NEW PATIENT PACKET

Welcome to Our Clinic!

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Shipping address: _____
Phone: (_____)_____-_____ E-mail: _____

Date of Birth:_____ Age:_____ Gender: F / M
Height:_____ Weight:_____

Marital Status: S M D W

Occupation:_____Employer:_____

Emergency Contact: _____Relationship: _____
Phone: _____

HOW DID YOU HEAR ABOUT US?

_____

Please rate your overall level of health (circle one): Excellent / Good / Fair / Poor

What are your most important health concerns? List in order of importance.
1.)_____Onset: _____
2.)_____Onset: _____
3.)_____Onset: _____
4.)_____Onset: _____
5.)_____Onset: _____

Name and location of current physician(s): _____

Date of last:
Physical _____ Blood test _____
Female exam _____ Prostate exam _____
Dental visit _____ Chiropractic visit_____
Acupuncture visit _____ Naturopathic visit _____

ALLERGIES
List all drug, food and environmental allergies: _____
_____

PAST MEDICAL HISTORY
List any major illnesses with approx. dates: _____
_____
List any surgery or operations with approx. dates: _____
_____
Past accidents or injuries: _____
_____

FAMILY HISTORY
Please list any medical conditions that run in your family (parents, siblings, grandparents, aunts and uncles): _____
_____

MEDICATIONS / SUPPLEMENTS
List of medications and nutritional supplements currently taking (please include dosage):

DIETARY INTAKE 2 DAYS PRIOR TO VISIT

Day One

Breakfast:

Lunch:

Dinner:

Snacks/desserts:

Water in glasses or ounces:

Other drinks:

Day Two

Breakfast:

Lunch:

Dinner:

Snacks/desserts:

Water in glasses or ounces:

Other drinks:

Cigarette smoking: ___Past ___Present ___No smoking history

Cigarettes: _____ # each day x _____ total years smoking

Coffee: _____ ounces daily (1mug=14oz)

Alcohol: _____ # of beers, glasses of wine and hard alcoholic drinks per week

Recreational drug usage: _____

Exercise: _____

Clinic Policies

PLEASE READ CAREFULLY BEFORE INITIALING OR SIGNING.

Please **initial** that you understand and agree to the following statements:

_____ **Payment Agreement**

Payment for all services, tests, and medicinary items (that are not covered by your insurance) are due at the time of service. Insurance verifications are done by our office as a courtesy. It is ultimately the patient's responsibility to know and understand their benefits. By initialing you agree to pay any amount due, not covered by insurance for any reason. We accept all credit cards. Returned checks will be subject to a $35.00 NSF fee.

_____ **Product Returns**

We use a variety of nutritional supplements, homeopathic remedies, and botanical medicines. Once these products leave our office, we cannot bear responsibility for their storage or their use. For the health and safety of our patients, we cannot accept returns on ANY medicinary products.

_____ **Cancellations and Missed Appointments**

If you are unable to make your scheduled appointment, please call the clinic at least **24-hours** in advance of your scheduled time. You will be charged a $45 missed appointment fee if you miss a scheduled appointment or fail to cancel at least 24-hours in advance.

_____ **Email Correspondence**

Stellar Health and wellness staff may use email to correspond with patients as a convenience. However, these emails are not encrypted and could theoretically be read by a malicious outside party with the technical skills to intercept such correspondences. By initialing this line, you are consenting to allow correspondence **by email** and to **other practitioners necessary for your care** in spite of these potential risks.

I have read and understand the above-stated policies and will comply with those I have initialed in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

_____

Print Name Signature of Patient/Guardian Date

Informed Consent
PLEASE READ CAREFULLY BEFORE INITIALING OR SIGNING.

Consent to Treatment
The therapeutic procedures of naturopathic medicine are considered safe and effective methods of care. Any procedure intended to help may also have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them.

Please read and sign below that you understand the following procedures:

Nutritional supplements, herbs, and homeopathy may be used to aid in healing. Be sure to inform your practitioner about all medications you are taking to minimize drug/supplement interactions. If you believe you are experiencing any side effects from your supplements/herbs/homeopathy be sure to alert your health care provider.
____ Initial and circle if you have any severe food allergies to shellfish, gluten, soy, dairy, other _____.

Nutritional Response Testing is a safe and non-invasive natural method of analyzing the body's physical and nutritional needs. It is not a method of "diagnosing" or "treating" any particular disease.

Dried Blood Cell Analysis is a tool used to help the doctor and patient conceptualize the effectiveness of natural treatments. It does not "diagnose" any particular disease.

I have read and understand the above statements. I understand that the health improvement program recommended to me is not for the treatment, or "cure" of any particular disease. No promise or guarantee has been made regarding the results of Nutrition Response Testing, or any natural health, nutritional or dietary programs. Rather, the above will be used for bringing about a more optimum state of health.

_____

Print Name Signature of Patient/Guardian Date

YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination
  Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that ***you identify*** who are involved in your health care or health care bills
- To protect the public's health, such as reporting when the flu is in your area
- To make required reports to the police, such as gunshot wounds
- Obtain payment from third party payers

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please **check all that apply**:

☐ Please do not phone me at home.
Use this alternate phone number: _____
☐ Please do not phone me at work.
Use this alternate phone number: _____
☐ Please do not call my cell phone.
Use this alternate phone number: _____
☐ Please do not leave messages on my answering machine.
☐ Please do not contact me by email.
☐ Please send mail, including my bills, to this alternate address:
_____
☐ Other request (please describe):
_____

_____

Print Name Signature of Patient/Guardian Date