New Patient Intake Form

Name____ **Date**____________________

Date of Birth____________________ **Age**_______________ **Male** **Female**

Address____

City____________________ **State** ________ **Zip**____________ **Email** ____________________

Phone__________________ **Cell**______________________ **Work Phone**______________________

May we leave confidential voice mail messages at any of the above numbers/emails? **No** **Yes**

Occupation______________________________ **Employer** ______________________________

Referred by:____

Emergency Contact: ____

Health concerns in order of importance:

1._______________________ 2._______________________ 3.____________________________

Current Physicians:

Name:______________________________________Specialty:___________Phone:______________

Name:______________________________________Specialty:___________ Phone:______________

Name:______________________________________Specialty:___________ Phone:______________

Allergies (medication, food, environmental):

____

Current Medications/Supplements:

____

____

I certify that the above is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges. Appointments cancelled with less than 24-hours will incur a fee.

Signature__________________________________ **Date**__________________________________

Provider Fees and Policies

Regular Office Hours: Dr. James is available by appointment. Phone calls and email messages are returned Monday through Thursday within 24-72 hours.

Visit Consultations and Fees: Dr. James is an out-of-network provider. Payment for office visits is due at the time of service. Credit card information will be required at the time of appointment scheduling to hold your timeslot, and charged after your visit. The first office consult, which includes a comprehensive intake, review of medical records, physical exam and/or evaluation of records, imaging, and labs, and initial treatment plan, generally lasts 60-90 minutes and costs $450. Follow-up visits last up to 30 minutes and cost $200. We accept cash, checks and Mastercard or Visa. There is a $25.00 fee for all returned checks.

Telephone and Video Conferencing Consultations: Telemedicine consultation appointments are available for those who live more than 100 miles away. Fees for a telephone consult are commensurate with in-person fees. Brief (5 minutes or less) phone calls are accepted at no charge.

Electronic Policy: Electronic messages are not a substitute for an office visit. If you need clarification of supplement dosage, medication instruction or refill, this can be provided by message or telephone. Changes in symptoms or changes to the treatment protocol must be addressed in person. Messages are preferred through the Patient Portal of your provider's electronic health record.

Medical Records and Confidentiality: Your medical records are confidential and require your written authorization before they can be released to other health care providers or other approved recipients.

Appointment Cancellations: We understand that circumstances occasionally arise that will change your plans. You may cancel at no charge if you call **at least 24 hours** before your appointment. If you do not cancel or fail to come for your appointment, a fee of $50.00 will be charged.

I have read and understand these guidelines and agree to the terms therein.

Signature_________________________________ **Date**_________________________________

HIPAA Consent for Use and Release of Information

I give permission to **Laura James, ND, FABNO/Red Cedar Wellness Center** to release any information about me, my health, the health services provided to me, or payment for my health services which may be necessary:

For my **treatment** – to any physician, or other health care providers or facilities which need the information for my continued care, or

For **payment** purposes – to determine my coverage eligibility for out-of-network charges or laboratory fees.

For my **treatment** to persons associated with me named below.

Relationship	Name
______________________	______________________
______________________	______________________
______________________	______________________

By signing this form, I authorize **Laura James, ND, FABNO/Red Cedar Wellness Center** to communicate via **electronic message, telephone, video conferencing, and in person** with me and with other health care providers and associated persons as necessary for my medical care and treatment.

My signature on this authorization indicates that I am giving permission for the uses and disclosures of my protected health information. I hereby release Laura James, ND/Red Cedar Wellness Center (RCWC), and its employees from any and all liability that may arise from the release of information as I have directed.

My signature confirms that I am informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that I may request in writing that this clinic restricts how my private information is used or disclosed to carry out treatment, payment, or other healthcare operations. I understand that RCWC is not required to agree to my requested restrictions, but if agreeable is then bound to abide by such restrictions.

Patient or Guardian Signature: ______________________________ **Date:** ________________

INFORMED CONSENT FOR TREATMENT

I, ______________________________, hereby authorize Laura James, ND, FABNO, to perform or refer for the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g., venipuncture, Pap smears, radiography, laboratory, X-ray.
Minor office procedures: e.g., dressing a wound, ear cleansing.
Medicinal use of nutrition: e.g., therapeutic nutrition, nutritional supplementation, IV nutrients, and intramuscular vitamin injections.
Botanical medicine: botanical substances may be prescribed as teas, alcohol-containing tinctures, capsules, tablets, creams, 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.
Physical Medicine: e.g., use of massage, cupping, muscle stretching, exercise therapy, naturopathic manipulation to relieve pain and improve function. May also include use of heating pads, micro-current electrical therapy, craniosacral therapy, or low-level laser therapy.
Hydrotherapy: e.g., constitutional hydrotherapy treatments with electrostimulation, contrast baths, and hydrocollator packs.
Pharmaceutical medicine: e.g., prescription of drugs or over-the-counter medication.
Lifestyle counseling and hygiene: e.g., diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.
Psychological counseling
Contraception
Acupuncture

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

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures.

Potential benefits: restoration of health and the body's maximal functional capacity, 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 as 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 Laura James, ND/Red Cedar Wellness Center or any of its personnel 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 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 so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for seven years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my physician to the best of her ability.

______________________________ ______________________________

Signature of Patient/Patient Guardian or Representative **Date**