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Introduction Letter

Thank you for choosing our clinic to help you with your healthcare needs. We are here to help in any way possible. We are enclosing a new patient information packet which contains:

1) History and Intake forms
2) Patient Payment Responsibility
3) Acknowledgment of Receipt of Notice of Privacy Practices

All of these forms need to be filled out completely. If the forms are not filled out completely we will ask you to finish them before you see your doctor. This may take up some of the appointment time reserved for you. Along with your new patient information, please bring current lab reports and any supplements that you are currently taking.

48 hour notice is appreciated and a minimum of 24 hours is required for cancellation of appointments. There is a missed appointment fee of the full cost of your scheduled visit should you not give proper notice

We do not accept any insurance. We will give you a receipt suitable for reimbursement from most insurance carriers.

In consideration of our chemically sensitive patients we request that you wear no fragrance of any kind to our office, this includes natural oils and products.

If you have any questions, please contact the office. Thank you for trusting us to care for you. We look forward to meeting you and being part of your healthcare team!

Our Clinic Protects Your Health Information and Privacy

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- *Limited access to facilities where information is stored.*
- *Policies and procedures for handling information.*
- *Requirements for third parties to contractually comply with privacy laws.*
- *All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.*

Types of information that we gather and use:

- *About your financial transactions with us (billing transactions).*
- *From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.*
- *From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (e.g. requests for medical records, claim payment information).*

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - e.g. your name, address, Social Security number, etc.).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 310.395.0077.

Kindly,

Well Being Medical Center

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Patient Information

Last Name: First Name:

☐ Parent/Guardian of patient? Name and Relationship to Patient: _____

Today's Date: ____/____/____ ☐ Male ☐ Female

Date of Birth: ____/____/____ Age: _____ Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Others _____

Physical Address: _____ Apt.: _____ City: _____ State: _____ Zip: _____

Billing Address: _____ Apt.: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ - _____ Work: ( ) _____ - _____ Cell/Alternate: ( ) _____ - _____

Fax: ( ) _____ - _____ Email: _____

Employer: _____ Occupation: _____ Hours/Week: _____

Employer Address: _____ Telephone: ( ) _____ - _____

Retired: _____

Would you like to receive our quarterly Well Being Medical Center newsletter (via email)? ☐ Yes ☐ No

Emergency Contact

Name: _____ Relationship to you: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: ( ) _____ - _____ Evening: ( ) _____ - _____ Cell/Alt: ( ) _____ - _____

Referred by (specify)

Name: _____

☐ INTERNET: Search Engine / Browser (ex Google, Citysearch, Yelp, etc.)

_____

☐ WALK-IN

☐ RCVD EMAIL, Re: _____

☐ WORKSHOP: Title: _____

☐ FLYER, From: _____

Has any other family member already been a patient at the clinic? _____

Health History Questionnaire

SUCCESSFUL HEALTH AND PREVENTATIVE MEDICINE ARE ONLY POSSIBLE WHEN THE DOCTOR HAS A COMPLETE UNDERSTANDING OF THE PATIENT PHYSICALLY, MENTALLY AND EMOTIONALLY. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE. PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

Are you currently receiving healthcare? _____

If yes, where and from whom? _____

If no, when and where did you last receive medical or health treatment?

_____

_____

What was the reason? _____

What are your most important health problems? List in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Do you have any known contagious diseases at this time? _____

If yes, what? _____

Family History

	Father	Mother	Brother	Sister	Spouse	Child
Age (if living)						
Health *(G = good/P = poor)*						
Age at death *Check those applicable*						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma/Hay fever/Hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						
Cause of Death						

Childhood Illness

Scarlet fever? _____ Diphtheria? _____ Rheumatic fever? _____

Mumps? _____ Measles? _____ German measles? _____

Hospitalizations and Surgery

What hospitalizations or surgeries have you had?

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

X-Rays and Special Studies

X-rays, CAT scans, or other studies you have had:

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

Electrocardiogram? _____ Date _____

Electroencephalogram? _____ Date _____

Immunizations

Polio? _____ Measles? _____ Diphtheria? _____

Tetanus Shot? _____ Pertussis? _____ Other? _____

Allergies

Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental? _____

Current Medications

Do you take or use?

Laxatives? _____ Pain Relievers? _____ Antacids? _____ Cortisone? _____

Appetite Suppressant? _____ Antibiotics? _____ Tranquilizers? _____ Thyroid Medication? _____

Sleeping Pills? _____ Prednisone? _____ Hormone Replacement Therapy? _____ Birth Control? _____

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking.

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Typical Food Intake

Breakfast _____
Lunch _____
Dinner _____
Snack _____
Foods you crave: _____
Foods you dislike: _____
Foods you are allergic/sensitive to: _____
Any present or past eating disorders? _____

General

Height: _____ Weight: _____ Weight 1 yr ago: _____
Max Weight: _____ When: _____
When during the day is your energy the best? _____
The worst? _____

For all the following sections please write Y, P or N on the line:

Y = a condition you have now
N = a condition you have never experienced
P = a condition you have had in the past

Mental /Emotional

Treated for emotional problems? _____ Depression? _____ Anxiety? _____
Mood Swings? _____ Considered/Attempted Suicide? _____ Tension? _____
Poor concentration? _____ Memory Problems? _____

Endocrine

Hypothyroid? _____ Fatigue? _____ Excessive Hunger? _____
Hypoglycemia? _____ Diabetes? _____ Seasonal Depression? _____
Excessive thirst? _____ Heat or Cold Intolerance _____

Immune

Vaccinations? _____ Chronically swollen glands? _____ Chronic Infections? _____

Chronic fatigue Syndrome? _____ Reactions to vaccinations? _____ Slow wound healing? _____

Neurological

Seizures? _____ Paralysis? _____ Numbness or tingling? _____

Muscle weakness? _____ Loss of memory? _____ Loss of balance? _____

Vertigo or dizziness? _____ Easily stressed? _____

Musculoskeletal

Joint pain or stiffness? _____ Muscle spasms or cramps? _____ Weakness? _____

Broken bones? _____ Arthritis? _____ Sciatica? _____

Vascular

Easy bleeding or bruising? _____ Varicose Veins? _____ Cold hands/feet? _____

Deep leg pain? _____ Anemia? _____ Thrombophlebitis? _____

Skin

Rashes? _____ Eczema/Hives? _____ Lumps? _____

Color change? _____ Perpetual hair loss? _____ Acne/Boils? _____

Night sweats? _____

Head

Headaches? _____ Head injury? _____

Migraines? _____ Jaw/TMJ problems? _____

Eyes

Spots in eyes? _____ Double vision? _____ Eye pain/strain? _____

Impaired vision? _____ Cataracts? _____ Tearing/dryness? _____

Blurriness? _____ Glasses or contacts? _____ Glaucoma? _____

Color blindness? _____

Nose and Sinus

Frequent colds? _____ Sinus Problems? _____ Nose bleeds? _____

Stuffiness? _____ Hay fever? _____ Loss of smell? _____

Mouth and Throat

Frequent sore throat? _____ Gum problems? _____ Copious saliva? _____

Teeth grinding? _____ Dental cavities? _____ Sore tongue/Lips? _____

Hoarseness? _____ Jaw clicks? _____

Neck

Lumps? _____ Swollen glands? _____

Goiter? _____ Pain/Stiffness? _____

Respiratory

Cough? _____ Emphysema? _____ Sputum? _____ Pneumonia? _____

Spitting up blood? _____ Pain on breathing? _____ Wheezing? _____ Asthma? _____

Bronchitis? _____ Shortness of breathing at night? _____ Pleurisy? _____ Difficulty breathing? _____

Shortness of breath? _____ Shortness of lying down? _____

Cardiovascular

Heart disease? _____ Rheumatic fever? _____ Blood clots? _____ Murmurs? _____

High blood pressure? _____ Swelling in ankles? _____ Phlebitis? _____ Angina? _____

Palpations/Fluttering? _____ Fainting? _____ Low blood pressure? _____ Chest pains? _____

Gastrointestinal

Trouble swallowing? _____ Is this a change? _____ Heartburn? _____ Change in thirst? _____

Constipation? _____ Vomiting? _____ Nausea? _____ Diarrhea? _____

Blood in stool? _____ Vomiting blood? _____ Gall bladder disease? _____ Pain/Cramps? _____

# of Bowel Movements per week___ Ulcer? _____ Belching/Gas? _____ Jaundice? _____

Black stools? _____ Liver disease? _____

Urinary

Pain on urination? _____ Pain on urination? _____ Inability to hold urine? _____

Frequency at night? _____ Increased frequency? _____ Kidney stones? _____

Mark **Y** = for current **P** = for past

Female Reproduction

Age of 1st menses? _____
Are cycles regular? _____
Bleeding between cycles? _____
Painful menses? _____
Heavy/Excessive flow? _____
PMS? _____
PMS Symptoms? _____

Date of last menses? _____
Length of cycle _____
Duration of menses? _____
Clotting? _____
Discharge? _____
Sexually active? _____

Birth Control? _____
Number of pregnancies? _____
Number of miscarriages? _____
Endometriosis? _____
Difficulty conceiving? _____
Menopausal Symptoms? _____
Pain during intercourse? _____
Chlamydia? _____
Herpes? _____
Syphilis? _____
Sexual orientation? _____

What type? _____
Number of live births? _____
Number of abortions? _____
Ovarian cysts? _____
Cervical Dysplasia? _____
Abnormal PAP? _____
Sexual difficulties? _____
Gonorrhea? _____
Condyloma? _____
Do you do breast exams? _____
Breast tenderness/lumps? _____
Nipple discharge? _____

Mark **Y** = for current **P** = for past

Habits

Main interest and hobbies? _____

_____

Do you have a religious or spiritual practice? _____ What? _____

Do you exercise? _____ How often? _____

What kind of exercise? _____

Hours of sleep? _____ Enjoy your work? _____

Sleep well? _____ Take vacations? _____

Awaken rested? _____ Spend time outside? _____

Have a supportive relationship? _____ Watch television? _____

Have a history of abuse? _____ How many hours? _____

Any major traumas? _____ Read? _____

Used recreational drugs? _____ How many hours? _____

Been treated for drug dependence? _____ Use alcoholic beverages? _____

Do you eat three meals a day? _____ Treated for alcoholism? _____

Do you go on diets often? _____ Do you use tobacco? _____

Do you drink coffee? _____ Smoked previously? _____

Do you drink black/green tea? _____ How many years? _____

Do you drink cola/soda? _____ How many packs per day? _____

Do you eat refined sugar/artificial sweeteners? _____ Do you add salt? _____

How does your condition affect you? _____

_____

_____

What do you think is happening? _____

_____

Why? _____

_____

What do you feel needs to happen for you to get better? _____

_____

_____

What do you enjoy most about your life? _____

_____

_____

How much effort are you willing to make at this time to improve your health? ☐ Minimal ☐ Some ☐ Complete

Please write any additional information below: _____

_____

_____

Please bring in any and all medications, vitamins or supplements you are currently taking. If you have any questions, please ask!

Patient Payment Responsibility Agreement

Dear Patient,

This letter is to keep you informed of the policies regarding your payment responsibilities.

As a patient you are responsible for the total charges incurred from each visit to your practitioner. Charges are to be paid at the time of each visit.

We recognize and appreciate that health care can involve major financial commitment. We aim to provide you with effective and affordable health care.

Visa, MasterCard, American Express, Checks and Cash are all acceptable forms of payment.

Please remember that you have the primary relationship with your insurance company and you are responsible for the total amount owed at the time of your visit. We will provide you with the appropriate super-bill with the appropriate codes needed for you to be reimbursed by your insurance company. You will need to mail the super-bill provided to your insurance company and your insurance company will reimburse you for all the amounts covered. Before your first appointment contact your insurance company or refer to your insurance contract agreement regarding coverage for Alternative and Complementary medical services. Items to note are: 1) the service covered, 2) which diagnosis are covered, 3) how many visits are allowed per calendar year, 4) the amount of your deductible, 5) any limitations. Answers to these questions will help clarify treatment and financial responsibility.

When you schedule an appointment, the time you schedule is reserved for you and only you. We do not overbook or double book patients. We recognize there may be occasions when you need to cancel or reschedule an appointment. If you need to make any changes to your appointment for any reason, we appreciate a 48 hours notice, but require a minimum of 24-hours advanced notice for any changes. Otherwise, you will be charged a cancellation/rescheduling fee in the full amount of your scheduled visit. This charge will not be billable to your insurance.

Payment for all pharmacy items is due at the time of the visit. Most insurance companies do not cover Naturopathic pharmacy items.

Please sign this form acknowledging you have read and agreed to the above notice. Please feel free to contact us regarding any questions.

Signature: _____ Date: _____

I have read the above stated policies and will comply with them henceforth.

Acknowledgement of Receipt of Notice of Privacy Practice

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

I, _____, hereby acknowledge that I have been provided with a copy of the 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 Well Being Medical Center. I also understand that I am entitled to receive updates upon request if the Notice of Privacy Practices in a material way.

_____ _____

Signature | Relationship to patient, if signed by someone other than the patient.

_____

Date

THIS SECTION IS TO BE COMPLETED BY WELL BEING MEDICAL CENTER IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT.

I made 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