8130 North Lake Blvd
P.O. Box 368
Kings Beach, CA 96143
PH: 530-546-0400
Fax: 530-546-0401

Confidential Patient Information

Please fill in all portions of this form printing clearly and legibly to ensure accuracy.

Today's Date: ____________

Patient name: ____ Age: _______ Marital Status: _______

Mailing Address: ___________________________________ City: _____________ State: ____ Zip: ______

Physical Address: __________________________________ City: _____________ State: ____ Zip: ______

Home phone: ___________________ Work phone: ___________________ Cell phone: __________________

Birthdate____/____/____AGE:____SS#:___________________Email:______________________________

Occupation: _____________________Employer: ____________________ Referred by: __________________

Work Address: ____________________________________ City: ______________ State _______ Zip ______

Name of nearest relative not living with you: _______________________________ Phone # _______________

Name of spouse (or parent for minor child) _______________________________ SS# __________________

Occupation ____________________________ Employer ________________________ Work # ____________

Emergency contact: __________________________ Relationship __________________ Phone: ___________

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. *Furthermore, any charges, fees or court costs incurred as a result of collection efforts will be added to my account balance*. Permission is hereby given for any medical treatment and any diagnostic procedures required for my health care; or (when a patient is a minor child) for the health care of my minor child.

Examination Policy

This office specializes in the diagnosis and treatment of acute and chronic internal, hormonal, and nutritional conditions. Evaluation is done to determine the nature and extent of your problem. In addition to our in-office evaluation, out-of-office laboratory and/or x-ray evaluation may also be recommended, depending on what is necessary in your case. Your Doctor will explain what tests are necessary or recommended during your consultation with her.

CLINIC POLICY REQUIRES PAYMENT AT THE TIME OF SERVICES. PAYMENT TODAY WILL BE BY:

CASH ________ CHECK _______ VISA/MC_______

We require 24 hours advance notification of cancellations or changes in appointments, and we reserve the right to charge if sufficient notice is not given.

Patient's signature ____ Date ______________

OR:

Printed: ____Signed: ____________________________________

(Guardian/Parent signature authorizing care for minor child)

NaturaMed
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Patient's Name (please print):____

We are a cash-based practice. At this time we are not able to accept, nor do we bill, insurance for any of our in-house services. Full payment of all charges is required at the time of service. We accept payment by cash, check, and credit card (MasterCard/Visa). Checks denied for insufficient funds will incur a fee of $35.00. We are not contracted with any insurance providers, and our services are generally not covered by insurance in California. Please see "**An Explanation of Our Financial Policy**" on our website or available by email or in person at the front desk.

TELEPHONE/EMAIL POLICY

Phone Consultations: Charged accordingly with in-office visits. The phone consultation fee is not charged if you are calling for clarification of an on-going medical therapy, or when the doctor has specifically requested you call with a treatment status. The practitioners have full schedules and are generally not available for unscheduled phone conversations. The front desk staff is instructed to take detailed messages from our patients if an answer from the doctor or practitioner is required. Be respectful of their time and be concise. They will get back to you with a response in 24-48 hours.

I understand that if any questions require a phone call from the Doctor or practitioner, any telephone conversation over 5 minutes will be billed at the same consultation rate as in-person visits. If you have any questions or concerns regarding this charge, feel free to ask at the time of your call

Emails: At this time we do not conduct patient communication via email. By sending an email, I acknowledge and agree that a prompt reply is NOT required, expected or contemplated. I acknowledge that I will not use email communication to deal with emergencies or other time-sensitive issues. I understand that email communications may not be secure and that there is some possibility that confidentiality of such communications may be breached by a third party. I understand that NaturaMed Natural Family Medicine may keep copies of email communications and that such messages may be included in my or my child's medical record. If I choose to send an email which requires *the doctor or practitioner* to spend over 5 minutes to read and reply to it I will be billed at the in-person consultation rate.

Pleases initial here to indicate you have read and accept the terms of this section: _______

FINANCIAL POLICY

Payment is expected for all services at the time care is provided. We are unable to carry open balances for our patients for either services or supplements. If an open balance is accrued, any open balance over $200 will result in termination of services and supplements until such time as the open balance is paid in full. In cases of financial hardship, special circumstances for payment may be considered. Such arrangements must be made in advance with the front desk. We participate in MedLoan Finance, a company that specializes in 0% interest loans for medical services. Our front desk is happy to assist you with an application.

We are not contracted with any insurance providers, and our services are not generally covered by insurance in California or Nevada. Upon request we can provide a services only receipt for you, it is your responsibility to submit it to your insurance company for reimbursement. Any questions you may have about reimbursement for our services should be directed to your insurance company. If you will be requesting a services receipt for submission, you must notify the front desk PRIOR to your appointment with the doctor. We are not able to provide these for services previously rendered, nor can we recreate these forms if you misplace them. Coding and billing for insurance company reimbursement is a full time job for a billing specialist and we do not offer this service. *Please see "An Explanation of our Financial Policy" for further information regarding this.*

<u>Please note:</u> As a rule, most insurance companies consider nutritional evaluation and treatment to be "preventative" health care and will not reimburse for these services. Most insurance companies do not cover "Alternative Medical" procedures. This includes but is not limited to:

- Vitamin Injections
- Intravenous Nutrition and Metabolic Therapy
- Nutritional Counseling
- Nutritional Supplements
- Functional Laboratory Assessment
- SpectraVision Bio-Feedback Body Balancing

Clearly, we do not share this view. We will print all of your charges, whether billable to your insurance or not, on a receipt. For clarification of our financial policy, please refer to our "An Explanation of our Financial Policy" available on our website or from the front desk.

We currently accept payment by cash, check, MasterCard or Visa.

Please initial here to indicate you have read and accept the terms of this section: _______

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CANCELLATION POLICY

NaturaMed has a 24 hour cancelation policy. Our doctors and therapists have very busy schedules and many patients that would like to see them. If you do not give 24 hour notice NaturaMed has the right to bill you for the price of a complete office visit. If you "no-show/no call" for your appointment, NaturaMed has the right to bill you for a complete office visit.

All returned checks will be assessed a $35.00 charge in addition to the payment fees covered by that check. Returned check fees and service fees for that check are payable by cash, money order, credit card or cashier's check. If need be NaturaMed will turn delinquent accounts over to a collections agency and *any charges, fees or court costs incurred as a result of collection efforts* *will be added to the account balance*.

Please initial here to indicate you have read and accept the terms of this section: _______

At the time of your first visit, a credit card will be taken and kept securely in your file. We will contact you prior to any charges being placed on the credit card on file, however, by initialing the above statements and by signing below, you are agreeing to our financial policy as outlined, including charges for telephone and email communication as well as appointment cancellations without 24 hours notice and acknowledging that you have read and understand "An Explanation of Our Financial Policy".

By signing below, I acknowledge that I have read, understand and agree to comply with the above listed policies of NaturaMed LLC as stated above.

Patients Printed Name: ____

Patients Signature:____
(or signature of responsible adult if patient is a minor)

Date: ______________________________

Office Staff Witness Signature: ________________________________

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Your Name: ___________________________ DATE: ________________

Thank you for taking the time to tell us a little more about you. By filling this out before your appointment, it gives us much more time to discuss your concerns and our plan to address them.

1. Why did you choose to come to our office?

2. What 3 expectations do you have for your initial visit?

3. What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

4. What behaviors or lifestyle habits do you currently engage in regularly that ***do not*** support your health?

5. What potential obstacles do you see in making changes to your lifestyle and following the directions necessary to support your health?

6. What is your present level of commitment to address lifestyle changes that are underlying causes of your signs and symptoms? Please circle a number:

(No commitment) 1 2 3 4 5 6 7 8 9 10 (100% committed)

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Health History

Please List All Major Illnesses, Surgeries and Hospitalizations you have had throughout Your Lifetime:		
Approximate Dates	Illness or Reason	Outcome

Health Habits: Check all that apply				
✓	Habit	What Forms	Amount	For How Long
	Alcohol			
	Caffeine			
	Tobacco			
	Recreational Drugs			
	Exercise			

Review of Systems: Check all that apply

HEAD

	Headaches		Light-Headed		Dizziness				Earaches/Pain
	Other:								

SKIN, HAIR and NAILS

	Itching		Rashes		Breakouts		Dry Skin		Skin Tags
	Easy Bruising		Hair Loss		Ridges on Nails				
	Other:								

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EYES

	Pain		Itchy		Watery		Recent Change in Vision
	Wear Glasses		Wear Contacts				
	Other:						

EARS

	Excessive Wax		Infections		Itching		Ringing		Earaches/Pain
	Other:								

NOSE AND SINUSES

	Runny Nose		Sinus Infections		Nose Bleeds		Seasonal Allergies
	Other:						

MOUTH and THROAT

	Frequent Sore Throats		Frequent Strep Throat		Recent Pain or Problems with Teeth		Trouble Swallowing		Dripping down back of Throat
	Other:								

RESPIRATORY

	Asthma		Pneumonia		Bronchitis		Cough		Difficulty Breathing
	Shortness of Breath		… with exercise		… with lying down		… at night		
	Other:								

CARDIAC

	Chest Pain		Palpitations		High Blood Pressure		Low Blood Pressure		High Cholesterol
	Other:								

GASTROINTESTINAL

	Stomach Pain		Gas		Bloating		Diarrhea		Constipation
	Heartburn		Indigestion		Nausea		Belching		Ulcers
	Blood in Stool		Mucus in Stool		Undigested Food in Stool		Colitis		Hemorrhoids
	Other:								

How often do you have a bowel movement? ____

Is this a change for you? ______yes ______no

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URINARY

	Burning/Pain		Change in Frequency		Blood in Urine		Urgency		Leakage
	Other:								

GENITAL (Male)

	Testicular Mass or Pain		Erectile Dysfunction		Prostatic Hypertrophy		Poor Libido		Genital Herpes
	Heterosexual		Bisexual		Homosexual				
	Other:								

GENITAL (Female)

	Irregular Cycles		Painful Menses		Birth Control Pills		Pain During Intercourse		Yeast Infections
	Itching		Discharge		Genital Herpes		Infertility		Spotting
	PMS		Endometriosis		Heavy Bleeding		Tender Breasts		Hysterectomy
	Hot Flashes		Night Sweats		Vaginal Dryness		Poor Libido		
	Heterosexual		Bisexual		Homosexual				
	Other:								

Date of Last Period: ________________ Number of Days from Period to Period: ___________
Number of Days You Bleed: ___________ How Many of these Days are Heavy: ___________
Number of Pregnancies: ___________ Age your Periods began: ___________
Age Menopause Began: ___________

MUSCULOSKELETAL

	Muscle Pain		Joint Pain		Arthritis		Joint Swelling		Spasms
	Other:								

NEUROLOGICAL

	Weakness		Numbness		Tingling		Hyperactivity		Seizures
	Anxiety or Nervousness		Mood Swings		Poor Memory		Depression		Irritable
	Other:								

ENDOCRINE

	Cold Intolerance		Heat Intolerance		Hypoglycemia		Diabetes		Excessive Thirst
	Hyperthyroid		Hypothyroid		Fatigue				
	Other:								

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How do you feel if you miss a meal? ____

IMMUNE

	Recurrent Illnesses		History of Cancer		Allergic to Everything		Chemical Intolerance		Autoimmune
	Other:								

Height? __________ Weight Today?______________

Overweight? _______ Underweight?_________ Just right? ___________

Environmental and Toxic Exposures

What type of heat do you have for your home?

	Gas		Oil		Electric		Wood		Wood Pellets		Coal
	Other:										

Are you currently being exposed to any of the following? (check all that apply)

	Tobacco smoke		Fabric Softener		Hair Dyes/ Permanents		Electric Blankets		Metal Tooth Fillings
	Paints		Solvents		Dry Cleaning		Nail Polish		Mothballs
	Breast Implants		Dental Implants		New Carpet		Chemical Pet Collars		Candles
	Other:								

Do you have symptoms of fatigue if you are exposed to any of the above? ○ Yes ○ No

Check all that apply to you:

- ______ Live in an agricultural area now or in the past
- ______ Live near industrial areas
- ______ Live in an area that is sprayed with herbicides or pesticides
- ______ Use of pesticides on your personal grounds

List any known chemical exposures:

____

____

____

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Medications and Supplements

Please list any and all prescription medications, over-the-counter medications, vitamins, herbs, and stimulants you are currently taking.

On your first visit, please bring all of your supplement bottles with you.

Name of Product	Brand	Dose	Frequency/How Long
Ex) Vitamin C	Thorne Research	1.000 mg per day	2 years

Do you have any adverse (or opposite) reactions to medications: Y ___ N __
If so, please explain:

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Health Coach Nutritional Program Informed Consent

Mark Sura, M.S., CSCS our certified Health Coach and nutritional counselor has a B.S. in Cell Physiology and a Master's Degree in Exercise Physiology. Since 1999 he has exclusively focused his post-graduate and continuing education in the application of clinical and therapeutic nutrition in health and dis-ease. He is certified in the FirstLine Therapy Lifestyle program to address high cholesterol, pre diabetes and diabetes and overall health strategies to prevent these as well. He is also certified in the Eat Right for Your Type program as well as having extensive experience in cleansing and detoxification programs.

ALL patients seen by the Naturopathic Doctors at NaturaMed Natural Family Medicine will meet with Mark for education about their individual nutritional needs as well as to be guided through a detoxification program. As the nutritional counselor he assists our doctors by providing specific information regarding how to implement the doctors' recommendations on diet, nutrition, exercise, and other lifestyle issues.

Mark is also passionate about helping athletes of all levels achieve their best performance using nutrition to support their athletic endeavors and improve recovery. He has helped numerous amateur and professional athletes on their journey to better their performance. In these circumstances, clients may consult with Mark directly, rather than being directed to him from one of our Naturopathic Doctors.

Mark's role in our practice is strictly as a nutritional counselor and educator, and the information provided is not intended to diagnose or treat any disease, health condition, or particular symptom. His advice and nutritional counseling are provided solely to support your body's physiological and biomechanical processes through the use of nutrition.

If at any time you do not understand any of the information provided you may consult him or one of our doctors for clarification. They may also refer you to other resources for additional information.

While people generally experience greater health and wellness as a result of embracing a healthier attitude, lifestyle, and diet, Mark does not promise or guarantee protection from future illness.

By signing below, you acknowledge that you understand that Mark is a health consultant and not a Doctor, and that you should see a doctor if you think you have a medical condition. Mark Sura will not be held liable for failure to diagnose or treat an illness, nor will he be liable for failure to prevent future illness.

Additionally, you promise to give Mark a complete and accurate account of any medical conditions that you may have and any medications that you are taking.

I have read and understand the above and agree to nutritional counseling with Mark Sura:

____ ______________________
Signature Date

____ ______________________

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Notice of Privacy Practices Consent Form

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, ___________________________, herby acknowledge that NaturaMed, LLC has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed and how I can access this information. I understand that if I have questions or complaints I may contact:

Dr Ann Sura
530-546-0400

I also understand that I am entitled to receive updates upon request if NaturaMed, LLC amends or changes its Notice of Privacy Practices in a material way.

____
Printed Name

____ ____________
Signature Date

____
Relationship to Patient, if signed by someone other than patient.

THIS SECTION IS TO BE COMPLETED BY NATURAMED, LLC IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT.

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgement

[ ] Other (specify): ____

____ ____________________
Name and title of employee Date