New Hampshire Natural Health Clinic

304 Riverway Place, Bedford, NH (Inside Bedford Commons) 603-623-6800

REGISTRATION INFORMATION (Please Print and bring with you to your first appointment)

Last First Name

Street Address

City State Zip

Phone (H) (W) Mobile

Permission to leave a message Yes No

Email (for appointment reminders)

Birth date AGE Sex

Height WEIGHT

Employer

Occupation

Retired **PRIMARY INSURANCE INFORMATION**

Policy # Do you have insurance coverage for Naturopathic doctors?

Policy Holder (NAME) Insurance carrier (i.e. BCBS, Cigna, HP)

Policyholder (BIRTHDATE) Your relationship to Policyholder

Next of Kin Last First

Relation to Patient

Address and phone if different from above

Primary Care Doctor Information

Name:

Address:

City: State: Zip:

Telephone: Fax:

Pharmacy information

Name:

Address:

City: State: Zip:

Telephone: Fax:

Who referred you?

Please indicate your primary health concerns below (in order of importance) and indicate how these problems limit you.

1)

2)

3)

List all past medical conditions, surgeries & hospitalizations, including date occurred:

Please list all medications and supplements that you are taking

List all known allergies (food, medications, environment)

Please indicate below all known medical conditions in your family.

Mother

Father

Siblings

Paternal Grandmother

Maternal Grandmother

Paternal Grandfather

Maternal Grandfather

Uncles

Aunts

Other

Exercise Habits

Hobbies:

Please tell us a little bit about your sleep habits.

How long per night? If you wake up frequently, what is the reason?

Do you wake up refreshed? Do you take naps?

Social History

Where did you grow up? List other places you have lived

Are you a smoker? If yes, how many packs per day & number of years:

Do you drink alcohol? If yes how often?

Have you had any recreational drug use?

Have you had any past alcohol or drug treatment programs?

What do you do for work? Do you enjoy your job?

Do you have history of sexual, mental/emotional, physical abuse? If so, at what age and by whom:

List any below that you are particularly sensitive to.

New carpeting, perfumes, gasoline, other vapors

If you listed any of the above what happens when you are exposed to them?

Do you use pesticides, herbicides or other chemicals around your home?

Typical Day's Diet (soda/coffee daily, water intake daily, typical breakfast/lunch/dinner/snacks

Did you receive all the recommended vaccinations?

Rate your energy level from 1-10:

Head: Head injury, frequent headaches, migraines, other types of headaches, gum disease, silver amalgums,

Eyes: Blurring, double vision, irritation, discharge, vision loss, eye pain, sensitive to light, glaucoma, cataracts.

Ears: earache, ear discharge, ringing in the ears, decreased hearing, frequent ear infections

Nose: Nasal congestion, sinus congestion, nasal polyps, nosebleeds, frequent runny nose, frequent itchy nose

Throat: Sore throat, hoarseness, difficulty swallowing.

Cardiovascular: High blood pressure, low blood pressure, angina, heart attack, heart murmur, valve disease, chest pains, palpitations, fainting, difficulty in breathing on exertion, difficulty breathing when lying down, sudden shortness of breath when sleeping, edema

Respiratory: Cough, difficulty breathing, excessive sputum, bloody sputum, wheezing, asthma, emphysema

Gastrointestinal: Heartburn, stomach ulcer, gastric bleeding, nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, black stools, bloody stools, jaundice, gastritis, hemorrhoids, belching, flatulence, abdominal bloating

Genitourinary: Kidney disease, hepatitis, vaginal discharge, incontinence, painful or difficult urination, blood in the urine, urinary frequency, weak urine stream, amenorrhea, excessive menstrual flow, abnormal vaginal bleeding, pelvic pain, urinary tract infections.

Musculoskeletal: Back pain, neck pain, limb pain, arthritis, muscle pain, muscle spasms, muscle cramps, morning stiffness

Skin: Rash, itching, dryness, psoriasis, eczema, hives, moles that have changed.

Neurologic: Transient paralysis, weakness, symptoms of numbness, prickling or tingling, seizures, fainting, tremors, dizziness.

Psychiatric: Depression, anxiety, memory loss, mental disturbance, suicidal ideation, hallucinations, paranoia, addiction, foggy Thinking, seasonal depression, excessive irritability, excessive anger

Enodocrine: Diabetes, cold intolerance, heat intolerance, excessive thirst, excessive hunger, excessive urination, weight change.

Heme/Lymphatic: Abnormal bruising, bleeding, enlarged lymph nodes.

Allergic/Immunologic: allergic skin rashes, hay fever, persistent infections, frequent infections, HIV exposure, poor wound healing, food allergies, chemical sensitivities

Female: endometriosis, PCOS, infertility, dyspyrunia, menopausal sx, PMS, cervical dysplasia, abnormal PAP, vaginal discharge, breast discharge, irregular menstruation, clotting.

New Hampshire Natural Health Clinic Credit Card and Payment Agreement

Dr's. Mathieson, ND, Scholl, Murray and Klasman ND -- Kristi Mathieson, RD

I _____ authorize New Hampshire Natural Health Clinic to charge all balances of allowed fees (not paid by my insurance company) to my credit card. All insurances policies are different, we have found most patients have either a co-insurance, a co-payment, or an unmet deductible that will need to be paid after the visit. This amount changes over the year. To expedite billing we are requesting all patients have a credit card on file.

I understand that New Hampshire Natural Health Clinic will send me a receipt for all charges New Hampshire Natural Health Clinic applies to my credit card. I assign my insurance benefits to the provider listed above. I understand this form is valid unless I cancel this in writing to New Hampshire Natural Health Clinic.

Credit card number _____

Card holders Name _____

Card holders Signature (typed name will suffice if no electronic signature)

_____

Exp. date _____

Security code _____

Billing zip code _____

Additional instructions (if necessary - ex. please send invoice I do not have an email)

_____

NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program which requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information. As required by “HIPAA,” we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for the following purposes: treatment, payment, and health care operations:

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.
- We may also create and distribute de-identified health information by removing all references to individually identifiable information.
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services which may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.
- You have the following rights with respect to your protected health information which you can exercise by presenting a written request
- to New Hampshire Natural Health Clinic LLC:

    - The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
    - The right to reasonable requests to receive confidential communication of protected health information from us by alternative means or at alternative locations.
    - The right to inspect and copy your protected health information.
    - The right to amend your protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of below date and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please feel free to contact us for more information.

PATIENT/GUARDIAN SIGNATURE_____ DATE _____

Consent for Purposes of Treatment, Payment, and Health Care Operation

I consent to the use of disclosure of my identifiable health information by the New Hampshire Natural Health Clinic LLC for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that my diagnosis or treatment by the practitioners at New Hampshire Natural Health Clinic LLC may be conditioned upon my consent as by my signature on this document.

Practitioner means a Naturopathic Doctor, Naturopathic Doctor Assistant, Dietitian or other healthcare worker employed by or under contract with the New Hampshire Natural Health Clinic LLC. ***Patient*** means any person seeking the health care advice and/or treatment of a practitioner at the New Hampshire Natural Health Clinic LLC through consultation by phone or in person.

My *identifiable health information* means health information collected from me and created or received by my practitioner, another health care provider, a health plan, and my employer. This ***identifiable health information*** relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand that I have the right to request a restriction as to how my health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. New Hampshire Natural Health Clinic LLC is not required to agree to the restrictions that I may request. However, if the New Hampshire Natural Health Clinic LLC agrees to a restriction that I request, the restriction is binding upon the New Hampshire Natural Health Clinic LLC. I have the right to revoke this consent, in writing, at any time except to the extent that the New Hampshire Natural Health Clinic LLC has taken action in reliance of this consent.

I understand that I have the right to review the New Hampshire Natural Health Clinic LLC Notice of Privacy Practices prior to signing this document. This notice describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of New Hampshire Natural Health Clinic LLC. New Hampshire Natural Health Clinic LLC reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices at any time by requesting the most current notice in writing or in person at the time of my office visit.

Emergency Care: Our clinic does not administer emergency medical care. In the case of an emergency, please see your family physician or the emergency room of the nearest hospital. After emergency care has been administered, patients often respond well to Naturopathic care to accelerate the healing process.

Payment:

Payment is expected in full at time of service unless patient requests submission through private insurance. New Hampshire Natural Health Clinic does not preauthorize coverage the patient is responsible for knowing if their particular policy covers the services at the clinic. We accept personal checks, cash, Visa, Mastercard, and American Express. New Hampshire Natural Health clinic does not currently participate in Medicare or Medicaid insurances.

- Although New Hampshire Natural Health Clinic does participate as preferred providers in most NH private health insurance carriers it **does not guarantee reimbursement by the patient's individual policy**.
- I understand that I am financially responsible for payment for all services and co-pay's at the time of service if my policy does not cover the services at the clinic.
- I understand I am responsible for payment should my insurance deny payment for **ANY** reason. I understand that if I disagree with my insurance response, it is my responsibility to pay in full the outstanding payment and contact the insurance company myself to rectify the issue.
- I understand that New Hampshire Natural Health Clinic has a policy where we ask for a credit card which may be used later to pay any balance that may be due on your bill.
- Co-pays are still due at the time of service.
- At check in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. At that time we will bill your credit card. Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged.
- I understand that if a credit card is not kept on file that New Hampshire Natural Health Clinics billing policy includes three billings (over a 4 week period). After the third billing the outstanding balance will be placed in collections.
- I understand and agree to reimburse New Hampshire Natural Health Clinic the fees of any collection agency, which will be added to the account at the time it is placed with an agency for collection and may be based on a percentage at a maximum of 30% of the debt, and all reasonable costs and expenses, including reasonable attorneys' fees, incurred in such collection efforts.
- I consent to treatment as agreed upon between the practitioner and myself. Any therapy will proceed only with our mutual consent. I agree to discuss any problems in my care with the practitioner.
- I understand that when treated by the Naturopathic doctor or Dietitian that the care given to me is Naturopathic Medicine and Medical Nutritional Therapy and give consent to this form of treatment.

PATIENT/GUARDIAN SIGNATURE_____ DATE _____

Cancellation Policy:
The New Hampshire Natural Health Clinic LLC requires at least 48 hours notice of cancellation in advance of the scheduled appointment time. Unless an emergency has occurred missed appointments without due notification will be charged a late cancellation fee.

- **I agree to pay for services rendered at time of service. I acknowledge that I may request the fees for various procedures before they occur and include that information in my decision regarding healthcare.**
- **I am aware that my practitioner will charge for telephone consultations that extend past a very short 1-2 minute conversation.**
- I understand that this office requires notice of cancellation at least 48 hours in advance of the scheduled appointment time.

Email Policy
Effective November 20'th 2013
We recognize that many of our patients find email as a quick and easy way to communicate with a health care provider. We would like to offer this as a method to communicate for business and healthcare matters but there are privacy issues that we are concerned about as this type of communication is not secure or confidential. Therefore New Hampshire Natural Health Clinic does not offer email as a communication tool for medical support. If you have questions please call the clinic and set up a time to discuss these concerns with your provider.

I HEREBY,

- CERTIFY THAT I HAVE READ AND SIGNED THE HIPAA PRIVACY NOTICE,THE CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATION, POLICIES
- AUTHORIZE INSURANCE PAYMENTS TO BE SENT TO NH NATURAL HEALTH CLINIC LLC IF APPLICABLE
- CERTIFY THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED TO ME AND/OR MEMBERS OF MY FAMILY, IF INSURANCE DOES NOT REIMBURSE THE HEALTHCARE PRACTITIONER
- I CERTIFY THAT I HAVE RECEIVED AND AGREE TO THE PATIENT CANCELLATION AND EMAIL POLICIES
- I CERTIFY THAT I AM RESPONSIBLE FOR ANY LATE FEES IF MY COPAY IS NOT PAID AT THE TIME OF SERVICE, MY BALANCE IS NOT PAID WITHIN 30 DAYS AND/OR COLLECTION FEES OF 30% IF MY BALANCE HAS BEEN SUBMITTED TO COLLECTIONS.

PATIENT/GUARDIAN SIGNATURE_____DATE _____

New Hampshire Natural Health Clinic

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Authorization to Disclose Medical Records

This Authorization must be written, dated, and signed by the patient to give authorization

Name of Patient | **Date of Birth**

Home Phone Number | **Alternate Phone Number**

I herby authorize **Doctor:**	**To send or disclose my medical records to:** **Doctor:**
Name of Clinic/Hospital/Agency:	**Name of Clinic/Hospital/Agency** **New Hampshire Natural Health Clinic, LLC**
Street Address: **Fax:**	**Street Address:** ***304 Riverway Place*** ***Phone: 603-623-6800*** ***Fax: 603-623-6812***
City, State, Zip Code	**City, State, Zip Code** **Bedford, NH 03110**

By checking the spaces below, I authorize the release of the following medical records, if such records exist:

- ☐ Entire medical record
- ☐ Progress notes
- ☐ Laboratory report
- ☐ Pathology reports
- ☐ EKG
- ☐ X-Ray
- ☐ Operative report
- ☐ Other, Please specify

The following items much be **checked** to be included:

- ☐ HIV/AIDS related record
- ☐ Mental health record
- ☐ Genetic Testing Information
- ☐ Drug/Alcohol diagnosis, treatment or referral information

I understand that such information cannot be released without my specific consent, except in a medical emergency. I further understand that this authorization is valid for six months from the date of signing unless revoked earlier by the patient. The only exception is when the action has already occurred as instructed in the consent.

SIGNATURE OF PATIENT *DATE*

SIGNATURE OF LEGAL GAURDIAN--RELATIONSHIP *DATE*