

Patient Intake Form

Naturopathic Living

Name:	
Date of birth:	
Social security number:	
Telephone:	
Address:	
E-mail:	
May we leave you a message regarding your healthcare? If so, preferred route?	
Emergency contact/telephone #:	
Employer: address and telephone #:	
How did you hear about us?	

Patient Intake Form

Naturopathic Living

Have you consulted a naturopath before?	
Primary care doctor: name and telephone #	
Specialist: name and telephone #:	
Please list all the allergies/reactions to medications:	
Please list all other allergies:	

Please list all medications, supplements and herbs that you are taking:		
Name	Strength/Dosage	Directions for taking/Frequency

Patient Intake Form

Naturopathic Living

--	--	--

Please check whether you or your close relative have ever had any of the following:

Condition	Self	Relative	Condition	Self	Relative
Allergies			HIV/AIDS		
Anemia			Hypertension		
Anxiety			Irritable Bowel Syndrome		
Arthritis			Kidney disease		
Asthma			Meningitis		
Blood transfusion			Nerve/Muscle disease		
Cancer			Osteoporosis		
Cataracts			Parkinson's/Alzheimer's		
Congestive heart failure			Seizures		
Clotting disorder			Sickle cell anemia		
COPD			Stroke		
Depression			Substance abuse		
Diabetes			Thyroid disease		
Emphysema			Tuberculosis		
GERD			Ulcers		
Glaucoma			Other		
Heart attack			Other		

Patient Intake Form

Naturopathic Living					
Other			Other		

Please list all injuries, surgeries and hospitalization:

Consent for Evaluation and Treatment

I _____, a patient, or a patient's parent or legal guardian give my consent to Dr. Nadia Ciuha, ND to provide evaluation and naturopathic treatment according to the current standards. I understand that my services may include physical examination, laboratory testing, psychological or lifestyle counseling, prescription of natural substances, as well as of certain medications, and physical medicine.

Signature

Date

Financial agreement

Currently, Naturopathic Living does not bill insurance companies for the services provided in our office. Payments for all of the services rendered are due at the time of the visit. We provide you with the itemized receipt, which you may submit to your insurance carrier for a direct reimbursement to you. Most insurance companies reimburse their members at the out-of-network rate. If you have an FSA and HSA account, those typically cover the cost of the visit fully.

Rates:

Initial consultation, adult: 300\$

Initial consultation, child: 200\$

Return consultation, adult: 150\$

Return consultation, child: 130\$

Telephone consultation, new patient: 150\$

Telephone consultation, established patient: 130\$

We accept cash, personal checks and all major credit cards.

Brief telephone/e-mail consult:

Dr. Ciuha typically provides brief courtesy telephone or e-mail consultation to you if you have questions immediately after your visit and those questions pertain to the issues/symptoms/treatment discussed during your visit.

If your e-mail or telephone call is pertaining to new symptoms, or you are requesting new information, you will be charged at the rate of the return patient telephone consultation. We might wave a telephone consultation fee for you if you have an in-office visit within 72 hours of your call.

Financial agreement (cont.)

Cancellation/No shows

In case of cancellation, we request that you provide us with at least 24 hour notice. In case of late cancellation we will charge 50% of the cost of the missed visit.

In case of no-shows we will charge 100% of the cost of the missed appointment.

Returned checks:

We charge a 35\$ fee for all returned checks.

I hereby acknowledge that I am financially responsible for the services rendered and agree to the terms of this financial agreement.

Name of the patient or guarantor: _____

Signature: _____

Date: _____

Patient Intake Form

Naturopathic Living