WOLFEBORO
NATUROPATHIC
MEDICINE

Naturopathic Intake:
Dr. Erik O. Nelson, ND

Legal Name:

____

How would you like to be addressed?

____

Date of birth?

____

Mailing Address:

____

Land Address:

____

Email:

____

Phone numbers:
Home:
Cell:
Work:

____

What is your gender?

☐ **Male** ☐ **Female** ☐ **Other:___________**

Thank you for taking the time to fill out this intake form. We know it's comprehensive, but by gathering this information about your health history and goals helps give your naturopathic doctors a more complete understanding of you. We want to help you reach your optimal health.

CONCERNS:

Most important concern you would like to address?

____

Additional concerns?

____

FAMILY HISTORY:

Grandparents:
Ages:
Living/Deceased:

Parents:
Ages:
Living/Deceased:

Siblings:
Ages:
Living/Deceased:

Has any blood relatives ever had any of the following?

☐ Cancer	☐ Tuberculosis
☐ Asthma	☐ Mental illness or suicide
☐ Diabetes	☐ High blood pressure
☐ Allergies	☐ Autoimmune disease
☐ Heart attack	☐ Heart Disease
☐ Stroke	☐ Osteoporosis
☐ Other:	

If YES, check appropriate box and please indicate who below (maternal aunt, paternal grandmother, father, son, sister, etc)

MEDICAL HISTORY:

Who is your primary care physician Please include address, phone & fax number:

Please indicate the doctors or practitioners that have been involved in your care in the last three years. Provide name, date of last visit, visit reason, office number?

☐ Nephrologist	☐ Urologist
☐ Acupuncturist	☐ Chiropractor
☐ Gastroenterologist	☐ Hematologist/Oncologist
☐ Surgeon	☐ Endocrinologist
☐ Cardiologist	☐ Naturopath
☐ Gynecologist	☐ Other

List any significant prior illness, diagnosis, or injuries, including date occurred (ie hypertension March 2015):

Surgeries and hospitalizations: (Reason and date)

Please list any major accident or illness during childhood not already indicated:

Date of last physical exam:

Date of last blood work:

VACCINATION HISTORY:

Have you ever had the disease (D), been immunized (I), neither (N) or Unknown (U) for the following?

	D	I	N	U	Date
Tetanus	☐	☐	☐	☐	________
Whooping cough (pertussis)	☐	☐	☐	☐	________
Haemophilus (HiB)	☐	☐	☐	☐	________
Hepatitis A	☐	☐	☐	☐	________
Hepatitis B	☐	☐	☐	☐	________
Measles	☐	☐	☐	☐	________
Mumps	☐	☐	☐	☐	________
German Measles (rubella)	☐	☐	☐	☐	________
Chicken Pox:	☐	☐	☐	☐	________
Shingles:	☐	☐	☐	☐	________
Human Papilloma Virus (HPV)	☐	☐	☐	☐	________
Pneumococcus (PCV)	☐	☐	☐	☐	________
Polio	☐	☐	☐	☐	________
Meningococcal	☐	☐	☐	☐	________
Pneumonia	☐	☐	☐	☐	________
Influenza	☐	☐	☐	☐	________
Covid 19	☐	☐	☐	☐	________
Other vaccines:	☐	☐	☐	☐	________

Adverse reactions to vaccines?

☐ NO

☐ YES, describe:

MEDICAL IMAGING:
Date, area of body, reason:

X-ray:

MRI/CT Scan:

Ultrasound:

ALLERGIES:

☐ No known or suspected allergies
☐ Medication
☐ Food
☐ Environment

Please indicate allergy and describe reaction:

MEDICATIONS AND SUPPLEMENTS:

Current Medications and Supplements (please include ALL prescriptions, over-the-counter drugs, vitamins, herbs, etc.). Please include daily dose and reason for taking it.

SOCIAL HISTORY:

What is your current job?

Do you enjoy or job? ☐ Yes ☐ No

What are your hobbies?

Have you done any foreign travel within the last year?

☐ Yes, where? ☐ No

Please indicate your average level of energy throughout the day using the scale 1-10
(1 is the lowest, 10 is the highest)

Do you Exercise? If YES, indicate type, how many times a week, for how long?
(ie soccer, 3 days, 60 minutes)
☐ Yes, describe ☐ No

SLEEP:

How many hours of sleep do you usually get per night? .

Do you wake feeling refreshed?
☐ Always ☐ Usually ☐ Rarely ☐ NO

Do you have difficulty sleeping?	☐ Yes	☐ No
Any trouble falling asleep	☐ Yes	☐ No
Any trouble staying asleep	☐ Yes	☐ No
Do you snore?	☐ Yes	☐ No
Do you grind your teeth?	☐ Yes	☐ No
Do you have nightmares?	☐ Yes	☐ No
Do you sleepwalk?	☐ Yes	☐ No
Do you wake due to pain?	☐ Yes	☐ No

Do you use a sleep aid?
☐ Yes, Indicate: ☐ No

ALCOHOL, TOBACCO AND REACTRATIONAL DRUG USE:

Do you drink alcohol?
☐ Daily ☐ Weekly ☐ Monthly ☐ No

What type of alcohol do you prefer?
☐ liquor ☐ Wine ☐ Beer ☐ Other

How much do you drink per sitting?
Indicate amount consumed per occasion.

Do you smoke or chew Tobacco?
☐ Yes ☐ No ☐ In the past
If yes, how many cigarettes or packs per day?

If past, when did you quite smoking? Number of years of smoking and packs per day?

Do you use recreational drugs?
☐ Yes ☐ No ☐ In the past

If yes, how often?
☐ Daily ☐ Weekly ☐ Monthly ☐ Other

Specify what kind:
☐ Cannabis ☐ Barbiturates/ Benzodiazepines
☐ Solvents ☐ Psychedelic mushrooms
☐ Heroin ☐ LSD
☐ Opium ☐ Peyote
☐ Ecstasy ☐ Amphetamines
☐ Cocaine
☐ Other: ____________

Have you ever been told you have an addition or been treated for an addiction? ☐ Yes ☐ No

Does the use of alcohol or drugs impair your activities or daily living? ☐ Yes ☐No

RELATIONSHIP STATUS:

☐ Single ☐ Separated
☐ Married ☐ Divorced
☐ Domestic partner ☐ Widowed
☐ In a relationship ☐ Other

Are you satisfied with your significant relationship?
☐ Yes ☐ No

Do you Live alone?
☐ Yes ☐ No

Do you have a support system?
☐Strong ☐ Moderate ☐ Limited

Major stressors last year?
☐ Money ☐ Job
☐ Marriage/relationship ☐ Home life
☐ Children ☐ Loss
☐ Health ☐ Other

How do you find your life? ☐ Satisfactory
☐ Too demanding ☐ Unsatisfactory ☐ Boring

REVIEW OF SYSTEMS:
Do you have, or have you had within the past year, any of the following?

General:
- ☐ Weight Change
- ☐ Appetite Change
- ☐ Fever/Chills
- ☐ Weakness
- ☐ Fatigue
- ☐ Night sweats

Eyes:
- ☐ Dryness
- ☐ Watery eyes
- ☐ Itchy eyes
- ☐ Redness
- ☐ Eye Strain
- ☐ Cataracts
- ☐ Other
- ☐ Styes
- ☐ Dark circles
- ☐ Discharge from eyes
- ☐ Contacts/glasses
- ☐ Vision problems
- ☐ Glaucoma

Date of last eye exam: ______________________

Ears, Nose, Throat:
- ☐ Ringing ears
- ☐ Change in hearing
- ☐ Ear discharge
- ☐ Ear Pain
- ☐ Vertigo
- ☐ Nose bleeds
- ☐ Polyps
- ☐ Problems smelling
- ☐ Nasal Congestion
- ☐ Nasal discharge
- ☐ Sinusitis
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Gum disease
- ☐ Mouth sores
- ☐ Swallowing problems
- ☐ Goiter
- ☐ Neck movement restricted/diminished
- ☐ Problems tasting
- ☐ Cavities

Cardiovascular:
- ☐ Murmurs
- ☐ Palpitations
- ☐ Heart attack
- ☐ arrhythmias
- ☐ Angina
- ☐ TIA/Stroke
- ☐ Chest pain
- ☐ Leg cramps
- ☐ Congestive heart
- ☐ Blue hands/feet
- ☐ Rheumatic fever
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Varicose veins
- ☐ Edema

Date of last ECG (if any):_____________________

GASTROINTESTINAL:
- ☐ Indigestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Food intolerance
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Ulcers
- ☐ Rectal bleeding, burning or itching
- ☐ Gas/bloating
- ☐ Nausea
- ☐ Vomiting
- ☐ Liver disease
- ☐ Hernias
- ☐ Fatty meals aggravate
- ☐ Hemorrhoids

How often do you have a bowel movement?______

Date of last colonoscopy if any?________________

Urinary Tract:
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Blood in urine
- ☐ Urgency
- ☐ Frequent urination
- ☐ Frequent infections
- ☐ Pain with urination
- ☐ Waking to urinate

Musculoskeletal:
- ☐ Muscle weakness
- ☐ Muscle aches
- ☐ Tremors
- ☐ Arthritis
- ☐ Leg cramps
- ☐ Stiffness
- ☐ Past injury
- ☐ Head injury

Skin/Integumentary:
- ☐ Positive skin exam
- ☐ Color change
- ☐ Abnormal mole
- ☐ Dry skin
- ☐ Acne
- ☐ Rash
- ☐ Hives
- ☐ Dandruff
- ☐ Oily Hair
- ☐ Hair/nail changes
- ☐ Psoriasis
- ☐ Itchy skin
- ☐ Rosacea
- ☐ Eczema
- ☐ Skin cancer
- ☐ Warts
- ☐ Dry Hair
- ☐ Hair los

Neurological:
- ☐ Paralysis
- ☐ Sciatica
- ☐ Seizures
- ☐ Weakness
- ☐ Headaches
- ☐ Migraines
- ☐ Numbness/tingling
- ☐ Tremors
- ☐ Carpal tunnel
- ☐ fainting/blackouts
- ☐ Dizziness
- ☐ Lightheadedness

Mental/Emotional:

- ☐ Anxiety
- ☐ Fear/panic
- ☐ Eating disorder
- ☐ Anger/irritability
- ☐ Feeling down
- ☐ Depression
- ☐ Suicidal thoughts
- ☐ Psychiatric hospitalization

Endocrine:

- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Mood swings
- ☐ Snacking often
- ☐ Irritability
- ☐ Change in glove or shoe size
- ☐ Increased urination
- ☐ Increased thirst
- ☐ Heat/cold intolerance
- ☐ Need to eat regularly
- ☐ Hormone Therapy

Hematologic/Lymphatic:

- ☐ Anemia
- ☐ Easy bruising/bleeding
- ☐ Hemorrhoids
- ☐ Swollen Lymph nodes
- ☐ Circulation issues
- ☐ Fragile/sensitive skin
- ☐ Blood clot history
- ☐ Deep bone pain
- ☐ Reaction to insect bites
- ☐ Brittle nails

Allergic/Immunologic:

- ☐ Seasonal allergies
- ☐ Chemical sensitivity
- ☐ Dry or itchy eyes
- ☐ Asthma
- ☐ Sinusitis
- ☐ Organ transplant or donation history
- ☐ Sick often
- ☐ Rash
- ☐ Hives
- ☐ Have pets
- ☐ History environmental chemical exposure
- ☐ Family history wheat allergy or celiac disease

Is there anything else you would like the doctor to know about you?

FEMALE:

Menstrual Cycle:

Age of first menses?____________________

First day of last menses?_________________

Length of menses?______________________

Do you experience any of the following before or during your menses?

☐ Diarrhea
☐ Bloating
☐ Food cravings
☐ Mood changes
☐ Breast tenderness swelling
☐ Menstrual cramping
☐ Fatigue during menses
☐ Back/body aches
☐ Heavy Bleeding
☐

Menopause:
Age at menopause:______________________

Age your mother entered menopause:______

Was onset of menopause ☐ Within normal
☐ Total Hysterectomy ☐Partial hysterectomy

Check all the symptoms you currently experience:
☐ Hot flashes
☐ Night sweats
☐ Vaginal dryness
☐ Decreased libido
☐ Brain fog or decreased memory
☐ Mood changes
☐ Incontinence
☐ Joint pain
☐ Sleep disruption
☐ Palpitations

Bone Density:
Date of last DEXA scan (bone scan)
Indicate if you have never had one:______________

Are you treating or supplementing for bone density?
Specify:

Breast Health:

Do you have any of the following
☐ Breast pain ☐ Breast discharge
☐ Breast masses ☐ Family history

Date of last mammogram and results:

____

Gynecology and PAP History:
Date of last PAP smear and results:

____

Have you ever had an irregular PAP smear?
☐ No ☐ Yes, list date and treatment received:

____

Check all, history of pelvic disease conditions:
☐ Ovarian cysts ☐ Ovarian/uterine disease
☐ Fibroids ☐ Endometriosis
☐ Pelvic inflammatory disease ☐ Ectopic pregnancy
☐ Other, describe:

Have you had any gynecological surgeries or procedures?
☐ No ☐ Yes, indicate date and type:

____

Contraception, Libido, and Sexually Transmitted Infections (STIs):

Are you currently sexually active? ☐ Yes ☐ No

Please indicate birth controls or other hormones previous or currently used:

____
Are you experiencing any of the following:
☐ Low libido
☐ Pain with intercourse ☐ Bleeding after intercourse

MALE:

Prostate/Urinary symptoms

☐ BPH	☐ Incomplete urination
☐ Nocturia	☐ Dribbling of urine
☐ Prostatitis	
☐ Prostate cancer	☐ Difficulty initiating urination

Date of your last PSA:______________________

Check all that apply:

☐ Testicular pain	☐ Impotency/ED
☐ Testicular swelling	☐ Decreased libido
☐ Hernias	☐ Prostate disease
☐ Penile discharge	☐ Rashes/skin changes

Contraception, Libido, and Sexually Transmitted Infections (STIs):

Are you currently sexually active ☐ Yes ☐ No

Do you experience:

☐ Low libido	☐ Difficulty achieving an erection
☐ Fertility changes	☐ Difficulty maintaining an erection

Please indicate any hormones previously or currently used:

____

WOLFEBORO NATUROPATHIC MEDICINE

Dr. Steve Clark, N.D.
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Phone: (603) 569-5545 Fax: (603) 569-0545
www.wolfeboronaturopathic.com

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:

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

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.