DOCERE CENTER
FOR NATURAL HEALTH

COMPREHENSIVE HEALTH HISTORY

Thank you for choosing Docere Center for Natural Health to assist you with your health care. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

Date:_____

First Name:_____ Middle:_____Last:_____

Address: _____ City: _____ State: _____ Zip Code:_____

Home Phone: (____) _____-_____ Work: (____) _____-_____ Cell: (____) ____-_____

Preferred way of contacting you or leaving messages: _____

Email: _____

Age: _____ Date of Birth: ____/____/_____ Place of Birth: _____Gender: Female__Male___

City or town & country, if not US

Referred by:_____

Name, address, & phone number of primary care physician:_____

_____

Marital Status:

Single____ Married____ Divorced____ Widowed____ Long Term Partnership____

Emergency Contact: _____

Relationship Name Phone

_____

Address

Occupation: _____ Hours per Week: _____ Retired: Y / N

Genetic Background (optional):

□ African American □ Hispanic □ Mediterranean □ Asian

□ Native American □ Caucasian □ Northern European □ Other

CURRENT HEALTH STATUS/CONCERNS

Problem	Date of Onset	Severity/Frequency	Treatment Approach	Success
Example: Headaches	May 2006	2 times per week	Acupuncture/Aspirin	Mild improvement

What diagnosis or explanation(s), if any, have been given to you for these concerns?

_____

_____

_____

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions?_____

_____

_____

PAST MEDICAL AND SURGICAL HISTORY

If you have experienced reoccurrence of an illness, please indicate when or how often under comments.

ILLNESSES	WHEN /ONSET	COMMENTS

INJURIES	WHEN	COMMENTS

DIAGNOSTIC STUDIES	WHEN	COMMENTS
SURGERIES & HOSPITALIZATIONS	**WHEN**	**REASON**

MEDICATIONS

How often have you taken antibiotics?	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

How often have you taken oral steroids? (e.g. Prednisone, Cortisone, etc.)	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

List all medications. Include all over the counter non-prescription drugs.

Medication Name	Date started	Date stopped	Dosage

List all vitamins, minerals, and any nutritional supplements that you are taking now.

Type	Date Started	Date Stopped	Dosage

Are you allergic to any medication, vitamin, mineral, or other nutritional supplement? Yes___ No ___

If yes, please list:_____

_____

CHILDHOOD HISTORY

PRENATAL HISTORY:

Were there any problems associated with your mother's pregnancy with you? *(Check all that apply)*

□ Falls/Injury □ Illness □ Difficult □ Other_____

During your mother's pregnancy with you, did she: *(Check all that apply)*

□ Smoke tobacco □ Use recreational drugs □ Drink alcohol □ Use estrogen

□ Use other prescription or non-prescription medications □ Unknown

BIRTH HISTORY:

Was your birth*: (Check all that apply)*

□ Drug-induced □ C-section □ Breech □ Natural □ Forceps/Suction

□ Prolonged □ Cord around neck □ Home □ Hospital □ Traumatic

NOURISHMENT:

As a baby, were you breastfed? Yes___ No ___ Bottle-fed? Yes___ No ___

Do you know at what age you were given solid foods? _____

How would you describe your diet as a child? _____

_____

IMMUNIZATION HISTORY:

□ I am fully vaccinated □ I am selectively vaccinated □ I am not vaccinated

Last tetanus booster: _____

Did you ever get the flu vaccine? Yes___ No ___

Ever had an adverse reaction to vaccine? Yes___ No ___

Please check if you have been vaccinated against any of the following diseases:

□ Chicken Pox □ DPT □ Hepatitis □ HIB □ MMR □ Pneumonia □ Polio

CHILDHOOD ILLNESSES:

How often did you get sick as a child? _____

Please indicate which of the following problems/conditions you experienced as a child (ages birth to 12 years):

□ ADD (Attention Deficit Disorder) □ Asthma □ Bronchitis □ Chicken Pox □ Colic

□ Congenital problems □ Ear infections □ Fever blisters □ Frequent colds or flu

□ Frequent headaches □ Hyperactivity □ Jaundice □ Measles □ Mumps □ Pneumonia

□ Seasonal allergies □ Skin disorders (e.g. dermatitis) □ Strep infections □Tonsillitis

□ Upset stomach, digestive problems □ Whooping cough

□ Other (describe) _____

As a child did you: Experience chronic exposure to second hand smoke in your home? Yes___ No___

Experience abuse? Yes___ No___

Have alcoholism or substance abuse present in your home? Yes___ No___

FEMALE MEDICAL HISTORY

(For women only)

OBSTETRICS HISTORY:

Check box if yes and provide number of pregnancies and/or occurrences of conditions.

- ❑ Pregnancies_____ ❑ Caesarean _____ ❑ Vaginal deliveries_____
- ❑ Miscarriage _____ ❑ Abortion _____ ❑ Living Children_____
- ❑ Postpartum depression___ ❑ Toxemia _____ ❑ Gestational diabetes_____

GYNECOLOGICAL HISTORY:

Age at first menses? _____ Frequency:_____ Length:_____

Date of last menstrual period: ____/____/_____

Do you experience breast tenderness, water retention, or irritability (PMS) symptoms in the second half of your cycle? Yes _____ No _____

Please advise of any other symptoms that you feel are significant._____

_____

Are you sexual active? Yes_____ No_____ Sexual orientation: _____

Do you currently use contraception? Yes____ No____ If yes, please indicate which form:

Non-hormonal

- ❑ Condom
- ❑ Diaphragm
- ❑ IUD
- ❑ Partner vasectomy
- ❑ Other (please describe)_____

Hormonal

- ❑ Birth control pills
- ❑ Patch
- ❑ Nuva Ring
- ❑ Other (please describe)_____

Even if you are *not* currently using contraception, but have used hormonal birth control in the past, please indicate which type and for how long._____

Are you menopausal? Yes_____ No_____ If yes, age of menopause:_____

Do you currently take hormone replacement? Yes___ No___ If yes, what type and for how long?_____

- ❑ Estrogen ❑ Ogen ❑ Estrace
- ❑ Premarin ❑ Progesterone ❑ Provera ❑ Other_____

Do you do self-breast exams? Yes____ No____

DIAGNOSTIC TESTING:

Last Pap test: _____/_____/_____ Results: Normal_____ Abnormal_____

Last Mammogram: _____/_____/_____ Breast biopsy? Date: _____/_____/_____

Last Bone Density test: _____/_____/_____ Results: High_____ Low_____ Within normal range_____

FAMILY HEALTH HISTORY

Please indicate current and past history to the best of your knowledge.

Check Family Members that Apply	**Father**	**Mother**	**Brother(s)**	**Sister(s)**	**Children**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**
Age (if still living)									
Age at death (if deceased)									
Allergies									
Alzheimer's									
Anemia									
Anxiety									
Arthritis									
Asthma									
Cancer									
Bipolar Disease									
Depression									
Diabetes									
Epilepsy									
Glaucoma									
Heart Attack									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Kidney Disease									
Multiple Sclerosis									
Obesity									
Osteoporosis									
Parkinson's									
Psychiatric Disorders									
Stroke									
Substance Abuse									
Thyroid Disorder									
Tuberculosis									
Ulcers									
Other									

REVIEW OF SYSTEMS

Check (√) those that applied to you in the ***past***. **Circle** those that ***presently*** apply.

CONSTITUTIONAL:
- ❑ Weight change
- ❑ Fever/Chills
- ❑ General weakness
- ❑ Night sweats
- ❑ Fatigue

SKIN:
- ❑ Rashes
- ❑ Eczema
- ❑ Hives
- ❑ Acne/Boils
- ❑ Itching
- ❑ Pigmentation
- ❑ Changing moles
- ❑ Lumps, Bumps
- ❑ Brittle nails
- ❑ Fungal infections
- ❑ Dandruff
- ❑ Hair loss
- ❑ Skin cancer

Is your skin sensitive to:
- ❑ Sun
- ❑ Fabrics
- ❑ Detergents
- ❑ Lotions/Creams

HEAD:
- ❑ Headache
- ❑ Migraine
- ❑ Whiplash
- ❑ Concussion
- ❑ Dizziness
- ❑ Memory loss

EYES:
- ❑ Glasses/Contacts
- ❑ Vision loss/Blurred vision
- ❑ Double vision
- ❑ Floaters
- ❑ Discharge
- ❑ Pain or strain
- ❑ Tearing or dryness
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Color blindness
- ❑ Night blindness

EARS:
- ❑ Frequent infections
- ❑ Tubes in ears
- ❑ Ringing
- ❑ Earache
- ❑ Vertigo/Dizziness
- ❑ Discharge
- ❑ Itching
- ❑ Pressure
- ❑ Diminished hearing
- ❑ Hearing aid

NOSE/SINUSES:
- ❑ Nose bleeds
- ❑ Stuffy/Congestion
- ❑ Runny/Discharge
- ❑ Postnasal drip
- ❑ Recurrent sinus infections
- ❑ Polyps
- ❑ No sense of smell
- ❑ Hay Fever

MOUTH:
- ❑ Coated tongue
- ❑ Sore tongue or lips
- ❑ Bleeding gums
- ❑ Canker sores
- ❑ Fever blisters/Cold sores
- ❑ Cracked lips/ corners
- ❑ TMJ Syndrome
- ❑ Bad breath
- ❑ Dry mouth
- ❑ Grind teeth when sleeping
- ❑ Dental cavities
- ❑ Wear dentures

THROAT:
- ❑ Mucus
- ❑ Frequent hoarseness
- ❑ Frequent sore throats
- ❑ Scratchy throat
- ❑ Tonsillitis
- ❑ Enlarged glands

NECK:
- ❑ Swollen glands
- ❑ Goiter
- ❑ Pain or stiffness in neck
- ❑ Lumps in neck

CARDIOVASCULAR:
- ❑ Heart disease
- ❑ Prior heart attack? When___/___/___
- ❑ Palpitations

CARDIOVASCULAR CONT.:
- ❑ Arrhythmia (irregular heartbeat)
- ❑ Angina (chest pain)
- ❑ High blood pressure
- ❑ Murmur
- ❑ Pacemaker
- ❑ Shortness of breath w/ mild exercise
- ❑ Orthopnea (shortness of breath lying flat)
- ❑ Fainting spells
- ❑ Swollen ankles

RESPIRATORY:
- ❑ Productive cough
- ❑ Hemoptysis (coughing up blood)
- ❑ Sputum
- ❑ Wheezing
- ❑ Asthma
- ❑ Chronic Bronchitis
- ❑ Pneumonia
- ❑ Emphysema
- ❑ Painful breathing
- ❑ Dyspnea (shortness of breath)
- ❑ Tuberculosis (TB)

GASTROINTESTINAL:
- ❑ Dysphagia (difficulty swallowing)
- ❑ Heartburn/GERD
- ❑ Hiatal hernia
- ❑ Poor appetite
- ❑ Nausea/Vomiting
- ❑ Hematemesis (vomiting blood)
- ❑ Abdominal pain/cramps
- ❑ Indigestion
- ❑ Gas or belch frequently
- ❑ Bloating
- ❑ Diarrhea
- ❑ Constipation
- ❑ Chronic laxative use
- ❑ Liver disease
- ❑ Peptic/Duodenal ulcer
- ❑ Gallbladder disease
- ❑ Colitis or IBS
- ❑ Rectal pain
- ❑ Hemorrhoids
- ❑ Blood in stools
- ❑ Black stools
- ❑ Undigested food in stools
- ❑ Bowel movements: How often? _____
  Is this a change? Y / N

GENITOURINARY:
- ❑ Dysuria (painful or burning urination)
- ❑ Nocturia (urination at night)
  - ❑ How many times at night? _____
- ❑ Hematuria (blood in urine)
- ❑ Frequent or urgent urination
- ❑ Incontinence
- ❑ Dribbling of urine
- ❑ Bedwetting
- ❑ Bladder infection
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Urinary tract infection

MUSCOLOSKELETAL:
- ❑ Trauma
- ❑ Swelling
- ❑ Joint pain or stiffness
- ❑ Muscle spasms or cramps
- ❑ Muscle weakness
- ❑ Poor balance, Osteoporosis
- ❑ Back pain
- ❑ Radiation (e.g. sciatica)
- ❑ Arthritis
- ❑ Herniated disc
- ❑ Fibromyalgia
- ❑ Gout

NEUROPSYCHOLOGICAL:
- ❑ Fainting spells
- ❑ Seizure/Convulsions
- ❑ Paralysis
- ❑ Numbness/Tingling
- ❑ Tics/Tremor
- ❑ Lack of coordination
- ❑ Speech difficulties
- ❑ Poor concentration
- ❑ Memory loss
- ❑ Hallucinations
- ❑ Parkinson's
- ❑ Multiple sclerosis
- ❑ Stroke
- ❑ Anxiety
- ❑ Phobia
- ❑ Depression
- ❑ Bipolar disorder
- ❑ Have considered or attempted suicide
- ❑ Previously admitted for psychiatric care

ENDOCRINE:
- ❑ Thyroid disorder (Hypo/Hyperthyroidism)
- ❑ Heat or cold intolerance
- ❑ Hypoglycemia
- ❑ Diabetes
- ❑ Excessive thirst, hunger, and/or urination
- ❑ Seasonal Affective Disorder (SAD)

HEMATOLOGIC:
- ❑ Anemia
- ❑ Easy bleeding or bruising
- ❑ Bleeding/Clotting disorder
- ❑ Cold hands/feet
- ❑ Varicose veins/Spider veins
- ❑ Vessel inflammation
- ❑ Deep leg pain
- ❑ Blood transfusion

IMMUNOLOGIC:

▪ How many times a year do you get sick?
_____

▪ Do you recover easily? Y / N

□ Lymph node swelling
□ Slow wound healing
□ Rheumatoid arthritis
□ Psoriasis
□ Chronic fatigue syndrome
□ Chemotherapy for cancer treatment
□ Organ transplant

FEMALE REPRODUCTIVE:

□ Spotting between periods
□ Irregular cycle
□ Dysmenorrhea (menstrual pain)
□ Heavy or excessive flow
□ Clotting
□ Pain during intercourse
□ Decreased libido
□ Infertility
□ Endometriosis
□ Vaginal discharge
□ Vaginal odor
□ Vaginal dryness
□ Partial/total hysterectomy
□ Hot flashes
□ Mood swings
□ Night sweats
□ Ovarian cysts
□ Fibroid tumors
□ Fibrocystic breasts
□ Lumps in breast
□ Breast pain/tenderness
□ Nipple discharge
□ Breast cancer

MALE REPRODUCTIVE:

□ Prostate disease
□ Sores/Discharge
□ Hernia
□ Testicular pain/swelling
□ Decreased libido
□ Impotence
□ Premature ejaculation

MALE REPRODUCTIVE CONT:

▪ Are you sexually active? Y / N
▪ Sexual orientation: _____
▪ Birth control? Type: _____
▪ Have you ever had an STD screening? Y / N
If so, when? _____
▪ Date of last Digital Rectal Exam? _____
▪ Have you had a PSA test done? Y / N
PSA Level:
□ 0-2 □ 2-4 □ 4-10 □ >10

SEXUAL HISTORY/EXPOSURES:

□ Herpes
□ Gonorrhea
□ Chlamydia
□ Syphilis
□Trichomonas
□ Hepatitis
□ HIV/AIDS
□ Other: _____

NUTRITIONAL HISTORY

Please list your dietary preferences and frequency of meals and snacks:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How many glasses of water do you drink per day? _____
Have you made any changes in your eating habits because of your health? Yes____ No_____
Do you eat three meals a day? Yes____ No_____
Do you go on diets often? Yes____ No_____
Do you eat out often? Yes____ No_____

Which of the following do you consume and how much do you consume at each week?

□ Candy_____ □ Cheese_____ □ Chocolate_____
□ Caffeinated coffee _____ □ Caffeinated tea _____
□ Decaffeinated coffee _____ □ Decaffeinated tea_____ □ Diet soda_____
□ Salty foods_____ □ Slices of white bread _____ □ Soda_____

LIFESTYLE HISTORY

Please check all that apply and note frequency of use:

□ Tobacco: _____ # of Years: _____ Year Quit: _____

□ Alcohol: _____

□ Recreational Drugs: _____

Have you ever been treated for drug/alcohol abuse and dependence? Yes ___No___

To your knowledge, have you ever been exposed to toxic metals in your job or at home? Yes ___No___

If yes, indicate which: □ Arsenic □ Aluminum □ Cadmium □ Mercury □ Other: _____

SLEEP & REST HISTORY:

Average number of hours that you sleep at night? Less than 10__ 8-10___ 6-8___ less than 6___

Please check those that apply:
□ Difficulty falling asleep □ Use sleeping aids □ Snore □ Sleepwalker □ Nightmares □ No dream recall
□ Early waking □ Feel rested upon awakening □ Daytime sleepiness

EXERCISE HISTORY:

Please list types of exercise/physical activity of frequency: _____

_____

SOCIAL/EMOTIONAL HISTORY

How do you grade your emotional/mental health?

□ Excellent □ Good □ Fair □ Poor □ Getting better □ Getting worse

How do you rate your overall quality of life?

□ Excellent □ Good □ Fair □ Poor □ Getting better □ Getting worse

Please check all that apply and note their severity on a 1-5 scale (1 is the easiest and 5 the most difficult).

Loss of a loved one_____ Recreation_____ Family_____ Work_____ Stress of illness_____ Relationships_____ Commuting_____ School_____

Divorce/separation_____ Parents' divorce_____ Financial_____ Lifestyle change_____

How would you rate your stress level over the last 90 days? Low – 1 2 3 4 5 6 7 8 9 10 – High

Comments:_____

Which of the following provide you emotional support? *(Check all that apply)*

□ Spouse □ Family □ Friends □ Religious/Spiritual □ Pets □ Other_____

Have you ever been involved in abusive relationships in your life? Yes ___ No___

Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes ___ No___

Is alcoholism or substance abuse present in your relationships now? Yes ___ No___

How important is religion (or spirituality) for you and your family's life?

a. _____ not at all important b. _____ somewhat important c. _____ extremely important

Do you practice meditation or relaxation techniques? Yes ___ No ___ If yes, how often? _____

Hobbies and leisure activities: _____

Is there anything that you would like to discuss with us today that you feel you cannot indicate here?

Yes_____ No_____

READINESS ASSESSMENT

Rate on a scale of: 5 (very willing) to 1 (not willing).

In order to improve your health, how willing are you to:

Significantly modify your diet	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Take nutritional supplements each day	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Keep a record of everything you eat each day	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Modify your lifestyle (e.g. work demands, sleep habits)	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Practice relaxation techniques	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Engage in regular exercise	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Have periodic lab tests to assess progress	5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Comments: _____

_____

DOCERE CENTER
FOR NATURAL HEALTH

INFORMED CONSENT FOR TREATMENT

I acknowledge that I am accepting treatment from a licensed Naturopathic Doctor at Docere Center for Natural Health. I hereby authorize Dr. Sanaz Forghani, ND to perform the following specific procedures as necessary to facilitate my diagnosis and treatment, which may include but not limited to:

Common Diagnostic Procedures (e.g. venipuncture, pap smears, radiography, blood and urine lab work, general physical exams, neurological and musculoskeletal assessments).
Minor Office Procedures (e.g. dressing a wound, ear cleansing).
Lifestyle Counseling; Psychological Counseling; Exercise Prescriptions
Botanical/Herbal Medicines (prescribing of various therapeutic substance including plants, shells, minerals, animal materials and other sources. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol, or raw herbs to be cooked; topical cremes, pastes, plasters washes; suppositories or other forms).
Homeopathic Remedies (use of highly dilute quantities of naturally occurring substance).
Dietary Advice and Therapeutic Nutrition (use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections or IV therapy).
Soft Tissue (use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, and craniosacral therapy).
Electromagnetic and Thermal Therapies (use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and infrared and ultraviolet therapies or moxa—warming or indirect burning of an acupuncture point and hydrotherapies).

I recognize that in the practice of Naturopathic Medicine there are some risks and benefits with evaluation and treatment including, but not limited to the following:

Potential Risks: Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of symptoms existing prior to the naturopathic treatment. I will notify Docere Center for Natural Health if I experience any symptoms which may be secondary to the above 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. Labor-stimulating techniques or any labor inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

Wth this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Sanaz Forghani, ND regarding cure or improvement of my condition. By signing below, I acknowledge that I have been provided ample opportunity to read, or have been read, this form and have had any questions satisfactorily answered. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment. 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 also understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

_____	_____	_____
Print Patient's Name	Patient's Signature	Date
_____	_____	_____
Print Name of Guardian/Responsible Party	Guardian/Responsible Party's Signature	Date

DOCERE CENTER
FOR NATURAL HEALTH

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. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds.
- Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please **check all that apply**:

□ Please do not phone me at home. Use this alternate phone number: _____
□ Please do not phone me at work. Use this alternate phone number: _____
□ Please do not call my cell phone. Use this alternate phone number: _____
□ 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: _____
□ Other request (please describe):_____

Receipt of Notice of Privacy Policies & Consent Form: We have provided a "Notice of Privacy Practices" that describes in detail how we may use and disclose your protected health information. You have the right to review this document at any time. You have the right to request restrictions on how we may use or disclose your health information. We are not required by law to agree to your requested restriction, but we will comply with any reasonable request. You also have the right to revoke/withdraw this consent, in writing, at any time, except to the extent that we have already taken action in reliance on the consent.

Please note that the privacy practices described in the "Notice of Privacy Practices" may change over time, and that you have the right to obtain any revised Privacy Notices, if requested. A copy of our "Notice of Privacy Practices" may be obtained by downloading it from our website, docerehealth.com.

I acknowledge that I have had full opportunity to read and consider the contents of this consent form and the "Notice of Privacy Practices." By signing this consent form, I understand that I am giving Docere Center for Natural Health permission to use and disclose my protected health information for treatment, to obtain payment for the treatment provided, and as necessary for the operations of this office.

_____
Print Name

_____ _____
Signature of Patient/Guardian Date

DOCERE CENTER
FOR NATURAL HEALTH

GENERAL POLICIES

Welcome to Docere Center for Natural Health. We look forward to providing you with the highest quality naturopathic medical care possible. Please sign below to acknowledge that you have read and understand the following policies.

Fees:
• First Office Visit (60-90 min) …… $250.00

• Return Office Visit:
Brief Visit (10-20 minutes)……..$75.00
Short Visit (21-40 minutes)…….$120.00
Standard Visit (41-60 minutes)…….$170.00
Extended Visit (61-80 minutes)…….$215.00

Insurance:
Docere Center for Natural Health is a **cash-based practice** that does not bill your insurance or Medicare. Upon request, we will provide a Superbill with diagnostic and procedural information for you to submit to your insurance provider for reimbursement. This does not ensure any coverage or reimbursement from your insurance company.

Payment:
Payment is due in full at the time of service. This includes fees for medical office visits and any product (nutritional supplements, herbal medicine, homeopathic remedies) prescribed for you. Please note that all sales of services and of products are final. We accept cash, credit (Visa, MasterCard, Discover, American Express) or check payable to “Docere Center for Natural Health”. Checks denied for insufficient funds will incur a fee of $30.00.

Phone & Email Consultations:
We are happy to answer short questions and clarify treatment instructions via phone or email for established patients. However, if the phone call extends beyond 10 minutes or if email consultations require multiple communications, a fee will be charged. Fees vary based on the complexity of the case. If there are any questions regarding this service, you are welcome to ask in your call or your email inquiry.

Social Media Policy:
In order to prevent violating HIPPA privacy laws, we will not follow, add, or friend patients on sites such as Twitter, Facebook, LinkedIn, etc.

Cancellation Policy:
At Docere Center for Natural Health, we respect your time, and we ask that you please respect ours.
For any appointment canceled with less than a 24-hour notice, or for any "no-show" appointment, you will be charged a $50.00 missed appointment fee before you may schedule your next appointment. The amount will be added to your next appointment.

Emergencies:
For after-hours *non urgent* questions please leave a message and we will return your call on the next business day. In the event of an emergency you are responsible to seek the appropriate medical care, call 911 or go to the nearest emergency room.

I understand and agree to the policies listed above.

_____
Print Name

_____ _____
Signature of Patient/Guardian Date