World Tree Wellness
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# Patient Information Form

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth (required): _____/_____/_____ Gender: _____ SSN: _____-_____-_____

Other name(s) that records may be kept under: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Phone (in order of preference): 1) _____ ☐ Home ☐ Work ☐ Cell
May I leave confidential voicemail messages at this number? ☐ Yes ☐ No

2) _____ ☐ Home ☐ Work ☐ Cell
May I leave confidential voicemail messages at this number? ☐ Yes ☐ No

3) _____ ☐ Home ☐ Work ☐ Cell
May I leave confidential voicemail messages at this number? ☐ Yes ☐ No

Emergency Contact: _____ Relationship: _____

Phone: _____ Email: _____

Are you currently employed? ☐ Yes ☐ No Employer: _____

Employer Address: _____

Marital Status (check one): ☐ Single ☐ Married ☐ Divorced ☐Separated ☐Widowed ☐Domestic Partner

Race/Ethnicity: _____

Guarantor Information
This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name: _____ First Name: _____ Middle Initial: _____ ☐ Male ☐ Female

Phone: _____ Date of Birth (required): _____/_____/_____ SSN: _____-_____-_____

Mother's Name (minors only): _____ Father's Name (minors only): _____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient.

_____ _____
Guarantor's Signature (required) Date

How did you hear about Nathan Walsh, ND, and World Tree Wellness? _____

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# Patient Profile

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth (required): _____ /_____ /_____ Gender: _____ Nickname: _____

A note to our patients: Please complete this 3-page questionnaire as thoroughly as possible in order to aid your clinician in their diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except if you have provided us with written authorization. Thank you for your help.

What goals do you have for your visit at the clinic today?

_____

_____

_____

In general would you say your health today is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Who is your Primary Care Provider? _____ Phone: _____

Please list other providers/specialists involved in your care and their clinic phone number:

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

When was your last physical?_____ When did you last have bloodwork? _____

Please indicate the type of care you are seeking:

☐ Primary management of my health
☐ Adjunctive care for my health
☐ On-going management of my health
☐ One time advice for my health
☐ I don't know at this time

Have you ever consulted a Naturopathic Physician, Acupuncturist, Nutritionist or Counselor before? ☐ Yes ☐ No
If YES, please circle with which type of practitioner you have previously consulted.

If you are seeking adjunctive Cancer support, who is your Oncologist?

Oncologist? _____ Phone: _____

Last Name: _____ First Name: _____ Date of Birth: _____ /_____ /_____

Do you have any medication, food, or environmental allergies? ☐ Yes ☐ No

If YES, please explain: _____

_____

**Please list all medications and supplements you are taking** including prescriptions, over-the-counter medications, vitamins, minerals, herbs and homeopathic remedies. Attach another page if needed.

| **Name of Medication** | **Strength** | **Directions** (including time of day) |
|---|---|---|
| ☐ Check if none | | |
| | | |
| | | |
| | | |
| | | |
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| | | |

## Medical History

**Please check box to indicate if you or a family member has ever had the following conditions. If condition does not apply leave blank.** Please indicate which relative has the condition, if applicable such as mother (M), father (F), sibling (S) or maternal or paternal grandmother/grandfather (MGM, MGF, PGM, or PGF).

| 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 | | |

Last Name: _____ First Name: _____ Date of Birth: ____ /____ /____

## Medical History continued

| Condition | SELF | RELATIVE | Condition | SELF | RELATIVE |
|---|---|---|---|---|---|
| Clotting Disorder | | | Sickle Cell Anemia | | |
| COPD | | | Stroke | | |
| Depression | | | Substance Abuse | | |
| Diabetes | | | Thyroid Disease | | |
| Emphysema | | | Tuberculosis | | |
| GERD | | | Ulcers | | |
| Glaucoma | | | Other | | |
| Heart Attack | | | Other | | |
| Heart Murmur | | | Other | | |

Please list any surgeries or hospital stays you have had and their approximate date/year:

Type of surgery/reason for hospitalization: Date:

_____ ____ /____ /____

_____ ____ /____ /____

## Social History

Do you use any of the following substances regularly?

☐ Coffee/Black Tea/Cola ☐ Alcohol ☐ Recreational Drugs ☐Tobacco – Current/Past

If Current or Past Tobacco Use: Packs Per Day: ____ How Long: _____ Quit: _____

Please mark those that apply: ☐ Single ☐ Married ☐ Significant Other ☐ Divorced ☐ Other: _____

Do you have children? ☐ Yes ☐ No If YES, what are their ages: _____

Do you follow any particular diet restrictions? ☐ Yes ☐ No If YES, please describe: _____

_____

Do you exercise regularly? ☐ Yes ☐ No If YES, please describe type of exercise and how often: _____

_____

_____ _____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.) Date

_____

Patient/Guardian Signature

*For Office Use Only:* Reviewed by Provider and ready to be scanned (initials): _____ Date: _____ /_____ /_____

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# Informed Consent for Treatment

Please read and sign the following in order to completely understand the risks and benefits of your care.

I, _____, hereby authorize World Tree Wellness to perform the following specific procedures as necessary to facilitate my healthcare:

- Common diagnostic procedures: e.g. laboratory, physical exam
- Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation.
- Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, plasters, or suppositories.
- Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.
- Counseling, including biofeedback.
- Lifestyle and hygiene counseling: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
- Injection Therapies such as: intramuscular nutrient therapy, trigger point therapy, neural therapy, and biopuncture.
- Hormone Replacement Therapy
- Physical modalities, including hydrotherapy and visceral manipulation.

**I recognize the potential risks and benefits of the procedures as described below:**

- **Potential risks:** allergic reactions to prescribed herbs, supplements and medications, side effects of natural medication, inconvenience of lifestyle changes, emotional release, emotional distress, healing crisis.
- **Potential benefits:** restoration of health and body's maximal functional capacity and optimal wellness, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
- **Notice to Pregnant women:** All female patients must alert the doctor if they know or suspect that they are pregnant. Some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by World Tree Wellness regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that any questions I have will be answered by my provider to the best of their ability. I realize that I play an integral role in my healing process and in order to produce results I must take responsibility for my health. By making this appointment for a visit with a provider at this medical office I am making an investment in my health.

I understand that I am expected to have a local primary care physician if I am conducting my appointments with my World Tree Wellness practitioner(s) by phone, Skype, or any other electronic means.

_____ _____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.) Date

_____

Patient/Guardian Signature

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# Payment Agreement Form

Dear New Patient,

Welcome to World Tree Wellness. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care. Please read and *initial* the following statements:

_____ Payment for all services and medicinary items is due at the time of the visit. Our office accepts cash, checks, Visa, and MasterCard. We also accept payment from Health Savings Accounts (HSA) or Flexible Spending Accounts (FSA). Returned checks will be subject to a $35.00 NSF fee.

_____ Phone calls and emails regarding an existing health issue that require more than 10 minutes of attention from your physician will incur a fee. Phone calls and emails regarding a new health issue, regardless of the length of time of attention required, will also incur a fee. Your physician will notify you of the need for a charge, so that you can determine whether you would like to address the issue and pay the fee, or schedule an appointment.

_____ On your first missed appointment you will be charged a fee of $50.00 for any missed appointments or late cancellations (less than 24 hours' notice). Every missed appointment there after you will be charged the entire appointment fee as described in the appointment fee schedule.

_____ Your health care provider may prescribe medication, which may be purchased at World Tree Wellness or online professional pharmacies. Most insurance companies do not cover the pharmacy items that we prescribe and dispense.

_____ World Tree Wellness has a 24 hour cancellation policy for office visits. I understand that if I am not able to cancel my appointment in a sufficient amount of time in advance, I will be charged 50% of the appointment fee for the first missed appointment and 100% of the appointment fee for each incidence thereafter.

I have read and understand the above-stated policies of World Tree Wellness and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

_____ _____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.) Date

_____

Patient/Guardian Signature

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# Your Health Information Privacy Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers, it is our responsibility to keep your information safe and secure.

In order to provide you with service that best meets your privacy needs, please tell us if there are any ways you do not want us to attempt to reach you. Please **check all that apply**: I understand that

- ☐ a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless specifically directed by myself or representative unless it is required by law.
- ☐ my information may be shared:
  - For coordination of care; multiple health care providers may be involved in my treatment directly and indirectly.
  - With other clinic members or students under their tutelage
  - With family, friends, relatives, or others that are specifically identified on this form as being involved my health care or health care bills.
  - To protect the public's health, such as reporting when the flu is in the area.
  - To make required reports to the police (i.e. gunshot wounds).
  - To obtain payment from third party payers (i.e. insurance companies)
- ☐ I may look at my health record or request a copy of it at any time.
- ☐ my health records will be kept for a minimum of seven years after the date of my last visit.
- ☐ this health clinic follows strict HIPPA guidelines to protect my health information.
- ☐ I am entitled to receive updates upon request if Fairhaven Integrative Health amends or changes its Notice of Privacy Practices in a material way.

In order to provide you with service that best meets your privacy needs, please tell us if there are any ways you do not want us to attempt to reach you. Please **check all that apply**:

- ☐ Please do not phone me at home. Use this alternate phone number: _____ or _____
- ☐ Please do not phone me at work. Use this alternate phone number: _____ or _____
- ☐ Please do not leave messages on my answering machine.
- ☐ Please do not contact me by email.
- ☐ Please send mail, including my bills, to this alternate address: _____

List those with whom you are willing to have us share your health information/discuss your treatment:

_____ _____ _____ _____

I, _____, hereby acknowledge that World Tree Wellness has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

_____ _____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.) Date

_____

Patient/Guardian Signature

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# Private Health Insurance Information Form

Patient Name: _____

Date of Birth: _____ Home #: (_____) _____

**In Order To Bill Your Private Health Company Please Complete The Following:**

**Primary Insurance Co. Name:** _____ Phone #: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance ID: _____ #: _____ Group/Plan #: _____
Alpha prefix

**Name of Insured:** _____ Date of Birth: _____ SS#: _____

Your Relationship to Insured: ☐ Self ☐ Spouse/Partner ☐ Child Insured's Gender: _____

**Insured's Employer or School:** _____

Do you have **secondary coverage** with another insurance company? ☐ Yes ☐ No If yes, please complete below:

**Secondary Insurance Co. Name:** _____ Phone #: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance ID: _____ #: _____ Group/Plan #: _____
Alpha prefix

**Name of Insured:** _____ Date of Birth: _____ SS#: _____

Your Relationship to Insured: ☐ Self ☐ Spouse/Partner ☐ Child Insured's Gender: _____

**Insured's Employer or School:** _____

**Please read and sign below:**

In fairness to our other patients and to us, 24 hour notice is required for cancellation of an appointment, or you will be charged in full for the time booked.

Once your insurance coverage has been verified, we will be glad to bill directly to and accept payment from the insurance company. It should be understood that all services are charged to you, the patient, who is legally responsible for payment. Patient agrees to pay all collection costs including, but not limited to reasonable attorney fees, late charges and litigation costs in the event of any breach, including failure to timely make any required payments.

I hereby authorize the release of my medical records to the above insurance company for the express purpose of payment for my medical bills incurred in this office.

I hereby authorize the insurance company or attorney to remit payment directly to this office.

**Signature:** _____ **Date:** _____
(Patient / Parent / Guardian)