):

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Previous Medical History

Yes indicates the child gets the problem regularly; No indicates the child never had the problem; Past indicates the child had the problem in the past but not recently. Please circle the correct one for your child.

Ear Infections? Yes No Past If has had, how many total? _____

Colds? Yes No Past If has had, how many total? _____

Strep throat? Yes No Past If has had, how many total? _____

Estimated rounds of antibiotics the child has taken:_____

What other medicines has the child taken? And how often?

1.

2.

3.

4.

Hearing Deficit? _____

Vision Deficit: _____

Any speech impediments: Yes No Past

Learning impediments: Yes No Unknown

Vaccination History: 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

Other: _____

Any reactions to vaccinations? If so, please explain: _____

_____

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Pertinent Family History:

Mother's Pregnancy history

Age at conception:_____

Did she have other children already? Yes No

Health During Pregnancy

Smoking:	Yes	No	Diabetes:	Yes	No
Coffee:	Yes		Nausea/Vomiting:	Yes	No
	No		Emotional Stress:	Yes	No
Preeclampsia:	Yes	No	Length of Labor:		
Vaginal birth:	Yes	No	Traumatic birth:	Yes	No

If the birth was difficult, please explain:

Health of baby at birth:

Child breastfed: Yes No For how long:

When put on formula:_____ What formula was used:

When was child put on solid food:

When did child walk: Talk:

When did child develop teeth:

Any particular household stressors child has witnessed or gone through:

1.

2.

3.

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Typical Day's Diet:

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Supper: _____

Snack: _____

Toxin Exposure:

Has the child ever lived near a refinery or other highly polluted area?_____

Has the child ever lived in a house with lead paint?_____

Has the child ever lived in a house that had new paint, cabinets, carpeting installed and did that seem to affect their health at all?_____

Do you spray pesticides or herbicides around the house or use other toxic chemicals?

_____

Does the child seem particularly sensitive to perfumes or other vapors?_____

Known Allergies (medications, environment, foods):

_____

Additional Comments:

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PATIENT FINANCIAL RESPONSIBILITY WAIVER

This form needs to be returned to our office via email, fax or USPS prior to your first visit.
Fax: 603.369.4627, Email: naturalmedicineNH@comcast.net

Patient Name:_____**Date**:_____

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 **Whole Health Concord, 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 will incur at **Whole Health Concord, LLC**. I also understand that I will be responsible for any charges incurred by not providing the most current, correct insurance information to **Whole Health Concord, LLC.**
2. I understand that **Whole Health Concord, 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. **Whole Health Concord, LLC** cannot bill insurance for unattended appointments.

I understand that my insurance benefits may have an "allowable amount" for each visit, that is determined by the benefit contract I have with the insurance company and does NOT always equal the doctor's fee. My insurance may pay a percentage of the "allowable," and I understand that I am responsible for payment of the remaining allowable balance. This payment may include my deductible (if not already satisfied), any co-payments, and any remaining portion of the doctor's bill that is not covered.

I understand I am financially responsible for services received from Whole Health Concord, LLC.

Signature of Patient or Legal Guardian:

_____**Date:**_____

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MEDICAL RECORDS RELEASE

Please note: Records that consist of more than 5 pages should be mailed rather than faxed.

Last name **First name** **MI** **Date of Birth**

I hereby authorize:

( ) Whole Health Concord
91 N. State Street
Concord, NH 03301
P: (603) 369-4626

( )_____
_____
_____
P: _____

To release information to:

( ) _____
_____
_____
P: _____

( ) Whole Health Concord
91 N. State Street
Concord, NH 03301
P: 603-369-4626

PURPOSE OF DISCLOSURE:

( ) Naturopathic Continuing care
( ) Payment of claim
( ) Legal
( ) Other (specify): _____
_____

( ) Worker's compensation
( ) School
( ) For personal use

INFORMATION TO BE RELEASED

Between the dates of: _____

( ) Progress notes/Provider notes _____
( ) Lab reports/Pathology _____
( ) X-Ray reports _____
( ) X-Ray films/MRI _____
( ) Other (specify content and dates): _____
_____
_____

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is one year.
- understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by federal privacy regulations.
- understand by authorizing this use or disclosure of information there will be no conditions placed on my health care or payment for my health care.
- understand I will receive a copy of this form after I have signed it.

_____ _____ _____
Signature of patient, parent of minor, or personal representative Relationship Date

AUTHORIZATION for USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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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 use or 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 the 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 a 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 Whole Health Concord, 91 N. State Street, Concord, NH 03301.

   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 Whole Health Concord, 91 N. State Street, Concord, NH 03301. 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. Laura Jones, at Whole Health Concord. 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 Whole Health Concord

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 Whole Health Concord.

If you have any questions regarding this notice or our health information privacy policies, please contact our medical director, Dr. Laura Jones, at Whole Health Concord.

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PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

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

Name: _____ Birthdate: _____

Signature: _____ Date: _____