**Partners in Health Care, Naturally**
**343 S. Montezuma Prescott, AZ 86303**
**Phone: (928) 445-2900 ▪ Fax: (928) 445-2053**

Name:_____ Date of Birth:_____

Cell Phone:_____ Alt/Home Phone:_____

**Do we have permission to leave a detailed message for you at a particular phone number? Yes No
If so, which number do you prefer we call? Cell Work Alt _____

Mailing Address:_____

_____

Physical Address if Diff from Above:_____

Email Address: _____

Social Security:_____ Gender: M F ___ Marital Status: S M D Sep W Partnered

Employer: _____ Occupation: _____ Phone: _____

Emergency Contact:_____ Phone:_____

Relationship:_____

*Do we have permission to speak openly with your Emergency Contact regarding your healthcare/status? **Yes No**
If not, then whom would you prefer we speak with?

Name:_____Phone:_____

Insurance Company:_____

ID:_____Group:_____

Insurance Address:_____

Card Holder's Name: _____Date of Birth:_____

Card Holders Relationship to you:_____

Card Holder's Employer:_____ Phone:_____

My signature below attests that all information is true and correct. I understand that I am responsible for all monies owed for services rendered and that I am giving permission to release any necessary medical information to my insurance company. I am aware that in the event I'm unable to keep my appointment I need to give a ***minimum 24 hour notice*** by calling 928-445-2900. In the event I fail to do so, I am aware that I may be charged for a fee or for the appointment time.

**SIGNATURE:_____DATE:_____**

**Printed Name: _____Relationship to Patient:_____**

How did you hear about us?_____

**Medical Information**

Height:_____ Weight:_____ Has your weight varied significantly throughout your life? _____

Number of Children: _____ Number of children at home: _____

What health concerns prompted today's visit? _____

_____

What are your health goals related to this concern? _____

_____

| √ Disorder | Self | Mother | Father | Sibling | Aunt/Uncle | Grandparent |
|---|---|---|---|---|---|---|
| Allergies: | | | | | | |
| Cancer/Type: | | | | | | |
| Depression/Anxiety: | | | | | | |
| Diabetes: | | | | | | |
| Heart Disease: | | | | | | |
| High Blood Pressure: | | | | | | |
| Mental Illness: | | | | | | |
| Obesity: | | | | | | |
| Stroke: | | | | | | |
| Thyroid Disease: | | | | | | |

**What areas of natural medicine have you had experience with? (Circle all that apply)**

Acupuncture Ayurveda Chelation Therapy Chinese Medicine

Herbal Medicine Homeopathy Massage Therapy Midwifery

Naturopathy Environmental Medicine Osteopathic Medicine Chiropractic

Others: _____

Childhood illnesses: Chicken pox_____ Measles_____ Mumps_____ Other_____

As well as you can recall, what vaccines have you had? _____

**Current Life Style** *(Please rate 1-10 1=very little 10=very much)*

How many hours do you work each week? ____ How would you describe your average stress level? _____

Occupational Stress (chemical, physical, psychological, etc.)? _____

How much water do you drink each day? _____ What type? _____

Other beverages:_____ How often? _____

How often do you eat in restaurants weekly? _____

Do you strongly crave any particular foods? _____

****Any known allergies or reactions to medicines/foods/ other agents? (write here:)** _____

_____

Do you exercise? Y / N Types:_____Frequency:_____
Do you use tobacco? Y / N Types:_____Frequency:_____
Do you use alcohol? Y / N Types:_____Frequency:_____
Do you use caffeine? Y / N Types:_____Frequency:_____
Do you use sugar? Y / N Types:_____Frequency:_____
Recreational drugs? Y / N Types:_____Frequency:_____

Have you unsuccessfully tried to stop using any of the above items?_____

Surgical History: (Operation & date):_____

Significant Trauma (auto accidents, falls, broken bones, etc. & dates):_____

_____

History of abuse (emotional, physical and sexual): _____

Which statement best describes your attitude to your health? (Check one)

- ☐ I will do whatever it takes to obtain optimal health
- ☐ I am willing to change my lifestyle somewhat to feel better
- ☐ I may consider change if needed to feel better
- ☐ Just give me a pill, do**c**

## Please list all current medications including herbs and dietary supplements.

| Medications | Dosages | How long have you taken it? | Prescribed by Dr's name or self | For what purpose? | Side effects |
|---|---|---|---|---|---|
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When was your last yearly medical exam/visit? _____

What is your blood type?_____ If unknown, would you like to know? Yes / No

Are you current with your medical preventative tests? Yes / No / Unsure

Recent tests: _____

## Please list other health professionals with whom you currently consult:

| Name | Specialty | Office location | Telephone |
|---|---|---|---|
| | | | |
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**MALES ONLY**

*Please check or explain if applicable:*

- ☐ Reduced sexual energies
- ☐ Prostate problems
- ☐ Vasectomy/operations
- ☐ Frequent urination
- ☐ Premature ejaculation
- ☐ Seminal emission
- ☐ Impotence
- ☐ Discharges
- ☐ Pain associated with genitals
- ☐ Pain associated with intercourse
- ☐ Other

**FEMALES ONLY**

Are you or might you be pregnant? ☐ Yes ☐ No ☐ Maybe If yes, how long?_____

What method of birth control do you use?_____

Are you experiencing reduced sexual energies? ☐ Yes ☐ No

Do you have regular exams?_____

*Please check or explain if applicable:*

**Menstrual cycle:**

Age started_____ Age stopped_____

- ☐ Irregular
- ☐ Painful
- ☐ Irritability
- ☐ Depression/anxiety
- ☐ Dark
- ☐ Light
- ☐ Heavy clotting
- ☐ Water retention
- ☐ Painful breasts
- ☐ Discharges

Breast/Gyn history or operations: _____

_____

**Pregnancy:**

Total number:_____ Children:_____ Miscarriages:_____ Abortions:_____

Complications:_____

**Other:**

☐Hot flashes ☐Night sweats ☐Bloating ☐Bleeding ☐Mood changes ☐Weight changes ☐Poor sleep

The top is birth and bottom present and the bottom is your present. Please mark events in your life that were pivotal. These may be religious events, marriages, divorces, childbirth, illnesses, relocations, accidents, occupational changes, educational milestones or impactful life events.

*(Birth)*



*(Present)*

*Partners in Health Care, Naturally*
*343 S. Montezuma Street, Prescott, AZ 86303*
*Phone: (928) 445-2900 | Fax: (928) 445-2053*

## Consent to Treat

Name: _____

Date of Birth: _____

I understand that this is a Naturopathic Medical Clinic and I give consent to this form of treatment. I understand that a Naturopathic Doctor is a physician who specializes in natural medicine. I am aware that with the guidance of the doctor, I may choose to be an active partner in helping determine my treatment plan and I will ask the doctor to explain when there may be a treatment that I am unfamiliar with or do not understand. I am aware that any type of medicine, conventional or otherwise, may have potential side effects. I am aware that treatment results are not guaranteed and that Naturopathic Medicine is not a substitute for conventional medical treatment. I will inform the doctor of any known allergies and provide previous medical history as necessary.

I hereby request Naturopathic Medicine treatment and therapies that may include nutritional consultations and other procedures, various modes of physiotherapy, nutritional therapy (including IV or IM injections if indicated) and diagnostic procedures, including laboratory testing, on me (or the patient named below for whom I am legally responsible) by a Doctor of Naturopathic Medicine and/or licensed doctors of Naturopathic Medicine who now or in the future treat me while employed by, working or associated with, or serving as back-up doctor in the offices of Partners in Health Care, Naturally. I also understand that Naturopathic Interns working under the doctor's direct supervision or the RN employed by the doctor may be directed by the doctor to perform certain diagnostic or therapeutic procedures on me during the time of my care.

Printed Name of Patient: _____

Patient/Guardian Signature: _____ Date: _____

## Financial Agreement

I claim full financial responsibility for services rendered by Partners in Health Care, Naturally and understand that full payment is required at the time of service.

Signature: _____ Date: _____

## Cancellation/ No Show Policy

I understand that Partners in Health Care, Naturally requires a 24-hour cancellation notice for all appointments. I understand that my failure to furnish notice will result in a charge of $55, which must be paid in advance of making a replacement appointment.

Signature: _____ Date: _____

# *Partners in Health Care, Naturally*

## Acknowledgement of Receipt of
## Notice of Privacy Practices for Protected Health Information

I, _____ (print patient name),
do hereby acknowledge receipt of a copy of the Notice f Privacy Practices, Policies, and Procedures.

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(Patient Signature) (Date)

In the event this request if made by the patient's representative/guardian:

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(Representative/Guardian) (Date)

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Partners in Health Care, Naturally, Staff/Witness (Date)

*** * * THIS DOCUMENT IS FOR THE PATIENT TO KEEP – DO NOT RETURN THIS DOCUMENT TO CLINIC * * ***

***Partners in Health Care, Naturally***
**Notice of Privacy Practices for Protected Health Information**
**Effective Date: January 1, 2012**

**This notice describes how medical information about you (as a patient) may be used and disclosed and how you can get access to this information.**
**Please review it carefully!**

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (Protected Health Information, PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of this Notice of Privacy Practices that we have in effect at this time.

*We will provide you with the following important information:*
How we may use and disclose your PHI
Your privacy rights and your PHI
Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by Partners in Health Care, Naturally. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that Partners in Health Care, Naturally has created or maintained in the past, and for any of your records that we may create or maintain in the future. Partners in Health Care Naturally will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

If you have questions about this Notice, please contact:
Paula Sarvani, Front Office Coordinator, 928-445-2900

**We may use and disclose your PHI in the following ways:**
**Treatment, Payment and Operations**

**Treatment Purposes:**

Partners in Health Care Naturally may use your PHI to treat you using laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We may disclose your information to a pharmacy when we order a prescription for you. Those who work for our practice – including, but not limited to, our doctors and staff—may use or disclose your PHI in order to treat you or to assist in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

**Payment Purposes:**

Partners in Health Care, Naturally, may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. We may contact your insurance company to verify eligibility of benefits. We may also provide details regarding treatment given to receive such payment. We may disclose to third party, such as family members that may be responsible for such costs. We may use your PHI to bill you directly for services and items rendered and will assist other health care providers and entities in their billing and collection efforts, such as labs.

**Health Care Operations:**

Partners in Health Care Naturally may use and disclose your PHI to operate our business. Examples, for our operations; our practice may use your PHI to evaluate the quality of care you received from us, quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance.

**Your Health Information Rights**

**The health and billing records we maintain are the physical property of the office/hospital. The information in it, however, belongs to you. You have a right to:** (next page→)

**You have a right to:**

• Request a restriction on certain uses and disclosures of your health information by delivering the request to our office/hospital — we are not required to grant the request, but we will comply with any request granted;
• Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full—we must comply with this request;
• Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
• Request that you be allowed to inspect and copy your health record and billing record. You may exercise this right by delivering the request to our office;
• Appeal a denial of access to your protected health information, except in certain circumstances;
• Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for the office/hospital;
- Is not part of the information that you would be permitted to inspect and copy; or
- Is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;
• Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
• Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office/hospital. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.
• Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken.
• Elect to opt out of receiving farther communications from the office or via e-mail.

If you want to exercise any of the above rights, please contact Paula Sarvani, 343 S. Montezuma; 928-445-2900, in person or in writing, during regular business hours. She will inform you of the steps that need to be taken to exercise your rights.

## Our Responsibilities

**Partners in Health Care, Naturally is required to:**

• Maintain the privacy of your health information as required by law;
• Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
• Abide by the terms of this Notice;
• Notify you if we cannot accommodate a requested restriction or request; and,
• Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

## Other Disclosures and Uses

**Communication with Family**
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

**Notification**
Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

**Disaster Relief**
We may use and disclose your protected health information to assist in disaster relief efforts.

**Food and Drug Administration (FDA)**
We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

**Workers Compensation**
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

**Public Health**
As authorized by law, we may disclose your protected health information to public health or legal authorities charged with pre-venting or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

**Abuse & Neglect**
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

**Employers**
We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

**Correctional Institutions**
If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

**Law Enforcement**
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

**Health Oversight**
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

**Judicial/Administrative Proceedings**
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

**Serious Threat**
To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

**For Specialized Governmental Functions**
We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

**Coroners, Medical Examiners, and Funeral Directors**
We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients of Covered Entities to funeral directors as necessary for them to carry out their duties.

**Other Uses**
Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights."

**Website --** If we maintain a website that provides information about our entity, this Notice will be on the website.

## To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact: Paula Sarvani, Front Office Coordinator, 928-445-2900. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to **Dr. Susan Godman.**