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, along with our Patient intake forms and return the paperwork to Whole Health Concord prior to your first appointment. We will use the forms 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 4**8-hour notice cancellation policy.** As you can imagine, "no shows" or last-minute cancellations can be very burdensome to our practice. If you cannot make your appt, 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:_____

Referred by another physician?: Yes No Referring Physician's Name:_____

Do you need a PCP referral for your specialist visits?: Yes No

Referring provider's NPI# (national provider identifier):_____

Provider's Phone:_____ Address, City, State, Zip: _____

Current Physician (if different from above):_____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:_____

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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: info@naturalmedicineNH.com

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. 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 pre-authorization 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 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 I am financially responsible for services received from Whole Health Concord, LLC.

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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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 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 ***If yes, please make sure we have your referral on file prior to appt.
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 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:
Signature:_____Date: _____

***Please send in this COMPLETED form prior to your first appointment.**

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DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties listed below to request and receive the release ofany protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verifiedbefore the release if any information.

Please give the name(s) of the individual(s) who you will allow to receive any part(s) of your health record.

Authorized Designees:

Name:_____ **Relationship**:_____.

Name:_____ **Relationship**:_____.

Name:_____ **Relationship**:_____.

Name:_____ **Relationship**:_____.

_____ **DOB**:_____.
Patient Name

_____ **Date**:_____.
Patient 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 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: _____

7 Broadway, Concord, NH 03301 Phone: 603.369.4626 Fax: 603.369.4627 www.NaturalmedicineNH.com

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PATIENT CONSENT FOR APPOINTMENT REMINDS VIA TEXT

Whole Health Concord 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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FEE SCHEDULE

Fees below are effective 1.1.2022

<u>For Dr. Jones and Dr. Otto:</u>	
25 min standard follow up appt:	$160
40 min long follow up appt:	$195 (most first follow ups are 40 min)
60 min extended follow up appt:	$245
First Office Visit (New Patient):	$345
<u>Selia Cox, MSN, ARNP:</u>	
25 min standard follow up appt:	$135
40 min long follow up appt:	$165 (most first follow ups are 40 min)
60 min extended follow up appt:	$195
First Office Visit (New Patient):	$295