WOLFEBORO NATUROPATHIC MEDICINE

Dr. Steve Clark ND
646 Center Street, Wolfeboro, NH 03894
Phone: (603) 569-5545 Fax: (603) 569-0545
www.wolfeboronaturopathic.com

Last name____________________________ First name_____________________________ MI_______

Mailing address______________________________ Town, state, zip ____________________________

Phone # (H)_______________________ (W)__________________________ (Cell)___________________

Email_______________________________ Date of Birth____________________ Age______________

How did you hear about us?__________________________

Height____’_____” Blood Pressure_______/_________ When?_________________________

Weight (current)______lbs One year ago______lbs Max weight_______lbs When?_____________

Do you know what Naturopathic medicine is? Yes____ No____

How familiar are you with “health foods”? Use the scale below.

Not at all 1 2 3 4 5 6 7 8 9 10 Very familiar

What current health goals would you like to address with Dr. Clark?

1.
2.
3.
4.
5.

To the best of your memory, please give a brief description of what you ate for breakfast, lunch, and dinner in the last two to three days. Include snacks, beverages and water intake.

//////////////////	TODAY	YESTERDAY	DAY BEFORE
BREAKFAST			
LUNCH			
DINNER			
SNACK			

Does this represent a “normal” diet for you? Yes______ No_______

If not, please explain:____

____

____

Alcohol use: Drinks/day?____________________ For how long_______________________

Cigarette use: _____No _____Yes , pack/day_____________ For how long _____________

Recreational drugs: _____ No Yes, specify:

Symptoms Questionnaire:
Please check the box for appropriate current or past symptoms.

	Present	Past	Severity: Mild	Severity: Severe
CIRCULATION				
Deep leg pain..........	☐	☐	☐	☐
Cold hands/feet.........	☐	☐	☐	☐
Swelling in ankles......	☐	☐	☐	☐
Easy bleeding/bruising	☐	☐	☐	☐
DIGESTIVE				
Nausea/vomiting.......	☐	☐	☐	☐
Diarrhea................	☐	☐	☐	☐
Constipation...........	☐	☐	☐	☐
Bloated feeling.........	☐	☐	☐	☐
Belching or gas.........	☐	☐	☐	☐
Heartburn...............	☐	☐	☐	☐
Change in thirst.........	☐	☐	☐	☐
Change in appetite.....	☐	☐	☐	☐
Blood in stool..........	☐	☐	☐	☐

Bowel movements: How often?____________ Is this a change? Yes_____ No______

	Present	Past	Severity: Mild	Severity: Severe
EARS				
Ear aches/infections....	☐	☐	☐	☐
Itchy....................	☐	☐	☐	☐
Ringing/hearing loss...	☐	☐	☐	☐
EMOTIONAL				
Mood swings...........	☐	☐	☐	☐
Anxiety.................	☐	☐	☐	☐
Anger/irritability.......	☐	☐	☐	☐
Depression.............	☐	☐	☐	☐
ENDOCRINE				
Heat or cold intolerant.	☐	☐	☐	☐
Excessive thirst.........	☐	☐	☐	☐
Excessive hunger.......	☐	☐	☐	☐
ENERGY				
Fatigue/sluggishness...	☐	☐	☐	☐
Apathy/lethargy........	☐	☐	☐	☐
Hyperactivity...........	☐	☐	☐	☐
Restlessness............	☐	☐	☐	☐
EYES				
Watery/itchy...........	☐	☐	☐	☐
Swollen/red/sticky.....	☐	☐	☐	☐
Pain......................	☐	☐	☐	☐

	Present	Past	Severity: Mild	Severity: Severe
Dry eyes................	☐	☐	☐	☐
Blurred/tunnel/double. vision	☐	☐	☐	☐

HEAD
Headache/migraine…..
Faintness……………..
Dizziness…..…………
Insomnia…...…………
Jaw pain………………

HEART
Irregular or skipped….
beat
Rapid or pounding…..
Chest pain……………

JOINTS OR MUSCLES
Pain in joints…………
Stiffness or limitations.
Pain or aches in muscle
Muscle weakness…….

LUNGS
Chest congestion…….
Deep chest coughing…
Shortness of breath…..
Difficulty breathing….
Pain on breathing…….
Spitting up blood…….
Wheezing……………

MIND
Poor memory…………
Confusion……………
Poor concentration…..

MOUTH AND THROAT
Chronic coughing……
Gagging or throat ……
clearing
Sore throat/horse…….
Swollen or discolored.
tongue
Canker sores…………
Difficulty swallowing..

	Present	**Past**	**Severity** Mild	Severe

NECK
Lumps……..…………
Swollen glands………
Pain or stiffness………
Muscle tension………

NEUROLOGIC
Seizures………………
Paralysis…..…………

Numbing or tingling… ☐ ☐ ☐ ☐
Vision changes……… ☐ ☐ ☐ ☐

NOSE
Stuffy nose..………… ☐ ☐ ☐ ☐
Sinus problems……… ☐ ☐ ☐ ☐
Hay fever…..………… ☐ ☐ ☐ ☐
Sneezing attacks…….. ☐ ☐ ☐ ☐
Excessive mucus……. ☐ ☐ ☐ ☐
Nose bleeds..………… ☐ ☐ ☐ ☐

SKIN
Acne/boils…………… ☐ ☐ ☐ ☐
Hives/rash/dry skin…. ☐ ☐ ☐ ☐
Hair loss…..………… ☐ ☐ ☐ ☐
Flushing or hot flashes. ☐ ☐ ☐ ☐
Excessive sweating…. ☐ ☐ ☐ ☐
Night sweats………… ☐ ☐ ☐ ☐
Itching……..………… ☐ ☐ ☐ ☐
Color change………… ☐ ☐ ☐ ☐
Lumps……..………… ☐ ☐ ☐ ☐
Rashes……..………… ☐ ☐ ☐ ☐

URINARY
Pain on urination……. ☐ ☐ ☐ ☐
Increased frequency…. ☐ ☐ ☐ ☐
of urination
Frequency at night….. ☐ ☐ ☐ ☐
Inability to hold urine.. ☐ ☐ ☐ ☐

WEIGHT
Binge eating/drinking.. ☐ ☐ ☐ ☐
Craving certain foods.. ☐ ☐ ☐ ☐
Excessive weight……. ☐ ☐ ☐ ☐
Compulsive eating….. ☐ ☐ ☐ ☐
Water retention……… ☐ ☐ ☐ ☐
Underweight………… ☐ ☐ ☐ ☐

FEMALE REPRODUCTIVE (if applicable)
Age menses began ________years old
Average length of cycle ________days
Average length of bleeding ________days
Are you sexually active? ______No ______Yes
Do you use birth control? ______No ______Yes
Which method of birth control?____
Number of pregnancies ________
Number of live births ________
Number of miscarriages ________
Number of abortions ________

	Present	**Past**
Bleeding between…… periods	☐.	☐

Pain during intercourse ☐ ☐
Painful menses……… ☐ ☐
Irregular cycles……… ☐ ☐
Excessive flow……… ☐ ☐
Menopausal symptoms ☐ ☐
Sexual difficulties…… ☐ ☐
Sexually transmitted… ☐ ☐
disease

BREAST Do you do self exams? ____No _____Yes
Lumps……..………… ☐ ☐
Pain or tenderness…… ☐ ☐
Discharge….………… ☐ ☐

Have you used any hormone modulating treatments: Ie birth control, bioidentical hormones, estrogen replacement. Hormone blockers including hormone modulating chemotherapy:
Specify:

MALE REPRODUCTIVE (if applicable)
Hernias……………… ☐ ☐
Testicular masses…… ☐ ☐
Testicular pain……… ☐ ☐
Prostate disease……… ☐ ☐
Discharge or sores…… ☐ ☐
Sexually transmitted… ☐ ☐
disease
Sexual difficulties…… ☐ ☐
Are you sexually active? ____No _____Yes

Have you used any hormone modulating treatments: Ie bioidentical hormones, testosterone replacement. Hormone blockers including hormone modulating chemotherapy:
Specify:

FAMILY history of significant illness:
____
____
____
____
____
____

Have you had any ALLERGY OR INFLAMMATORY REACTIVE SYMPTOMS to internal or external triggers including,
Food allergies/reactions, chemical sensitivity, environmental exposure reactions, topical dermatitis, etc.

OTHER HEALTH CONCERNS, CHRONIC CONDITIONS, ISSUES OF NOTE:

Medications & Supplements (attach separate sheet if necessary):

Signature

Date

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FINANCIAL POLICY

PAYMENT IS DUE WHEN SERVICES ARE RENDERED

SCHEDULE OF FEES AND SERVICES

Dr. Steve Clark, ND & Dr. Erik O Nelson, ND

Hourly rate: $260

New Patient and Established Patient Visits:

15 min	$65
30 min	$130
45 min	$195
60 min	$260
90 min	$390
120 min	$520
Blood draw charge	$50

Physical medicine appointments follow the above fee schedule.

CHECK-IN AND PAYMENT PROCEDURES

Please check in with the front office prior to each appointment. The staff will let you know when we are ready to start your appointment. At the end of your appointment, proceed to the front office where you will be provided an itemized Service Summary invoice. We accept cash, check, MC, VISA, or Discover. We add a 1% surcharge for AMEX due to higher merchant rates. The Service Summary will be returned to you as your receipt.

Note: In the case of a pandemic, guidelines from the CDC and WHO regarding medical offices will be followed. This includes the use of masks, social distancing and other safety precautions.

INSURANCE

Insurance companies may have specific policies or riders that cover naturopathic services. It is the patient's responsibility to ascertain this. The office of Wolfeboro Naturopathic Medicine will not bill insurance directly and is not contracted with any insurance company. Health insurance claim forms (HICFA) are available upon request. Please request a HICFA form directly from staff during your appointment. You can submit this HICFA directly to your insurance in attempt to get reimbursed, however reimbursement is not guaranteed. Wolfeboro Naturopathic Medicine does not otherwise assist with reimbursement efforts or communicate directly with your insurance company. If information beyond a coded bill is requested, *we will charge our*

regular billing rate to process those requests. This includes but is not limited to: pre-approvals, release of records, documentation for motor vehicle accidents, workers compensation or paperwork related to testing, treatments or prescriptions.

PHONE CONVERSATIONS

In accordance with RSA § 310:7 Dr. Clark and Dr. Nelson are licensed Naturopathic doctors in the state of New Hampshire, and **I the patient, confirm I am located in the state of New Hampshire for the first appointment, whether that be physically in person or via telehealth.**
Dr. Clark and Dr. Nelson shall be authorized to provide consultation services or follow-up care via telehealth to a patient who previously received services from the provider in the state of New Hampshire where the provider is licensed.

If you call for clarification regarding a recent visit, we will do our best to clarify the information presented in that appointment. Patients calling about new conditions, acute conditions, review of previous treatments, or expanded conversations, will be directed to schedule a follow-up appointment. If you are unsure whether or not there will be a charge for the doctor's time, please ask. Phone and video appointments are available and are billed at the same rate as in-office appointments. The amount of time it takes to clarify your notes, prepare and ship medicinary items, prepare lab kits and requisitions, etc., will be added to the Service Summary.
We are unable to accommodate international appointments due to the difficulty in processing medical requests and treatments. The State of New York places extensive restrictions on health care including testing and services. Accepting residents of New York as patients is at the discretion of the staff of Wolfeboro Naturopathic Medicine.

MEDICINARY

We are unable to dispense any medicinary items without payment. Please plan ahead in refilling your medicines. Twenty-four hours advance notice will help the doctors and staff manage our time in preparing your order. Staff will not dispense new medicinary items for patients without Dr. Clark's or Dr. Nelson's approval. UNOPENED items may be returned to the office for refund or exchange within 30 days of purchase only if the product was properly cared for (e.g. probiotics were stored in cool temperatures). Our staff reserve the right to determine if a product is restockable and eligible for refund or exchange. Custom tinctures and special order items are not returnable. We change inventory pricing based on our costs and current market value, and prices are subject to change. We do not ship inventory internationally.

LABS

Under no circumstances will labs be sent out without payment first. Please be prepared to pay for your lab work the day it is performed. Our test prices fluctuate according to what we are charged, and are subject to change without notice. You may request a refund for a test that was purchased but not completed within one year from the date of purchase. In most cases the test kit will not need to be returned, but it must be disposed of properly after a refund is issued. In some cases a laboratory or hospital can submit your test cost directly to your insurance provider. The cost of those tests change when the laboratory or hospital submits your invoice directly. If direct insurance billing options are available, it is at the patient's discretion to select that service. We will still charge a phlebotomy fee and/or lab preparation fee for labs that are billed directly to your insurance. Other costs incurred beyond phlebotomy or preparation will be billed from the lab or hospital, directly to you at your home address. You, the client, will be responsible for all charges and fees incurred using direct insurance billing. Wolfeboro Naturopathic Medicine is in no way responsible for coverage, or lack thereof, for those test services when laboratories bill your insurance directly.

CANCELLATION POLICY

Your appointment time is reserved for you. Please be courteous and give us 24 hours notice if you are unable to make your appointment. This allows us to help as many patients as possible. We understand that occasional emergencies and illnesses result in missed appointments. *We reserve the right to charge for repetitive missed appointments without appropriate notice*. The charge for missed appointments will start at $50, though may be higher based on the length of missed appointments and number of appointments missed, not to exceed $200.

REVIEW OF RECORDS

If you are able to obtain copies of past lab results, please bring them to your first appointment. *In the event that you have an extensive history of health issues that requires a significant amount of the doctor's time to review, time will be billed according to the doctor's fee schedule*. This includes but is not limited to review of complex testing or extensive case history.

SPECIAL ORDERS

We are happy to try to obtain special medicinary or prescription items that we don't typically stock. Please give us plenty of advance notice. We will require payment prior to ordering said items. We do not allow returns of special order items.

RETURNED CHECK FEE AND LATE PAYMENT.

There will be a returned check fee of $30. If for some reason you are late in payment, or there are other "disruptions or delays" in payment, an additional 10% will be added to the monthly balance. Wolfeboro Naturopathic Medicine does not accept payment plans.

RIGHT TO DISCONTINUE CARE

The doctor/patient relationship is sacred at Wolfeboro Naturopathic Medicine. Dr. Steve Clark, N.D. and Dr. Erik O. Nelson, N.D. have the right to discontinue care for any patient at our discretion. Reasons to discontinue care include but are not limited to: interacting with the staff in a hostile or inappropriate manner, skipping appointments without notice, non-payment, or acting in any manner that causes us to feel unsafe. This process will be accomplished in writing and is non-reversible. Discontinuation of care for one practitioner will extend to all practitioners and will also include access to medicinary items, prescriptions, lab requisitions and all provided services. Federal law allows you access to your medical files which will be sent to you or a different practitioner responsible for your care provided proper Release of Records paperwork has been filed.

I have received a copy of the above Financial Policy.

____

Patient Signature   Date

If you are a minor, or if you are being represented by another party:

______________________	______________________	____________
Representative (Printed)	Representative Signature	Date

Description of authority of person acting on behalf of the patient:________________________________

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Informed Consent Document

PATIENT NAME: ____ Date of Birth:________________

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of Naturopathic medicine

The primary treatments used by doctors of naturopathy are natural, non-invasive techniques which stimulate the body's natural healing capacity. Naturopathic medicine is considered a complement to traditional allopathic medicine. We may use clinical nutrition, pharmacologic medications, botanical treatments, injectable nutraceuticals, lifestyle counseling and physical medicine to treat you. Informed consent will be discussed.

Analysis / Examination / Treatment

As a part of your case history you are consenting to the analysis, examination, and treatment recommended by our clinic. This may include a consented physical examination including specific urine, blood, saliva, stool, hair or other laboratory tests.

The material risks inherent in Naturopathic medicine. As with any healthcare procedures, there are certain complications which may arise during even the most basic of Naturopathic treatments. These complications may include, but are not limited to, aggravation of pre-existing conditions, allergic reactions to supplements, herbs and injections, complications in certain physiological conditions such as pregnancy, lactation, medication interactions, young children, elderly patients, or those with specific diseases such as heart, liver, kidney, cancer, or diabetes. Complications from any manipulative therapy provided include, but are not limited to, fractures, disc injuries, muscle strain, cervical myelopathy, costo-vertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor of such conditions. Please advise the Doctor if you are pregnant, suspect you are pregnant, are trying to become pregnant, or if you are breast- feeding. I understand that my Doctor will answer any questions that I have to the best of their ability. I understand that, as with any type of treatment, results cannot be guaranteed. I do not expect my Naturopathic Doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to the assessment and therapeutic procedures/treatments recommended by the Doctor.

Pregnancy: All female patients must alert the Doctor if they know or suspect they are pregnant as some of the therapies used could present a risk to pregnancy. All individuals with bleeding disorders, pace makers, and/or cancer must also alert the Doctor. ______ (Initials)

The relationship with other healthcare providers

Naturopathic Medicine may be a complement to traditional allopathic medicine. I acknowledge that I have been informed and I understand that:

- Any treatment or advice provided to me as a patient is not mutually exclusive from any treatment or advice that I may now be receiving, or may in the future receive, from any other licensed health care provider.
- I am at liberty to seek or continue medical care from a physician or surgeon or other qualified health care provider.
- No employee or other practitioner under our clinic's direction or control is suggesting or advising me to refrain from seeking or following the directions of another licensed health care provider.
- The treatment and therapies rendered or recommended by our clinic may be different than those usually offered by a medical doctor or other licensed health care provider.

_________ (Initials)

The availability and nature of other treatment options

Other treatment options for your condition may include:

• Self-administered, over-the-counter analgesics and rest

• Medical care and prescription drugs • Hospitalization

• Surgery

If you chose to use one of the above noted other treatment options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may worsen your condition. Over time this may complicate treatment making it more difficult and less effective the longer it is postponed.

In the case of pandemic or natural emergencies Dr. Steve Clark, ND PLLC will act according to current CDC and WHO guidelines as applicable to a medical office, to the best of our ability.

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize (*insert your name*) to perform diagnostic tests and render naturopathic therapies and other treatment to my minor son/daughter:_______________________________. This authorization also extends to all other doctors and office staff members and is intended to include laboratory and radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Informed consent to treatment:

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the naturopathic medicine and related treatment. I have discussed it with *(insert your name)* and have had my questions answered to my satisfaction. I understand that it is my responsibility to request the Doctor to explain therapies and procedures to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: ______________________________________

Patient's Name: ______________________________

Signature: __________________________________

Signature of Parent or Guardian (if a minor): ____

Dated: _____________________________________

Date of Birth:________________________________

Doctor's Name: ______________________________

Signature: ___________________________________

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

NOTICE OF PRIVACY PRACTICES

In the course of your care as a patient of Dr. Clark's, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital for the purposes of providing, managing and/or coordinating healthcare or healthcare related services. For example, your case may be discussed between Dr. Clark and his staff.
- Your healthcare records, as well as your billing records, may be disclosed to another party such as an insurance carrier, HMO or PPO, an attorney, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and your healthcare records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of some interest to you.
- We may use and disclose your health information in connection with other healthcare operations. This includes quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
- If you are not at home to receive an appointment reminder, a message may be left on your answering machine or voice mail system. You have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Your authorization:

- You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

To your family & friends:

- If you agree, we may disclose your health information to a family member, friend or other persons to the extent necessary to help with your healthcare or with payment for your healthcare. Your family or friends are permitted in the room during your treatment with your permission. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up supplies, medicinary items, labs or other similar forms of health information.

Alternative communication:

- We normally provide information about your health to you in person at the time you receive treatment from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preferences. Your request must specify how payments will be handled under the alternative means or location you request.

Persons involved in care:

- In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care. If you are present, we will provide you with an opportunity to object to the use or disclosure of your health information prior to such uses or disclosures.

Marketing health related services:

- We will not use your health information for marketing communications without your written permission on the Patient Authorization form.

Required by law:

- We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices, our legal duties, and your rights with respect to your health information.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing healthcare services to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Abuse or neglect:

- We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Patient Rights:

Amendment & Access

- You have the right to inspect and/or copy your health information, with limited exceptions, for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Your request must be in writing and must explain why the information should be amended. We may deny your request under certain circumstances. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address on the front of this Notice. If you request copies, we will charge you $0.25 for each page, $20 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you.

Disclosure Accounting

- You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last six years but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Electronic Notice

- If you receive this Notice on our web site or by electronic mail (email) you are entitled to a hard copy.

- We reserve the right to alter or amend the terms of this privacy notice but we are required by law to abide by the terms of this Notice while it is in effect. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.
- Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.
- If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, you may issue your complaint to us by contacting the privacy officer on the front of this form. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with their address upon request.
- This Notice is effective as of June 1srt, 2021. This Notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this Notice.

Name (print:) Signature: Date:

If you are a minor, or if you are being represented by another party:

Representative (print) Representative signature: Date:

Description of authority of person acting on behalf of the patient:

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PATIENT AUTHORIZATION

The purpose of this form is to gain your permission to use your personal health information. Our concern for your confidentiality has not changed. We are required by the federal government to institute several new procedures. In compliance with the new federal regulations of the Health Insurance Portability and Accountability Act (HIPAA) we ask you to consider and approve the following:

Our staff may use your name, address, and/or telephone number for the purpose of contacting you to remind you about scheduled or missed appointments, re-evaluations, or other appointment related issues. We may send out various mailings such as, but not limited to, birthday cards, referral thank-you cards, and newsletters that may contain promotional offers or incentives.

We would like to continue to use your name, address, and/or telephone number for the purpose of contacting you to advise you about health related news, meetings, lectures, seminars, workshops, and other educational events.

We have testimonials submitted by our patients so that others may see the astounding results of continued naturopathic care, and we may ask your permission to participate in this activity. We display artwork created and sometimes signed by children in the waiting room. Patient files are sometimes stacked on the receptionist's desk and a patient's name may be in view; however, there is never any public access to personal information.

We intend to make your experience with our office more efficient, productive, and to further enhance your access to quality health care. You may refuse to sign this authorization. If you chose not to sign it, your decision will have no adverse effect on your care from Dr. Clark, or your relationship with our staff.

I agree with all statements made in this policy with the exceptions written below (if applicable).

Name: (print)____________________________ Signature: ______________________________ Date:______________

If you are a minor, or being represented by another party:

On what authority do you act on behalf of the patient: ______________________________________

Name: (print)____________________________ Signature: ______________________________ Date:______________

This authorization expires seven years from the date of signature. This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw. Please allow 60 days for the change in our system to be completed.

Wolfeboro Naturopathic Medicine
646 Center Street, Wolfeboro, NH 03894
Phone: (603) 569-5545 Fax: (603) 569-0545
www.wolfeboronaturopathic.com

Informed Consent for Treatment of Persistent Lyme Disease

Patient-centered care focuses on shared medical decision-making that takes into account the individual
circumstances and values of the patient. It is particularly important when the evidence base is uncertain. Patient involvement is also critical to make the "right choice" when different combinations of treatment options, uncertain outcomes and implicit trade-offs exist. Under shared decision-making, clinicians are viewed as the experts in the evidence and patients are the experts in what matters most to them.

There is considerable uncertainty regarding the diagnosis and treatment of Lyme disease. No single diagnostic and treatment program for Lyme disease is universally successful or accepted. Medical opinion is divided, and two schools of thought regarding diagnosis and treatment exist. Each of the two schools of thought is described in peer-reviewed, evidence-based treatment guidelines. Until we know more, patients must weigh the risks and benefits of treatment in consultation with their doctor.

Diagnosis. The diagnosis of Lyme disease is primarily a clinical determination made by the doctor based on your exposure to ticks and your signs and symptoms of the disease, with diagnostic tests playing a supportive role. Doctors differ in how they diagnose Lyme disease.

- Some physicians rely on the narrow surveillance case criteria of the CDC for clinical diagnosis even though the CDC itself cautions against this approach. These physicians may fail to diagnose some patients who actually have Lyme disease. These patients are likely to develop a more complicated and difficult-to-treat illness.
- Other physicians use broader clinical criteria for diagnosing Lyme disease. These physicians believe it is better to err on the side of treatment because of the serious consequences of failing to treat active Lyme disease. These physicians sometimes use the antibiotic responsiveness of the patient to assist in their diagnosis. Since no treatment is risk-free, use of broader clinical criteria to diagnose disease could in some cases expose patients to treatment side-effects and complications. This approach may result in a tendency to over-diagnose and over-treat Lyme disease.

Treatment Options. The medical community is divided regarding the best approach for treating persistent Lyme disease. At this time, many physicians follow the treatment guidelines of the Infectious Diseases Society of America (IDSA) that recommend short-term treatment only. They view the long-term effects of Lyme disease as an autoimmune process or permanent damage that is unaffected by antibiotics. Other physicians believe that the infection persists, is difficult to eradicate, and therefore requires long-term treatment with intravenous, intramuscular, or oral antibiotics, frequently in high and/or combination doses. These physicians follow the guidelines promulgated by the International Lyme and Associated Diseases Society (ILADS).

The guidelines of the IDSA strongly recommend against many of the common treatment approaches used by physicians who follow the ILADS guidelines, including larger doses of antibiotics, combination antibiotic therapy, repeated therapy, and pulsed-dosing (antibiotics used on some days, but not others).

Potential Benefits of Treatment. Very few clinical trials on the treatment of persistent Lyme disease have been conducted, the sample size have been small, and the results have conflicted. Some clinical studies support longer term treatment approaches, while others do not. In addition, patients vary in their clinical manifestations, the presence of co-infections, and their response to treatment.

Deciding Whether to Treat. There are potential risks involved in using any treatment, just as there are in foregoing treatment entirely. Some of the problems with antibiotics may include (a) allergic reactions, which may manifest as rashes, swelling, and breathing difficulty; (b) stomach or bowel upset; or (c) yeast infections. Severe allergic reactions may require emergency treatments, while other problems may require suspension of treatment or adjustment of medication. Other problems such as adverse effects on liver, kidneys, gallbladder, or other organs may occur. Patients who elect not to treat run the of permitting an infectious process to progress.

Factors to consider in your decision. No one knows the optimal treatment of symptoms that persist after a patient is diagnosed with Lyme disease and treated with a simple short course of antibiotic therapy. The appropriate treatment may be supportive therapy without the administration of any additional antibiotics. Or, the appropriate treatment might be additional antibiotic therapy. If additional antibiotic therapy is warranted, no one knows for certain exactly how long to give the additional therapy.

By taking antibiotics for longer periods of time, patients incur a greater risk of developing side effects. By stopping antibiotic treatment, patients incur a greater risk that a potentially serious infection will progress. Antibiotics are the only form of treatment shown to be effective for Lyme disease, but not all patients respond to antibiotic therapy. There is no currently available diagnostic test that can demonstrate the eradication of the Lyme bacteria in a patient. Other forms of treatment designed to strengthen the immune system also may be important. Some forms of treatment are only intended to make patients more comfortable by relieving symptoms and do not address any underlying infection.

The decision about continued treatment may depend on a number of factors and the importance of these factors to the individual patient, including (a) the severity of illness and degree to which it impairs quality of life, (b)whether co-infections are present,(c) a patient's ability to tolerate antibiotic treatment and the risk of major and minor side effects associated with the treatment, (d) whether the patient has been responsive to antibiotics in the past, (e) whether the patient's illness relapses or progresses when antibiotics are stopped, (f) the patient's willingness to accept the risk that, left untreated, a bacterial infection potentially may get worse, and (g) the costs associated with treatment.

For example, patients with severe illness that significantly affects quality of life who have been responsive to antibiotic treatment in the past, may wish to continue treatment. Patients who have been unresponsive to previous treatment, have less severe illness, or who are reluctant to take antibiotics may wish to terminate treatment. You can ask your doctor if you need any more information to make this decision and have the right to obtain a second opinion at any time if you think this would be helpful.

Antibiotics: I realize that the choice of treatment approach to use in treating my condition is will be a shared decision between me and my physician. After weighing the risks and benefits of the two treatment approaches, I have decided: (CHECK ONE)

□	To treat my Lyme disease through a treatment approach that relies heavily on clinical judgment and may recommend using antibiotics until my clinical symptoms resolve. I recognize that this treatment approach does not conform to IDSA guidelines and that insurance companies may not cover the cost of some or all of my treatment. I understand that I may stop treatment at any time.
□	Only to treat my Lyme disease with antibiotics for thirty (30) days, even if I still have symptoms.
□	Not to pursue antibiotic therapy
□	To treat my lyme disease with antibiotics for several months, and then re-evaluate. I may decide to continue antibiotic or discontinue with the possibility of utilizing other alternative treatments. I accept that this may lead to treatment failure and that this is my choice and not a consequence of poor medical practice on the part of my doctor.

To my knowledge, I am not allergic to any medications except those listed below:

-
-
- ____

I understand the benefits and risks of the proposed course of treatment, and of the alternatives to it, including the risks and benefits of foregoing treatment altogether. My questions have all been answered in terms I understand. All blanks on this document have been filled in as of the time of my signature.

Signature: ____

Date: ____

Print Name: _______________________________________

Handout adapted from Lymedesease.org 2021

Lyme Disease Symptoms:

The symptoms of Lyme disease are extraordinarily extensive. While you are highly unlikely to experience all, or even most, it is important to know what might be associated with this multi-symptom disease so that you can seed appropriate medical help promptly.

The tick bite
If you get a rash it may be:
Raised, hot to the touch, itchy, crusty or oozy
Circular, spreading out, oval, triangular or long thick line.
Disappear and return at the site of the bite or on other parts of your body
(Note: you may never see a tick or you may never get the rash. Generally the rash is larger than a fifty cent piece.)

Head, Face, Neck:
• Headaches • Facial paralysis ("Bell's palsy") • Tingling sensations • Stiff neck • Sore throat, swollen glands • Heightened allergic sensitivities • Twitching of facial/other muscles • Jaw pain/stiffness ("TMJ") • Change in smell or taste

Digestive/Excretory System:
• Upset stomach (nausea, vomiting) • Abdominal pain • Irritable bladder • Unexplained weight loss or gain
• Loss of appetite, anorexia

Respiratory/Circulatory Systems:
• Difficulty breathing, air hunger • Night sweats or unexplained chills • Heart palpitations • Diminished exercise tolerance • Heart block, murmur • Chest pain or rib soreness

Psychiatric Symptoms:
• Mood swings, irritability, agitation • Depression and anxiety • Malaise • Aggressive behavior / impulsiveness
• Suicidal thoughts (rare cases of suicide) • Overemotional reactions, crying easily
• Disturbed sleep: too much, too little, difficulty falling or staying asleep
• Feeling as though you are losing your mind • Obsessive-compulsive behavior

Cognitive Symptoms:
• Forgetfulness, memory loss • Attention problems, distractibility • Confusion, difficulty thinking • Difficulty with concentration, reading, spelling • Disorientation: getting lost in familiar areas

Reproduction and Sexuality
Females:
• Unexplained menstrual pain, irregularity • Reproduction problems, such as miscarriage, stillbirth, premature birth, neonatal • Extreme PMS symptoms • Pelvic pain

Males:
• Testicular or pelvic pain

Eye, Vision:
• Double or blurry vision • Sensitivity to light • Eye pain
• Floaters

Ears/Hearing:
• Decreased hearing • Ringing or buzzing in ears • Sound sensitivity • Pain in ears

Musculoskeletal System:
• Joint pain, swelling, or stiffness • Shifting joint pains • Muscle pain or cramps • Poor muscle coordination, loss of reflexes • Loss of muscle tone, muscle weakness

Neurologic System:
• Numbness in body, tingling, pinpricks • Burning /stabbing sensations in the body • Burning sensations in feet • Weakness or paralysis of limbs • Tremors or unexplained shaking • Seizures, stroke • Poor balance, difficulty walking • Increased motion sickness, wooziness • Lightheadedness, dizziness • Encephalitis (inflammation of the brain) • Meningitis (inflammation of the protective membrane around the brain) • Encephalomyelitis (inflammation of the brain and
spinal cord) • Difficulty with multitasking • Difficulty with organization and planning • Word finding problems • Slowed speed of processing

Skin Problems:
• Erythema Migrans (rash) • Benign nodules • ACA degenerative chronic atrophy of skin

General Well-being:
• Decreased interest in play (children) • Extreme fatigue
• Unexplained fevers (high or low grade) • Flu-like symptoms (early in the illness) • Symptoms seem to change or come and go

Other Organ Problems:
• Dysfunction of the thyroid (under or over active) • Bladder & kidney problems (including bed wetting, urgency/frequency to urinate) • Newly developed beef or meat allergy (usually from Lonestar ticks)