Tahoe Center Of Natural Medicine

PO Box 6869 ◦ 600 North Lake Blvd ◦ Tahoe City, CA 96145◦ Phone 530-583-0002 ◦ Fax 530-583-0044

Name: ____ Date:___________________

Sex: M F Age: __________

Date of Birth: _______________ Single: _____ Married: ____ Significant Partnership: ____

Mailing Address: ______________________ City: __________ State: ______ Zip __________________________

Home Phone: ___________________ Cell Phone: __________________ Work Phone: _____________________

Email: ____

Best Way To Confirm Appointment _______________________________

Occupation/Employer ____

Emergency Contact:

Name: _____________________ Phone: _____________ Relationship: ____________

Who referred you, so we may thank them! _____________________________________

Financial Agreement: *I agree to full financial responsibility for services rendered at Tahoe Center of Natural Medicine and understand that payment is required in full at time of service unless prior arrangements were agreed to in advance. Notice of 24 hours is necessary for cancelled appointments. We reserve the right to charge for a missed appointment.*

____

Signature (patient/parent/guardian)

History Questionnaire

When did you last receive medical care?

____

Where did you last receive medical care?

____

What were you seen for?

____

What are your most important health problems that you want to discuss today?

1. ____
2. ____
3. ____
4. ____

Current Medications:

Over-the-counter & Prescriptions	Current Vitamins & Herbs
___________________________	______________________________
___________________________	______________________________
___________________________	______________________________
___________________________	______________________________
___________________________	______________________________

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Allergies: Please list any food, drug or other allergies: ____
____

What hospitalizations and or surgeries have you had and when: _________________________________
____
____

What x-rays, CAT scans, MRI's, EKG's have you had and when: _________________________________
____
____

Have you or your family members had any of the following?
□ Cancer __________ □ Diabetes __________ □ Heart problems __________ □ Stroke ____________
□ High Blood pressure ___________ □ Asthma, Hay fever, Hives __________ □ Osteoporosis ________

Height____ Weight ____ Weight 1 year ago ____ Maximum weight ____ When? ____

Please note past or present conditions by marking the appropriate box:

Past	Present	Condition
Neck		
□	□	Swollen
□	□	Goiter
Skin		
□	□	Rashes
□	□	Eczema, Hives
□	□	Acne, Boils
□	□	Itching
□	□	Color Change
□	□	Night Sweats
Head		
□	□	Headaches
□	□	Head Injury
Eyes		
□	□	Eye Pain
□	□	Tearing or Dryness
□	□	Changing Vision
□	□	Glaucoma
□	□	Cataracts
Ears		
□	□	Ringing
□	□	Earache
□	□	Dizziness
Nose and Sinuses		
□	□	Frequent Colds
□	□	Stuffiness
□	□	Nose Bleeds

Past	Present	Condition
Mouth and Throat		
□	□	Sore Throat
□	□	Sore Tongue
□	□	Gum Problems
□	□	Hoarseness
□	□	Difficulty swallowing
Respiratory		
□	□	Cough
□	□	Spitting Blood
□	□	Bronchitis
□	□	Pleurisy
□	□	Emphysema
□	□	Wheezing
□	□	Asthma
□	□	Shortness of Breath
□	□	Pain on breathing
□	□	Pneumonia
□	□	Tuberculosis
Bowel Movements:		
		How often? _______
		Is this a change ___?
Urinary		
□	□	Pain on urination
□	□	Increased frequency
□	□	Inability to hold urine
□	□	Frequent infections
□	□	Kidney Stones

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Past	Present	Condition
Cardiovascular		
☐	☐	Chest Pain
☐	☐	Angina
☐	☐	High blood pressure
☐	☐	Murmurs
☐	☐	Rheumatic fever
☐	☐	Anemia
Endocrine		
☐	☐	Fatigue
☐	☐	Hypothyroid
☐	☐	Heat or Cold intolerance
☐	☐	Excessive thirst
☐	☐	Excessive Hunger
Musculoskeletal		
☐	☐	Joint pain or stiffness
☐	☐	Arthritis
☐	☐	Broken Bone
☐	☐	Muscle Spasms/cramps
☐	☐	Weakness
☐	☐	Cold hands/feet
☐	☐	Varicose veins

Habits

Yes	No	
☐	☐	Do you exercise?
☐	☐	Eat 3 meals per day?
☐	☐	Sleep well?
☐	☐	Awaken rested?
☐	☐	Average 6-8 hrs of sleep
☐	☐	Use tobacco?
☐	☐	Use alcoholic beverages?
☐	☐	Sexually Active

Past	Present	Condition
Gastrointestinal		
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Gallbladder disease
☐	☐	Liver Disease
☐	☐	Change in Thirst
☐	☐	Change in appetite
☐	☐	Belching/passing gas
☐	☐	Heartburn
☐	☐	Ulcer
Emotional		
☐	☐	Depression
☐	☐	Mood swings
☐	☐	Anxiety or nervousness
☐	☐	Tension
Neurological		
☐	☐	Fainting
☐	☐	Seizures
☐	☐	Paralysis
☐	☐	Muscle weakness
☐	☐	Numbness or tingling
☐	☐	Loss of Memory
Male reproductive		
☐	☐	Hernia
☐	☐	Testicular masses
☐	☐	Prostate disease
☐	☐	Sexual difficulties
☐	☐	Discharge or sores
☐	☐	Venereal Disease

Number of Children?____________

Female Reproductive

Length of cycle__________
# of menstrual days _____
Are cycles regular? Yes ________ No _________

Number of abortions _______
Number of live births _______
Number of miscarriages ____
Number of pregnancies _____

Past	Present	Condition
☐	☐	Bleeding between periods
☐	☐	Painful menses
☐	☐	Excessive flow
☐	☐	Menopausal symptoms
☐	☐	Venereal disease
☐	☐	Difficulty conceiving
☐	☐	Sexual difficulties
☐	☐	Pain during intercourse

Do you use Birth Control? Yes ___ No ___
If so what kind? ______________________________

Breasts

Lumps Yes ___ No ___
Pain or tenderness Yes ___ No ___
Nipple discharge Yes ___ No ___
Do you do self exams? Yes ___ No ___

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PATIENT CARE FINANCIAL POLICY

We are a cash-based practice. At this time we are unable to accept insurance for any of our in-house services, full payment of all charges is required at time of service. We accept payment by cash, check, and credit card (MasterCard, Visa only). *Checks denied for insufficient funds will incur a fee of $35.00.* ***We are NOT recognized providers for MediCare, Medicaid or MediCal***.

At this time we are NOT contracted with any insurance providers, our services are not covered by insurance in CA. As a courtesy, we can provide you with a Super Bill for services rendered. This can be submitted to your insurance company for review of possible benefits. The provided Super Bill and any insurance submission for possible reimbursement are the sole responsibility of the patient. ***Copies of Super Bills can not be reproduced if lost, please maintain copies for your own files***.

The following are general guidelines to patient fees, final charges are determined based upon both time and complexity of the appointment. We reserve the right to adjust pricing without notification. If you have any questions about fees please feel free to ask.

First Office Call: $295-$325 *(This does not include required tests or supplements)*
Chiropractic Only: *$115*

Return Office Call:
15-minute: $75-95
30-minute: $150
45-minute: $175-225
60-minute: $225-250
Chiropractic only Follow-up: *$65*
Annual Prescription Renewal Appt: *$175-195 (30 min)*
Venipuncture: *$25-75 (varies depending upon blood processing requirements)*

Re-establishing Care: *Patients not receiving care for a period greater than 3 years will require a more comprehensive return office call to re-establish healthcare baselines.*

Phone Appointments: Charged accordingly with in-office visits. If you have any questions or concerns regarding this charge, feel free to ask at the time of your call. Phone consults are not reimbursed by insurance.

Emails: At this time we do not conduct patient communication via email.

Cancellations: We require a minimum of 24 hours for any changes to your scheduled appointment. *We reserve the right to charge for missed appointments, or appointments cancelled with less than 24 hours notice*.

Supplements: Nutritional supplements, herbs, homeopathics, etc are often recommended as a part of your treatment plan. We do carry most of the products we recommend at competitive prices, although you are free to purchase from any source you choose. However, products available to heath care providers are often of a higher quality not found in many of over-the-counter brands. Most supplements are NOT FDA approved for treatment of any condition.

Other Tests: We do not mark-up any outsourced testing services offered through our offices.

Patient/Guardian Signature ______________________ Date ______________

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INFORMED CONSENT FOR NATUROPATHIC TREATMENT

I acknowledge that I am accepting treatment from a licensed Naturopathic Doctor (N.D) at the Tahoe Center of Natural Medicine. I understand that there are intrinsic differences between the care of Naturopathic Doctors (N.D.'s) and Medical Doctors (M.D.'s).

Dr. Christina Campbell holds a Naturopathic License in the state of California. Dr. Campbell is also a licensed Chiropractor in California. In the State of California, Naturopathic Doctors are licensed to diagnose and treat disease and have limited prescriptive rights.

I hereby authorize Dr. Christina Campbell to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g. venipuncture, Pap smears, urine analysis.

Minor office procedures: e.g. ear lavage or skin scraping

Medicinal use of nutrition: e.g. therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.

Botanical medicine: e.g. botanical substances may be prescribed as teas, tinctures, capsules, tablets, creams, plasters, or suppositories.

Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.

Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.

Physical medicine: e.g. massage, hot and cold therapy, stretching, manipulation, electrical muscle stimulation, and therapeutic ultrasound.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks include but are not limited to: allergic reactions and other side effects to prescribed herbs and supplements; aggravation of pre-existing symptoms; discomfort, pain, infection, burns, nausea, light headedness; inconvenience of lifestyle changes, injury from injections, venipuncture, or other procedures. Please notify Tahoe Center of Natural Medicine if you experience any symptoms which may be secondary to the above procedures.

Potential benefits include but are not limited to: restoration of health and the body's maximal functional capacity without the use of drugs or surgery; 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 doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

At this time, it is my decision to pursue Naturopathic treatment. I do understand that, as with any medical treatment, there is no guarantee that this treatment will offer complete resolution to any or all of the conditions I may have. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the Tahoe Center of Natural Medicine, or any of its personnel, regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures/ treatments at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself, or my representative, or as required by law.

____ Date _______________

Patient/Guardian Signature

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FINANCIAL DISCLAIMER

I claim full responsibility for services rendered at the Tahoe Center of Natural Medicine (TCNM). I understand that payment is required at the time of service, unless other arrangements have been made.

Naturopathic care is not recognized by Medicare or Medicaid. We are not contracted providers with either system. Any care provided through our offices can NOT be billed to either Medicare or Medicaid.

A Super Bill with diagnostic and procedural information is provided for you to submit to your insurance company for possible reimbursement. Again, this does not apply to either Medicare or Medicaid. At this time I understand there is no official insurance reimbursement for naturopathic care. TCNM does not submit to insurance on the behalf of the patient, it is the sole responsibility of the patient. The Super Bill is provided at the time of service, they can not be reproduced later and should be maintained for your own records.

It is our policy we receive 24-hour cancellation notice. If we do not, we reserve the right to charge the full fee for a missed appointment.

____ ______________

Patient Signature Date

PRIVACY RULE CONSENT

By signing this form, you are giving Tahoe Center of Natural Medicine permission to use and disclose your protected health information for the purposes of treatment and payment associated with your care.

We have a "Notice of Privacy Practices" that provides more detailed information regarding how we may use and disclose your health information. You have the right to review this document detail at any time. You have the right to request restrictions on how we may use and disclose your health information. We are not required by law to agree with your request, but we will do whatever we can to accommodate requests that are reasonable. You also have the right to revoke this consent in writing at any time, unless your health information has already been used or disclosed in reliance on this consent for the diagnosis, treatment or payment for the medical services for which you sought treatment.

A copy of our "Notice of Privacy Practices" may be obtained by contacting our offices at 530-583-0002, or in writing at POB 6869, Tahoe City, CA 96145. Please note that our "Notice of Privacy Practices" may be changed as needed to comply with Federal Law.

____

Printed Name

____ ______________

Patient Signature Date

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

I, ____, hereby acknowledge that The Tahoe Center of Natural Medicine 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 the office's Privacy Officer:

Christina Campbell
(530) 583-0002

I also understand that I am entitled to receive updates upon request if the Tahoe Center of Natural Medicine amends or changes it Notice of Privacy Practices in a material way.

____ _______________________________

Signature

Relationship to Patient- if signed by someone other than the patient

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THIS SECTION IS TO BE COMPLETED BY THE TAHOE CENTER OF NATURAL MEDICINE IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT 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

_____________________________________ _______________________________

Name and title of employee

Date