WELLNESS DOCTOR
Natural Healthcare & Chiropractic Sports Medicine


## Name

First: _____ Preferred: _____ Last: _____
Birth Date: _____ Gender: _____

## Contact

Phone: Cell: _____ Home: _____ Work: _____ Call first? cell/home/work
Permission to leave detailed voice messages on preferred phone: Yes ____ No____
Email: _____
Mailing Address: _____
Credit Card Billing Address, if different: _____

Emergency Contact: _____ Phone: _____

## Insurance

Insured Person's Full Name: _____
Relationship to you: _____ Birth date: _____ Gender: _____

## Current Medical Concerns

Please list any of your other current or recent providers and the clinic they are associated with:
_____.
_____.
_____.

What health concerns bring you to the clinic today? _____.
_____.

## Social History

Occupation: _____ Employer: _____ Hours Worked Weekly: _____
Relationship Status: _____ Children (ages and genders): _____
Exercise (type, duration, frequency): _____
Hobbies/Activities you enjoy: _____

Sexually active: Yes ____ No ____ Not currently ____ Contraceptive Method _____
Sexual Preference: Male ____ Female ____ Both ____

Tobacco use: Yes ____ Past (Quit Date _____) Form & Frequency _____ Never ____
Recreational Drugs: Yes ___ Past (Quit Date _____) Form & Frequency _____ Never ____
Alcohol use: Yes ____ Past (Quit Date _____) Amount & Frequency _____ Never ____

Briefly describe your diet, you can list what you normally eat in 24 hours, dietary plan (Paleo, keto, fast food), etc. _____
_____.
Water: _____ oz per day - Coffee: Yes ___ No ___ - Juice: Yes ___ No ___ - Soda/Pop: Yes ___ No___

## Family History

Please list any history of diabetes, heart disease, cancer, autoimmune condition, dementia or other medical history:

| Family Member | Age | Condition(s) | Year Diagnosed/Age |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Sister | | | |
| Brother | | | |
| Children | | | |
| Paternal Grandmother | | | |
| Paternal Grandfather | | | |
| Maternal Grandmother | | | |
| Maternal Grandfather | | | |

List any other relevant family history: _____.

## Past Medical History

Please list allergies and sensitivities to medications, foods, and environment: _____.
_____.

List your medications (including over the counter) and supplements (attach additional pages as necessary):

| Medication | Dose | Frequency | Reason | Prescriber |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Please provide the date of your last:

Physical examination: _____ Lab Work: _____
Pap Smear: _____ abnormal / normal result (circle one)
History of abnormal Pap? Yes ___ No ___
Mammogram: _____ Prostate Exam: _____
Colonoscopy: _____ Dexa Scan: _____
EKG: _____ Imaging: _____ Type _____

List any surgeries, serious illnesses (event, date): _____.
_____.

## Review of Systems

Mark (X) only the applicable symptoms

**General**
- Unintentional weight loss / gain
- Fever
- Chills
- Night sweats
- Fatigue
- Headache

**Eyes**
- Impaired vision
- Glasses / Contacts
- Blurred vision
- Eye pain
- Burning / Itching
- Sensitivity to light
- Night blindness
- Tearing / Dryness
- Double vision
- Glaucoma / Cataracts

**Ears**
- Impaired hearing
- Ringing
- Earache
- Dizziness

**Nose & Sinuses**
- Congestion
- Nose bleeds
- Sinus problems

**Mouth & Throat**
- Sore throat
- Gum problems
- Hoarseness
- TMJ

**Neck**
- Lumps
- Swollen glands

**Immune**
- Hay fever
- Frequent colds/illnesses

**Emotional**
- Depression
- Anxiety
- Mood swings

**Cardiovascular**
- Shortness of breath
- Angina
- High blood pressure
- Murmurs
- Chest pain
- Swelling in ankles
- Palpitations / Fluttering
- Easy bleeding and bruising

**Respiratory**
- Shortness of breath
- Cough
- Sputum
- Blood in sputum
- Wheezing
- Difficulty breathing
- Pain with breathing

**Peripheral Vascular**
- Deep leg pain
- Cold hands and feet
- Varicose veins

**Gastrointestinal**
- Heartburn
- Nausea
- Vomiting
- Constipation
- Diarrhea
- # of bowel movements per day ___
- Belching or passing gas
- Difficulty chewing
- Difficulty swallowing
- Change in thirst
- Change in appetite

**Urinary**
- Pain with urination
- Increased frequency
- Increased urgency
- Frequency at night
- Lower back pain
- Forked stream

**FEMALE Reproductive**
- # of Pregnancies ___
- # of live births _____
- # of miscarriages ___
- # of therapeutic abortions ___
- Difficulty Conceiving
- LMP _____
- Age of first period ____
- Cycle length _____
- Avg. days of menstruation ____
- Painful periods
- Irregular periods
- Heavy periods
- PMS symptoms
- Mood changes
- Breast tenderness
- Sexual difficulties

**MALE Reproductive**
- Testicular pain
- Sexual difficulties

**Musculoskeletal**
- Muscle pain
- Weakness
- Joint pain or stiffness

**Neurological**
- Numbness / Tingling
- Fainting
- Seizures
- Paralysis
- Loss of memory
- Difficulty sleeping
- Difficulty staying asleep
- Hours of sleep per night ____

**Skin**
- Rashes
- Itching
- Color change
- Lumps
- Nail changes
- Hair thinning

**Informed Consent to Naturopathic Medical Care**

In this document, "I" and "me" refers to the patient whose signature is below:

I hereby authorize and request evaluation, diagnosis and treatment services from the physician(s) at Ripple Health and Wellness (RHW). I understand that the services may include but are not limited to:

- Physical exam (including general, dermatological, musculoskeletal, EENT, heart and lung, orthopedic, and neurologic assessments)
- Common diagnostic procedures (including venipuncture, pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Soft tissue and osseous manipulation (including therapeutic massage, strain-counterstrain, naturopathic/osseous manipulation of the spine and extremities, and light therapy)
- Minor office procedures (including wound cleaning and dressing, ear cleaning)
- Dietary advice and therapeutic nutrition (including the use of foods, diet plans, nutritional supplements, intramuscular vitamin injections or intravenous nutrient infusions)
- Botanical/herbal medicines, prescribing of various therapeutic substances including plant, mineral and animal materials. These may be prescribed as teas, pills, plasters, suppositories, tinctures, etc.
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water, may involve transcutaneous electrode stimulation)
- Lifestyle counseling
- Over-the-counter and prescription medications

I recognize that I have the right to be informed about my condition and recommended care. This consent is to help me become better informed about potential treatments, so I may give, or withhold, my consent after discussing my condition. I acknowledge that the information provided by this consent is necessarily general, and I shall always have the right and am encouraged to discuss proposed treatments in further detail with my physicians. I always have the right to discuss potential benefits, risks, side effects, or hazards of any treatment; to inquire about the likelihood of any treatment; and to discuss alternative treatment options or the potential consequences if treatment or advice is not followed or nothing is done.

I understand and am informed that in the practice of naturopathic medicine, there are risks and benefits with evaluation, diagnosis and treatment, including but not limited to the following:

**Potential risks:** allergic reactions; side effects; adverse interactions with other therapies; inconvenience of lifestyle changes; or injury or infection from injections, venipuncture, medical devices, or other procedures. RHW follows universal precautions for infection prevention. These precautions greatly reduce, but do not fully eliminate, the risk of healthcare acquired infection.

**Potential benefits:** restore health and the body's maximal functional capacity; relieve pain or symptoms of disease; injury or disease recovery and prevention of disease or its progression.

**Notice to pregnant women:** all female patients must alert the provider if they know or suspect that they are pregnant, since some of the therapies could present a risk to the pregnancy.

_____ _____

Patient or Guardian Signature Date

_____ _____

Printed Name of Signing Patient or Guardian Name of Patient, if Different

**Ripple Health and Wellness (RHW)**
**Office Policies & Financial Responsibility Agreement**

**Office Hours:** Consults are by appointment. After hours messages will be returned the next business day.

**Appointment Scheduling:** You may call the office to schedule an appointment. Appointment reminders will be sent to the email address you have provided in your new patient packet.

**Missed Appointment Fees:** You will be charged a $50.00 fee for missed appointments, cancellations with less than 24-hour notice, or failing to arrive within 10 minutes of your scheduled time.

**Patient Portal:** Secure healthcare messaging is available through the patient portal on Charm. For non-urgent questions, please use the patient portal messaging service. Simple questions like dose clarification and updating your allergy list, are answered without fee. Answers to complex questions will be provided at your next appointment. Please use the secure, HIPAA compliant, patient portal and not email for healthcare related communication. You will be notified of any messages or posts to your patient portal via email.

**Emergencies:** In the case of a medical emergency, (including but not limited to excessive bleeding, severe difficulty breathing, or unconsciousness) please notify emergency medical services or seek care at an urgent care facility. RHW is not equipped to care for emergencies and your urgent care is of utmost importance.

**Medical Records Request:** You may request your medical records for up to 7 years after discontinuing services. A small processing fee (including printing and postage) will be charged. All medical records requests require a signed form.

**Supplements:** Dietary supplements recommended by RHW are typically not covered by health insurance, though you may be able to apply funds from your Health Savings Account (HSA). Your physician will recommend specific products that are selected for their purity, potency, and correct dose and type. You may purchase supplements from numerous sources. For your convenience, RHW offers an in-office medicinary as well as online accounts where you can acquire the selected supplements. **You assume all risk for supplements obtained through outside sources, as we cannot assure the quality or handling of these products.** Supplements purchased through RHW may be returned if they are unopened and have at least 3 months before the expiration date. Compounded, special order, open or heat sensitive products are non-returnable.

**Payment & Financial Responsibility Agreement**

It is your responsibility to pay for all services and products you receive through RHW. All fees are due at the time of service and are payable by cash, check, or major credit card. Account balances must be paid before further services or goods can be provided. You may put a credit or debit card on file with us to ensure prompt payment; by doing so, you are agreeing that we can charge it when fees are due.

Returned Checks and Late Penalty Interest: Checks returned for insufficient funds will result in a $30.00 fee in addition to the amount due. Any outstanding balance on your account is due in full within 30 days of billing. After 30 days, any outstanding balance will accrue interest at 9% per annum until paid. After 90 days, your bill will be forwarded to an outside collection agency. You are responsible for any fees or costs incurred in collection efforts.

Insurance Billing: If we are able to verify insurance coverage prior to your appointment, we will bill your insurer directly. Fees for co-payment, co-insurance, non-covered services and services exceeding your benefits limit are due at the time of service. Fees billed to your insurer that are denied are due after your insurer processes the claim.

**Insurance:** Insurance coverage can vary for naturopathic services. It is ultimately your responsibility to know the benefits, limitations and other details of your insurance. Health insurance is a contract between you and your insurer and does not limit your financial responsibility to pay for our services. It is also your responsibility to

keep your contact and insurance information up to date with our office. Any guarantor of your policy is subject to the same financial policies as the patient. Some third-party payers may require that your medical information, including copies of treatment notes, be submitted along with requests for payment.

**Covered Services:** For each covered service and/or procedure provided, we will only charge your insurance the "allowable amount", as defined uniquely by each individual carrier, and will not bill you for the difference (excluding co-payments, co-insurance, and any deductible as defined by your individual health plan).

**Non-Covered Services:** Some of the testing, services, procedures and therapeutic products recommended by RHW may not be covered by your insurance plan. Or, your insurance company may refuse coverage or pay only a portion or percentage of fees. As a courtesy, RHW will try to identify which services are covered. You are fully responsible for, and we will bill you directly for, any denied charges or non-covered services.

**Referral Release:** By signing below, I authorize RHW to provide referrals based on my healthcare needs and requests, rather than on the basis of insurance network membership. I take responsibility for verifying insurance network status of any referrals and will hold RHW harmless for any out-of-network costs related to these referrals.

**Assignment of Benefits:** I authorize Ripple Health and Wellness to release all medical information necessary to secure payment of benefits from third-party payers. I authorize the use of this signature on all related submissions. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

**Notice of Privacy Policy:** By signing below, I acknowledge that I have received and reviewed the Ripple Health and Wellness Notice of Privacy Policy, and that I am aware I can request another copy of my own records. The Privacy Policy is available in our office and on our website.

**By signing below, I agree to this Office Policies and Financial Responsibility Agreement and acknowledge that I am ultimately responsible for the payment of all fees relating to my treatment at RHW.**

_____ _____

Patient or Guardian Signature Date

_____ _____

Printed Name of Signing Patient or Guardian Name of Patient, if Different