Patient Intake Form

Naturopathic Living

Name:	
Date of birth:	MM/DD/YYYY
Telephone:	
Address:	
Email:	
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?	

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

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	☐	☐
COVID-19	☐	☐	Stroke	☐	☐
Depression	☐	☐	Substance abuse	☐	☐
Diabetes	☐	☐	Thyroid disease	☐	☐
Emphysema	☐	☐	Tuberculosis	☐	☐
GERD	☐	☐	Ulcers	☐	☐
Glaucoma	☐	☐	Other:		
Heart attack	☐	☐		☐	☐
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.

Printed Name of the patient: _____

Date: MM/DD/YYYY

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: $ 200
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 in case when you have questions immediately after your visit and if those questions pertain to the issues/symptoms/treatment discussed during your visit.
If your e-mail or telephone call is related 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.

Printed Name of the patient or guarantor:

SSN:

Date: MM/DD/YYYY