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

91 N. State Street, Concord, NH 03301 www.naturalmedicineNH.com 603.369.4626

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**

WHOLE HEALTH CONCORD
Individualized Health Care, Naturally!

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: ______________________________

PATIENT INTAKE FORM

Date: _______________

Age: _______________

Patient Name:____ **DOB:** ______________________

List your health concerns in order of importance:

1)____________________
2)____________________
3)____________________
4)____________________
5)____________________

Name and telephone number of Primary Care physician:_____________________________

Name of any other physicians you are currently under the care of:

____

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:						
Age when died:						
Reason for death:						
Cancer type:						
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 Mellitus:	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

List All Surgeries & Hospitalizations, including date occurred:

1) _________________________________ 4) _________________________________

2) _________________________________ 5) _________________________________

3) _________________________________ 6) _________________________________

Patient Name: ______________________________

Please Note When & Why You Have Had Each of the Following:

Last Bloodwork Assessment: ______________________________

Last Physical Exam: ______________________________

X-Rays: ____________ MRI/Cat Scans: ____________ Ultrasounds: ____________

HIV test: ____________ Last Dental Visit: ____________ Last Eye Exam: ____________

Did you receive the normal series of childhood vaccinations? Y N

Any vaccination reactions or other notes on vaccination history: ______________________________

____

Circle Currently **Y**es (**Y**), Currently **N**o (**N**) or **P**ast (**P**) regarding use of the following:

Antacids: Y N P Steroids: Y N P

Do you presently smoke or chew tobacco? Y N

How many cigarettes___Cigars____Chewing tobacco________Age when started_________

Did you smoke in the past if you don't smoke currently?: Y N How Long:____

When did you quit:____________________Does anyone else smoke in your household?: Y N

Does anyone in your workplace smoke?: Y N

Analgesics: Y N P Laxatives: Y N P Coffee: Y N P Cups per day if Yes/Past: ________

Soda Pop: Y N P Ounces per day if Yes/Past: ______________________________

Alcohol: Y N P How often & how much if Yes/Past: ______________________________

Alcohol Use: ____ drinks/day week month (circle one)Drug Addictions: Y N P Drug Treatment: Y N P

Do you presently use or have you ever used recreational drugs? Y N Please indicate type: ____________

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	Any side effects noted

Current supplements with brands and dosages:

Supplement, dose, and brand	Reason prescribed	Prescriber	Length of time taking this supplement	Any side effects noted

Patient Name: ____

Please rate your energy on a scale of 1-10 (1= poor, 10 = excellent): _______

If you are troubled by daytime fatigue, at what time do you experience this? ________________

Present Weight:_______ **Weight one year ago:**________ **Height:** ________

Maximum weight and when:_____________**Minimum weight as adult & when:** _________

Ideal Weight: __________________

REGARDING THE NEXT LONG SECTION: Please circle **Y**es (**Y**), **N**o (**N**) or **P**ast (**P**) regarding use of the following:

SKIN

Rash:	Y N P		Skin cancer	Y N P
Hives:	Y N P		Normal perspiration	Y N P
Psoriasis/eczema:	Y N P		Itchy:	Y N P
Dry:	Y N P		Warts/moles:	Y N P

HEAD

Headache:	Y N P		Migraine:	Y N P
Dandruff:	Y N P		Past Head Injury:	Y N P
Oil/dry hair:	Y N P		Hair loss:	Y N P

NOSE

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

EYES

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

MOUTH/THROAT

Canker sores:	Y N P		Cold sores:	Y N P
Persistent Sore Throat:	Y N P		Gum disease:	Y N P
Dentures:	Y N P		Cavities:	Y N P
Odd taste in mouth:	Y N P		Hoarseness:	Y N P
Chronic dry mouth:	Y N P		Swollen Glands:	Y N P

Patient Name: ____

RESPIRATORY

Cough:	Y N P		TB:	Y N P
Shortness of breath w/ exertion:	Y N P		Bronchitis:	Y N P
Shortness of breath sitting or lying down:	Y N P		Pneumonia:	Y N P
Wheezing:	Y N P		Asthma:	Y N P

CARDIOVASCULAR

High Blood Pressure:	Y N P		High Cholesterol:	Y N P
Low Blood Pressure	Y N P		Murmurs:	Y N P
Arrhythmias:	Y N P		Palpitations:	Y N P
Edema:	Y N P		Chest Pain:	Y N P

URINARY TRACT

Incontinence:	Y N P		Discharge/Blood:	Y N P
Frequent Infections:	Y N P		Kidney Stones	Y N P
Urgency:	Y N P		Do you get up to urinate at night?	No 1x 2x 3x or

GASTROINTESTINAL

Heartburn:	Y N P		How often do you have a bowel movement?	
Indigestion:	Y N P		Recent BM Change:	Y N P
Bloating:	Y N P		Diarrhea/Constipation:	Y N P
Nausea:	Y N P		Hemorrhoids:	Y N P
Vomiting:	Y N P		Gall Bladder Disease	Y N P
Change in Appetite:	Y N P		Date of last colonoscopy:	
Pancreatitis:	Y N P			

MALE GENITALIA

Testicular pain/swelling:	Y N P		Sexually Active:	Y N P
Hernia:	Y N P		STD?:	Y N P
Discharge:	Y N P		Prostate Disease/Symptoms:	Y N P
Impotency:	Y N P		Healthy libido?	Y N

Patient Name: ____

FEMALE GENITALIA

Age Periods Began:		How Often Period Occurs	
How long period lasts:		Heavy menstrual bleeding:	Y N P
Menstrual cramping:	Y N P		Y N P
PMS:	Y N P	Food cravings:	Y N P
Times Pregnant:		How many births:	
Miscarriages:			
Last Pap Smear:			
Any abnormal paps:	Y N	When was abnormal:	
Menopausal since what age:			Y N P
Sexually Active:	Y N P	Healthy libido:	Y N P
Vaginal dryness, itching of irritation:	Y N P	Pain w/ Intercourse:	Y N P
S.T.D.:	Y N P	Vaginitis:	Y N P
Bone Density Test:	Y N Date:	Mammography:	Y N

Current method of birth control:

Please list any types of hormonal birth control used in the past and how old you were when you used this method:

____

MUSCULOSKELETAL

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

NERVOUS

Paralysis:	Y N P		Sciatica:	Y N P
Tingling/numbness:	Y N P		Carpal tunnel syndrome:	Y N P
Seizures:	Y N P		Fainting:	Y N P

EMOTIONAL HEALTH

Depression:	Y N P		Anger/irritability:	Y N P
Suicidal:	Y N P		High-strung/tense:	Y N P
Anxiety:	Y N P		Fear/Panic	Y N P
Eating disorder:	Y N P		Psychiatric Hospitalization:	Y N

Patient Name: ____

Past health history

What was your health like as a child?

Were you breastfed as a baby? Y N

What was your health like as a teen/adolescent?

Estimated number of rounds of antibiotics: (fill in the blank with a number for each category below):

as a child: as an adult: in the last year:

Have you ever taken a probiotics (L. acidophilus, B. bifidum): ______________________________

Exercise

How often do you exercise? ____________ What type of exercise? ______________________________

For how long? ______________________________ Hobbies: ______________________________

Sleep

How long per night? __________ If you wake up frequently, what is the reason? ____________________

Nightmares:	Y N P	Wake Refreshed:	Y N P	Must nap during the day:	Y N P
Sleep walk:	Y N P	Grind teeth:	Y N P	Snore:	Y N P

Diet

What special diet do you follow, if any? (Vegetarian, Vegan, Food allergy, Atkins, etc.)

Eating Habits (circle any that apply):

Skip breakfast 3 meals a day 2 meals a day Graze (small, frequent meals)

Eat constantly whether hungry or not Generally eat on the run Crave sweet Crave salt

What do you drink during the day and how much? (Coffee, tea, soda, water, juice, etc.)

____

How often do you eat in restaurants? ____

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? ____

Have you had any jobs 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

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

What are your major sources of stress?

____

____

How do you best cope with stress?

____

____

What is your occupation? ___________________________________

How many hours do you work per week? ______________ Do you enjoy your work?

If you have a partner, what is the quality of your relationship? _________________

Known Allergies (medications, environment, foods):

____

____

What is your greatest health concern?

____

How committed are you to making changes?

Is there anything else we should know about you or what you are hoping to get from the experience of working with one of our practitioners?

____

____

____

____

____

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:**_________________

INSURANCE BENEFITS CHECKLIST

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: _________________________

Insurance Company: ____________________

Insurance ID# _________________________

Our office will happily bill your health insurance provider IF you have naturopathic specialist services covered under your plan. It is the patient's responsibility to be aware of his/her coverage and co-pay, 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? **Note: Please make sure to ask "Are there any exclusions under my plan and if so, what are these exclusions?"**
   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:_________
4. What is my deductibe 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:
Signature: ________________________________ Date: _______________

***Please send in this COMPLETED form prior to your first appointment.** If you have trouble getting this information please contact us at Whole Health Concord, (603) 369-4626.

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 F: 603.369.4627

PURPOSE OF DISCLOSURE:

( ) Naturopathic Continuing care
( ) Payment of claim
( ) Legal
( ) Worker's compensation
( ) School
( ) For personal use
( ) Other (specify): ________________

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

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.

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: ______________________