Kimberly M. Sanders, ND
Frank LaRosa, ND, MSAc
57 Plains Rd, Milford, CT 06461
Tel (203) 806-5138 Fax (203) 612-9882

Patient Name_____**Date**_____

Patient Date of Birth_____ **Patient Sex:** M/F

Address_____

City_____**State**_____**Zip**_____

Phone_____ **Alternate Phone** _____
Can we leave messages by phone? Y/N

Email_____Would you like to receive our Email Newsletter? Y/N

Emergency Contact_____**Relation**_____**Phone**_____

How did you learn about us?_____

Insurance Information: I.D.Number_____
Insurance Company _____Name of Policy Holder _____
Policy Holder's Date of Birth:_____

Submission of co-pay is **not** confirmation of insurance reimbursement. Please understand that **Insurance companies will not guarantee medical/naturopathic benefits over the phone**. As your insurance company processes claims and notifies us of any patient balance, *you will be billed accordingly.* Please contact your insurance company to verify coverage. All payments are due at time of service for office visit charges and nutritional supplements, which are **not** covered by insurances. If receiving private acupuncture, and your insurance *does not* cover acupuncture but *does* cover a Naturopathic office visit, then your acupuncture visit charges will be reduced to your co-pay + $20.00 (acupuncture service charge). Personal checks are accepted. A $25 return check fee will apply to all returned checks.

****AS OF JULY 1, 2014, OFFICE FEES WILL BE COLLECTED IN FULL AT THE TIME OF SERVICE FOR ALL PATIENTS WITH DEDUCTIBLE PLANS** **CANCELLATIONS (with less than 24-hour notice) AND MISSED APPOINTMENTS WILL BE SUBJECT TO A $50.00 CHARGE****

I understand and agree to the above criteria.

Signature_____**Date**_____

If patient is under 18:

I hereby authorize medical treatment for my child to be received by ArthroWell Naturopathic. I understand I have the responsibility of my child's healthcare, and have legal control of their medical records until the age of 18.

Guardian's Name (print)_____Signature of guardian_____

Please list current medical conditions & health concerns *(Reason for today's visit):*_____
_____
_____
_____

Current medications & supplements *(Please include dosage):*_____
_____
_____

Current Primary Care Provider and Other Specialists Managing your Health:
_____
_____
_____

Allergies:_____

Past Medical History: *(check boxes if yes and include dates)*

□ Cancer_____ □ Diabetes (Type I or II)_____
□ High blood pressure_____ □ Heart Disease_____
□ Hepatitis_____ □ Ulcers_____
□ HIV/AIDS_____ □ Lung Disease_____
□ Arthritis_____ □ Seizures_____
□ Rheumatic fever_____ □ Thyroid Disease_____
□ Mononucleosis_____ □ Strep Throat_____
□ Surgeries (types & dates)_____
Other_____

Family History:

(Please check the box if an immediate family member (mother, father, brother, sister, aunt, uncle, grandparent, or child) has one of the following conditions)

□ Cancer_____(type) □ Diabetes (Type I or II)
□ High blood pressure □ Heart Disease
□ Allergies □ High cholesterol
□ Stroke □ Alcoholism
□ Seizures □ Autoimmune disorder_____(type)
□ Arthritis_____(type) □ Mental illness
□ Inherited blood disorder □ Asthma
□ Other_____

Life Style:

Cigarettes_____(packs per day) Coffee Tea Cola
Alcohol_____(glasses per week) Sweets Salt Dairy Bread
Exercise (*type & number of times per week*):_____

Diet (*food restrictions or food sensitivities*):_____

Women Only:

Age menses began:_____ First day of last period:_____Length of cycle:_____
Date of last Pap smear:_____ Any Abnormal Paps?_____ Date/Year_____
Painful Periods? _____ Heavy periods?_____ PMS?_____

Review of Systems: (*circle if yes)*

Eyes, Ears, Nose, and Throat	General	Musculoskeletal and Nervous System
Changes in your vision Eye pain Eye redness Difficulty with hearing Ringing in your ears Vertigo Frequent nosebleeds Sinus trouble	Unusual weight loss Unusual weight gain Fatigue Chills Fever Skin rash Itchy skin Headaches Excessively hot or cold	Fainting or blackout Seizures Paralysis Numbness of fingers or feet Muscle pain or stiffness Back pain Joint pain Dizziness Loss of balance

Lungs	Heart	Stomach and Abdomen
Persistent daily coughing Cough up phlegm or sputum Coughed up blood Frequent chest colds Pneumonia or severe bronchitis Asthma Shortness of breath	Chest pain or tightness Rapid heartbeat Palpitations, heart skips Swelling Past heart problems Wake short of breath	Difficulty swallowing Indigestion Heartburn Stomach Ache Excessive gas Bloating Frequent vomiting Rectal bleeding Constipation Diarrhea

ArthroWell Naturopathic, LLC

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NOTICE OF PATIENT INFORMATION PRACTICES

This notice describes how medical information about you may be used or disclosed, and how you can get access to that information. PLEASE REVIEW CAREFULLY.

ARTHROWELL NATUROPATHIC, LLC. LEGAL DUTY

ArthroWell Naturopathic, LLC. is required by law to protect the privacy of your health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES DISCLOSURES OF HEALTH INFORMATION

ArthroWell Naturopathic, LLC. uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities; and evaluating the quality of care that we provide. For example, ArthroWell Naturopathic, LLC. may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.
ArthroWell Naturopathic, LLC, may only disclose your personal health information without prior authorization when required by law.

In any other situation, ArthroWell Naturopathic, LLC. policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

ArthroWell Naturopathic, LLC. may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas, and will be provided to you on your next visit. You may also request an updated copy of your Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purpose except when specifically authorized by you, when required by law, or in emergency circumstances. ArthroWell Naturopathic, LLC. will consider all such requests on a case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that ArthroWell Naturopathic, LLC. may have violated your privacy rights, or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact out practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on ArthroWell Naturopathic, LLC. health information practices, or if you have a complaint, please contact the following office:

ArthroWell Naturopathic, LLC.
Attn: Kimberly Sanders, N.D.
57 Plains Rd, Suite 3C
Milford, CT 06461
Phone: (203) 806-5138

PATIENT INFORMATION CONSENT

If you would like a copy of the HIPPA policy, please ask us for one.

I have read and fully understand the ArthroWell Naturopathic, LLC. ***Notice of Patient Information Practices****. I understand that ArthroWell Naturopathic, LLC. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that ArthroWell Naturopathic, LLC. Will consider the request for restrictions on a case by case basis, but does not have to agree to request for restrictions*.

I hereby consent to the use and disclosure of my personal health information for purpose as noted in the ArthroWell Naturopathic, LLC. ***Notice of Patient Information Practices****.*

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name (Printed)_____

Patient/ Guardian Signature Date_____

Informed Consent for Naturopathic Treatment

I, _____, do voluntarily, knowingly and willingly give my consent to treatment by Naturopathic Medical Care. A number of different approaches are used. Diet and nutritional supplements, botanical medicine, homeopathy, hydrotherapy, physical medicine and lifestyle counseling are the mainstays of naturopathic medicine. Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes and promote health. The benefits include increased energy, increased gastrointestinal function, improved immunity and general well being.

We will take a thorough case history, do pertinent physical examinations, and order lab testing. If your case requires, the physical may include more specific examinations.

Even the gentlest therapies may have complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those with multiple medications. Some therapies should be used with caution in certain diseases such as diabetes, heart, liver or kidney disease.

Please inform your Naturopathic Doctor immediately of any disease that you are suffering from, and if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding, please advise your Naturopathic Doctor immediately.

There are some slight health risks to treatment by Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Risks and Side Effects associated with nutrients, homeopathy, and botanical medicines

I understand that the Naturopathic Doctor will answer any questions that I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. I will rely on the Naturopathic Doctor to exercise judgment during the course of the procedure which they feel at that time is in my best interests, based on the facts then known. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above.

I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.
I state that I do not have the following conditions: pregnancy, bleeding disorders, pacemaker, local infections; or am currently taking anticoagulants. If I have any of the above conditions, I have listed them here:

_____

_____

By voluntarily signing below I, _____, hereby certify that I have read this entire form, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions and that I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment to be performed for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

[Date] [Signature of Patient/Guardian]