EVND
east valley naturopathic doctors

Personal Information

Legal Name:_____ **Preferred Name:**_____ **DOB:**_____
Address: _____
City:_____ **State:**_____**Zip:**_____
Email:_____
Primary phone:_____**Secondary phone:**_____
Emergency contact:_____**Relationship:**_____**Phone:**_____
Preferred Pharmacy (including cross streets):_____
Insurance Co:_____
How did you hear about EVND?_____
Occupation:_____

Health Information

What are your current symptoms or conditions that you would like to be addressed?

_____
_____
_____
_____
_____
_____

Past medical history including surgeries, procedures, hospitalizations and previous diagnoses?

_____
_____
_____
_____

Please list all known food and drug allergies:

_____
_____
_____

Family Health History: (Parents, siblings, grandparents)

_____
_____
_____

List all current medications (including strength and dosing):

_____
_____
_____
_____
_____

List all current supplements (including strength and dosing):

_____
_____
_____
_____
_____

Environmental exposure

Answer Yes or No or provide detailed answers where appropriate

Have you worked or lived in an environment where mold was found or water damage occurred?_____
Are you highly sensitive to medications and supplements?_____
Have you lived in what is considered a Lyme endemic area?_____
Have you or a family member been diagnosed with Lyme or other tick-borne illness?_____
Have you traveled outside the U.S?_____ If so where?_____
Do you or have you consumed sushi, poke bowls often?_____
Do you or have you had more than 4 silver fillings in your mouth?_____
Females only: Do you have breast implants? If so which kind: _____
Average antibiotic intake in the past 5 years? _____

Do you have any of the following symptoms? (Check the boxes that apply)

- ☐ **Fatigue**
- ☐ **Itchy ears**
- ☐ **Hair loss**
- ☐ **Shingles**
- ☐ **Eczema, rosacea, psoriasis or acne**
- ☐ **General skin itching without evidence of a surface rash**
- ☐ **Compulsive eating or cravings**
- ☐ **Inability to lose weight**
- ☐ **Unable to gain weight**
- ☐ **Anxiety and/or depression**
- ☐ **Frequent sinus infections**
- ☐ **Asthma, wheezing or shortness of breath**
- ☐ **Brain fog, confusion, or difficulty focusing**
- ☐ **Headaches or migraines**
- ☐ **Asthma, wheezing, or shortness of breath**
- ☐ **Runny nose or congestion**
- ☐ **Constipation**
- ☐ **Diarrhea**
- ☐ **Alternating between constipation and diarrhea**
- ☐ **Bloating, can be worsened with eating**
- ☐ **Belching**
- ☐ **Excessive flatulence**
- ☐ **Abdominal pain, discomfort or cramps generally or worse with eating**
- ☐ **Nausea or Vomiting**
- ☐ **Acid Reflux**
- ☐ **Food reactions or sensitivities**
- ☐ **Issues with falling and or staying asleep**
- ☐ **Unexplained fevers, sweats, chills, or flushing**
- ☐ **Recurring or persistent sore throats**
- ☐ **Lightheaded, poor balance, vertigo, or difficulty walking**
- ☐ **Body aches, muscle pain**
- ☐ **Joint pain**
- ☐ **Tingling, burning, numbness that migrates and/or comes and goes**
- ☐ **Received a diagnosis of Chronic Fatigue Syndrome or Fibromyalgia**

INFORMED CONSENT and Request for Naturopathic Medicine

I understand and agree that:

·The Naturopathic Physicians at the offices of East Valley Naturopathic Doctors are independent medical practices

·East Valley Naturopathic Doctors assumes no liability arising from treatments administered by such independent Naturopathic Physicians

·Any claims for injuries from treatments administered by such independent Naturopathic Physicians must be brought solely against the independent Naturopathic Physician(s) providing the treatment that caused the injury and not against East Valley Naturopathic Doctors

I understand that naturopathic evaluation and treatment may include, but is not limited to:

- Physical exam (general and female)
- Common diagnostic procedures (pap smears, endometrial biopsies, diagnostic imaging, laboratory evaluation of blood, urine, and stool and saliva)
- Dietary advice and therapeutic nutrition (use of foods, diet plans, nutritional supplements, and intramuscular vitamin injections)
- Acupuncture (insertion of specialized disposable stainless steal sterilized needles through the skin into underlying tissues at specific points on the body surface)
- Herbs/natural medicines (prescribing of various therapeutic substances including plant, mineral and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures, suppositories, which may contain alcohol, topical creams or other forms.
- Homeopathic remedies (often highly diluted quantities of natural occurring substances)
- Over the counter and prescription medications

I understand and I am informed that in the practice of Naturopathic Medicine and Traditional Chinese Medicine there are some risks and benefits with evaluation and treatment including, but not limited to the following:

- Potential risks: pain, discomfort, minor bruising from Acupuncture; allergic reaction to prescribed herbs, supplements, prescription medications; and aggravation of pre-existing symptoms.
- Potential benefits: restoration of the body's maximal functioning capacity, relief of pain and symptoms of disease, assistance in injury and 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.

By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I also understand that it is my responsibility to request that the provider explains therapies and procedures to my satisfaction. I further acknowledge that no guarantees or services have been made to me concerning the results intended from the treatment. I consent to receive notifications for scheduled appointments and other reminders pertinent to the continuity of care, via phone, email and/or text. I intend that this consent form is to cover the entire course of treatments for my present condition and any future conditions for which I am seeking treatment.

By signing this I acknowledge that I am to take responsibility for when my prescription medication is running low. In doing so I will give the office a minimum of 7 days notice in order to give ample time for the doctor to call it in and the pharmacy time to fill it. Most prescription medications by law can only be prescribed and refilled for one year. It is necessary to have labs and follow up with your physician before the year mark. Controlled substances can only be refilled every 3 to 6 months.

Signature **Printed name** **Date**

Financial Policy of East Valley Naturopathic Doctors

Payment Policy

Payment for services are due at the time services are rendered, including for products and labs not specifically covered by insurance.

Insurance Reimbursement Policy

For your information Medicare does not cover Naturopathic Medicine, including visits and labs ordered by Naturopathic providers. We do not submit directly to any insurance, however if labs are drawn here in the office, we will send a copy of your insurance card to the lab and they will submit to your insurance. If you would like to submit for reimbursement on your own for visits, a superbill a summary of the services rendered, diagnoses and charges applied, will be provided for you upon request to send to your insurance company.

Returned Checks

For checks returned as unpaid by your bank, you will be charged a $35 returned check fee.

Cancellation Policy

Please provide at least 24 hours notice of cancellation as a courtesy. Doctor or IV appointments that are missed or cancelled less than 24 hours of the scheduled time, a charge of $50 will be applied to the card on file or invoiced. Blood Draw appointments that are missed or cancelled less than 24 hours of the scheduled time, a charge of $15 will be applied to the card on file or invoiced.

Credit Card Information

Master card Visa Discover AMEX Other: _____

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____

CVV code (3 or 4 digit code on back of card): _____

By signing below I am stating that I have read and understand the Financial Policy of East Valley Naturopathic Doctors.

_____

Signature **Date**

_____

Printed name

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HIPAA - Patient Consent of Information

East Valley Naturopathic Doctors, in order to comply with the HIPAA Privacy Regulation, requires an authorization from the patient before detailed messages are left for the patient. This policy is to protect the privacy of the patient and to protect the physicians and staff of East Valley Naturopathic Doctors from violating the patient' s confidentiality. If there is not a signed consent on file, physicians and staff will only leave their name and telephone number on an answering machine, voicemail, or with a live person answering the phone requesting the patient to return the call.

By completing the consent below, you are allowing East Valley Naturopathic Doctors physicians and its staff to leave a message on an answering machine, voicemail, or with a specified individual. You may specify what information is left and with whom by noting the information on the bottom of this form. By signing, you are also consenting to the mailing or faxing of any results, requested by you, to your primary care physician or another physician involved in your care.

_____ I give my consent to East Valley Naturopathic Doctors physicians and staff to leave a message regarding scheduling, treatment, lab or radiology results, or other information as necessary via text message, via email, on an answering machine or voicemail at home or cell phone, and/or with_____ relationship_____ and/or with_____ relationship_____

_____ I do not consent to messages being left at home, work or with any other person. I wish to be contacted directly.

_____ _____
Patient's Name (Print Please) Date of Birth

_____ _____
Patient's Signature Date

_____ _____
Witness Date

HIPAA – Notice of Privacy Practice Acknowledgement

_____I have been provided, if I so choose, a copy of East Valley Naturopathic Doctors Notice of Privacy Practice.

_____I have declined a copy of East Valley Naturopathic Doctors Notice of Privacy Practice.

_____ _____
Patient's Signature Date

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Name: _____ DOB: _____ Date:_____

PLEASE INITIAL THE FOLLOWING:

_____ **Consent to Injections; Vitamin & Antibiotic:** I consent to all injection procedures rendered by the doctor who are now or will in the future treat me while employed by or associated with this practice. I understand there are risks to injections including but not limited to severe pain, bruising, inflammation, injury, numbness, allergic reaction and infection. I do not expect the doctor to anticipate and or explain all risks and possible complications. I rely on the doctor to exercise judgment during the course of treatment with regards to any procedure. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

_____ I understand that injection therapies provided may not be approved by the United States Food and Drug Administration for the treatment of my medical condition.

____ **Consent to Intravenous Therapy:** I consent to all intravenous therapy procedures rendered by the doctor(s) who are now or will in the future treat me while employed by or associated with this practice. I understand that there are risks to intravenous therapy including but not limited to pain, bruising, inflammation, injury, infection, allergic reaction and metabolic disturbances. I do not expect the doctor(s) to anticipate and or explain all risks and possible complications. I rely on the doctor(s) to exercise judgment during the course of treatment with regards to my procedure. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

_____ I understand that injection therapies provided may not be approved by the United States Food and Drug Administration for the treatment of my medical condition.

I have read, understood and agreed to all of the above initialed policies.

_____ _____

Patient / Guardian Name (Print) Patient / Guardian Signature Date