



West Valley Naturopathic Center

Time to listen, Time to Care, Time to Heal

Name _____ Date of First Visit _____

Address _____

City _____ State _____ Zip Code _____

Telephone # (home) _____ (work) _____

Age _____ Date of Birth _____ Gender: female ____ male ____

Education _____

Married ____ Separated ____ Divorced ____ Widowed ____

Single ____ Partnership ____

Live with: Spouse ____ Partner ____ Parents ____ Children ____

Friends ____ Alone ____

Occupation _____ Hours per week _____ Retired _____

Employer _____ S.S.# _____

(Work Address)

Health insurance co. name and address:

Policy Holder's name: _____ Employer _____

Policy/Group # _____ Tel.: () _____

Identification/Social Security # _____

How did you hear about our clinic?

Has any other family member already been a patient at the clinic?

Next of Kin or other to reach in an emergency?

Relationship: _____ Phone: _____

Address: _____

PLEASE FILL OUT BOTH SIDES OF EACH PAGE

HEALTH HISTORY QUESTIONNAIRE

SUCCESSFUL HEALTH CARE AND PREVENTIVE MEDICINE ARE ONLY POSSIBLE WHEN THE PHYSICIAN HAS A COMPLETE UNDERSTANDING OF THE PATIENT PHYSICALLY, MENTALLY AND EMOTIONALLY. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE. PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

Are you currently receiving healthcare? Y N

If yes, where and from whom? _____

If no, when and where did you last receive medical or health care? _____

What was the reason? _____

What are your most important health problems? List as many as you can in order of importance.

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

Do you have any known contagious diseases at this time? Y N

If yes,

what? _____

FAMILY HISTORY

	<u>FATHER</u>	<u>MOTHER</u>	<u>BROTHERS</u>	<u>SISTERS</u>	<u>SPOUSE</u>	<u>CHILD</u>
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=good P=poor)	_____	_____	_____	_____	_____	_____
Age at death (if deceased)	_____	_____	_____	_____	_____	_____

Check () those applicable

Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hayfever/Hives	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Kidney Dz	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

For all the following sections,

Y = a condition you have now **N** = never had

P = a condition you have had before

Childhood Illnesses

Scarlet fever	Y N	Diphtheria	Y N	Rheumatic fever	Y N
Mumps	Y N	Measles	Y N	German measles	Y N

Hospitalization and Surgery

What hospitalizations or surgeries have you had?

_____ year: _____

_____ year: _____

_____ year: _____

X-Rays and Special Studies

X-rays, CAT scans, or other studies you have had:

Electrocardiogram Y N

Electroencephalogram Y N

Immunizations

Polio Y N Pertussis Y N

Tetanus shot Y N Diphtheria Y N

Measles/Mumps/Rubella Y N Other _____

Allergies

Are you hypersensitive or allergic to...

Any drugs? _____

Any foods? _____

Any environmental? _____

Current Medications

Do you take or use?

Laxatives Y N Pain relievers Y N

Tranquilizers Y N Antacids Y N

Cortisone Y N Sleeping pills Y N

Antibiotics Y N Thyroid medication Y N

Appetite suppressants Y N

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking?

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

Do you drink cola or other sodas? Y P N Do you drink water?
Number of ounces _____ How many cups? _____
Do you eat refined sugar? Y P N Do you add salt? Y P N
Do you have a religious or spiritual practice? Y N
If yes, what? _____

How does your condition affect you? _____

What do you think is happening? _____

Why? _____

What do you feel needs to happen for you to get better? _____

What do you enjoy most in your life? _____

How much change are you willing to make at this time for improving your health?
MINIMAL SOME COMPLETE

Is there any information about your health you would like to add?

GENERAL

Weight _____ lbs. Weight 1 year ago _____ lbs.
Maximum Weight _____ When _____
Height _____
When during the day is your energy the best? _____ worst? _____

REVIEW OF SYSTEMS FOR THE FOLLOWING, PLEASE CIRCLE

Y = a condition you have now
N = never had
P = a condition you have had before

MENTAL/ EMOTIONAL

Treated for emotional problems?	Y P N	Depression?	Y P N
Mood Swings?	Y P N	Anxiety or nervousness?	Y P N
Considered/Attempted suicide?	Y P N	Tension?	Y P N
Poor concentration?	Y P N	Memory problems?	Y P N

ENDOCRINE

Hypothyroid?	Y P N	Heat or cold intolerance?	Y P N
Hypoglycemia?	Y P N	Diabetes?	Y P N
Excessive thirst?	Y P N	Excessive hunger?	Y P N
Fatigue?	Y P N	Seasonal depression?	Y P N

IMMUNE

Vaccinations?	Y P N	Reactions to vaccinations?	Y P N
Chronic Fatigue Syndrome?	Y P N	Chronic infections?	Y P N
Chronically swollen glands?	Y P N	Slow wound healing?	Y P N

NEUROLOGIC

Seizures?	Y P N	Paralysis?	Y P N
Muscle weakness?	Y P N	Numbness or tingling?	Y P N
Loss of memory?	Y P N	Easily stressed?	Y P N
Vertigo or dizziness?	Y P N	Loss of balance?	Y P N

SKIN

Rashes?	Y P N	Eczema, Hives?	Y P N
Acne, Boils?	Y P N	Itching?	Y P N
Color Change?	Y P N	Perpetual Hair Loss?	Y P N
Lumps?	Y P N	Night Sweats?	Y P N

HEAD

Headaches?	Y P N	Head Injury?	Y P N
Migraines?	Y P N	Jaw/TMJ problems	Y P N

EYES

Spots in Eyes?	Y P N	Cataracts?	Y P N
Impaired vision?	Y P N	Glasses or contacts?	Y P N
Blurriness?	Y P N	Eye pain/strain?	Y P N
Color blindness?	Y P N	Tearing or dryness?	Y P N
Double Vision?	Y P N	Glaucoma?	Y P N

EARS

Impaired hearing?	Y P N	Ringling?	Y P N
Earaches?	Y P N	Dizziness?	Y P N

NOSE AND SINUSES

Frequent colds?	Y P N	Nose Bleeds?	Y P N
Stuffiness?	Y P N	Hayfever?	Y P N
Sinus problems?	Y P N	Loss of smell?	Y P N

MOUTH AND THROAT

Frequent sore throat?	Y P N	Copious saliva?	Y P N
Teeth grinding?	Y P N	Sore tongue/lips?	Y P N
Gum problems?	Y P N	Hoarseness?	Y P N
Dental cavities?	Y P N	Jaw clicks?	Y P N

NECK

Lumps?	Y P N	Swollen glands?	Y P N
Goiter?	Y P N	Pain or stiffness?	Y P N

RESPIRATORY

Cough?	Y P N	Sputum?	Y P N
Spitting up blood?	Y P N	Wheezing	Y P N
Asthma?	Y P N	Bronchitis?	Y P N
Pneumonia?	Y P N	Pleurisy?	Y P N
Emphysema?	Y P N	Difficulty breathing?	Y P N
Pain on breathing?	Y P N	Shortness of breath?	Y P N
Shortness of breath at night?	Y P N	" " " " " "lying down?	Y P N
Tuberculosis?	Y P N		

CARDIOVASCULAR

Heart disease?	Y P N	Angina?	Y P N
High/Low Blood Pressure?	Y P N	Murmurs?	Y P N
Blood clots?	Y P N	Fainting?	Y P N
Phlebitis?	Y P N	Palpitations/Fluttering?	Y P N
Rheumatic Fever?	Y P N	Chest pain?	Y P N
Swelling in ankles?	Y P N		

GASTROINTESTINAL

Trouble swallowing?	Y P N	Heartburn?	Y P N
Change in thirst?	Y P N	Change in appetite?	Y P N
Nausea?	Y P N	Vomiting?	Y P N
Vomiting blood?	Y P N	Bowel Movements:	
Blood in stool?	Y P N	Number/day_____	
Is this a change _____			
Pain or cramps?	Y P N	Constipation?	Y P N
Belching or passing gas?	Y P N	Diarrhea?	Y P N
Black stools?	Y P N	Gall Bladder disease?	Y P N
Jaundice (yellow skin)?	Y P N	Ulcer?	Y P N
Liver Disease?	Y P N	Hemorrhoids?	Y P N

URINARY

Pain on urination?	Y P N	Increased frequency?	Y P N
Frequency at night?	Y P N	Inability to hold urine?	Y P N
Frequent infections?	Y P N	Kidney stones?	Y P N

MALE REPRODUCTION

Hernias?	Y P N	Testicular masses?	Y P N
Testicular pain?	Y P N	Prostate disease?	Y P N
Venereal disease?	Y P N	Discharge or sores?	Y P N
Are you sexually active?	Y N	Chlamydia?	Y P N
Sexual orientation: _____		Gonorrhea?	Y P N
Impotence?	Y P N	Condyloma?	Y P N
Premature ejaculation?	Y P N	Herpes?	Y P N
Birth control? Type? _____		Syphilis?	Y P N

FEMALE REPRODUCTION/BREASTS

Age of first menses? _____		Age of last menses? _____	
Are cycles regular?	Y P N	Length of cycle? _____ days	
Bleeding between cycles?	Y P N	Duration of menses? _____ days	
Pain during intercourse?	Y P N	Painful menses?	Y P N
Clotting?	Y P N	Heavy or excessive flow?	Y P N
Discharge?	Y P N		
PMS?	Y P N		
If yes, what are your symptoms?			

Birth control? _____	Y P N		
What Type? _____			
Number of years? _____			
Number of pregnancies? _____		Number of live births? _____	
Number of miscarriages? _____		Number of Abortions _____	
Endometriosis?	Y P N	Ovarian cysts?	Y P N
Difficulty conceiving?	Y P N	Menopausal symptoms?	Y P N
		If yes, what? _____	
Cervical Dysplasia?	Y P N	Abnormal PAP?	Y P N
Sexual difficulties?	Y P N	Chlamydia?	Y P N
Gonorrhea?	Y P N	Condyloma?	Y P N
Herpes?	Y P N	Syphilis?	Y P N
Are you sexually active?	Y N	Sexual orientation: _____	
Do you do breast self exams?	Y P N	Breast lumps?	Y P N
Breast pain/tenderness?	Y P N	Nipple discharge?	Y P N

MUSCULOSKELETAL

Joint pain or stiffness?	Y P N	Arthritis?	Y P N
Broken bones?	Y P N	Weakness?	Y P N
Muscle spasms or cramps?	Y P N	Sciatica?	Y P N

BLOOD/PERIPHERAL VASCULAR

Easy bleeding or bruising?	Y P N	Anemia?	Y P N
Deep leg pain?	Y P N	Cold hands/feet?	Y P N
Varicose veins?	Y P N	Thrombophlebitis?	Y P N

Welcome!

We're glad to serve you!
If you have any questions, please ask!



West Valley Naturopathic Center

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Terms of Agreement

Patient Name: *Last* _____ *First* _____ *M.I.* _____

Age: _____ Date of Birth: _____/_____/_____ Social Security #: _____/_____/_____

Welcome to the *West Valley Naturopathic Center* and thank you for selecting us for your health care needs. We look forward to helping you along the way to great health.

Office hours: Our hours of operation shall be M-F 9am-5pm and Thursdays from 1pm-7pm. We will close on Mondays in the summer time. We also reserve the right to change our office hours without prior notification.

Cancellation: Please give at least 24 hours notice to reschedule an appointment. Failure to cancel an appointment without giving the clinic a 24-hour notice will result in a \$50.00 charge to you.

Fees & Financial Policy: Payment of fees is the direct responsibility of the patient. *We shall collect payment for services and products at the time of visit.* We accept cash, check, visa, mastercard and discover as forms of payment.

Insurance Billing: Please see our separate Insurance Policy

Medicinary: To pick up refills of your medicinary items, please call the center in advance so that any waiting time will be minimized.

Terms: All of our fees are subject to change without prior notice. Past due balances are subject to a 2% per month (18% per annum) service charge, plus a monthly billing charge of \$10.00.

Statement: I have read and understand the above policies of West Valley Naturopathic Center, LLC and agree with them. I consent to treatment with Dr. Karen Freeze, N.M.D., and/or Dr. Brian Archambault, N.M.D. and accept full responsibility for all expenses incurred by or on the account of the patient. In the event of non-payment, I will bear the cost of collection and/or all court costs and legal fees should it be required.

I authorize the release of any medical information necessary to process an insurance claim and authorize payment directly to the signed physician.

Due to the new privacy policies, this form must be signed by you to disclose your private health information. A copy of our privacy policy is available upon request.

Signature of Patient or Guardian

Date (D/M/Y)

West Valley Naturopathic Center
10320 W. McDowell Rd Suite M-1342
Avondale, AZ 85323
Tel: 623.643.9598

SUMMARY OF NOTICE OF PRIVACY PRACTICES

We strongly believe in maintaining the confidentiality of the personal information we obtain and/or receive about you and we are committed to protecting your privacy. We do not disclose any non-public information about you to anyone, except as permitted or required by law. We do not sell or otherwise disclose your personal information to anyone for purposes unrelated to our health practice. We maintain physical and procedural safeguards that comply with federal and state regulations to protect information about you from unauthorized disclosure. We may disclose any information we believe necessary to conduct our business as is legally required. You have the right to access, review, and correct all personal information collected. You may review our Privacy Policy in its entirety. You may also request the Privacy Policies of other entities who provide information to our office. We will provide phone numbers and addresses.

Please take a moment to sign the Acknowledgment of Receipt of Notice of Privacy Practices Summary on the opposite side of this page.

West Valley Naturopathic Center
10320 W. McDowell Rd. Suite M-1342
Avondale, AZ 85323
Tel: 623.643.9598

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES SUMMARY

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that The West Valley Naturopathic Center has provided me with a copy of its Notice of Privacy Practices Summary that summarizes how medical information about me may be used and disclosed. I further acknowledge that a complete copy of Privacy Practices Policies (approx.13 pages) is available upon request and in the waiting area.

I understand that if I have questions or complaints I may contact:

Privacy Officer: Erin Cortise
Tel: 623.643.9598

I also understand that I am entitled to receive updates upon request if The West Valley Naturopathic Center amends or changes its Notice of Privacy Practices in a material way. Privacy Practices Policy effective July 1, 2004

Signature

Relationship to Patient, if signed by someone other than patient.

Date

**THIS SECTION IS TO BE COMPLETED BY THE WEST VALLEY
NATUROPATHIC CENTER IF UNABLE TO OBTAIN WRITTEN
ACKNOWLEDGMENT FROM PATIENT**

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices Summary from the above-named patient, but was unable to because:

Patient declined to sign this Written Acknowledgment.

Other (specify): _____

Name and title of employee

Date



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Insurance Billing Office Policies

1.) We will as a courtesy to our patients, bill any PPO insurance plan. Your plan should reimburse for office visits at West Valley Naturopathic Center once your deductible has been reached, however, we cannot guarantee this for any plan, nor will your insurance provider. It is your responsibility to contact your insurance provider to determine what your deductible is and how much of your deductible has been met.

2.) If you have our office bill your insurance on your behalf you agree to follow up with your insurance provider in **30 days** from the time of your office visit if they have not either accepted or denied your claim. This will allow our office to follow up with your insurance provider to ensure that your claim gets processed.

3.) Upon your initial visit you will be asked to complete the highlighted portions of a health claim form which will be kept in your chart to help our staff to facilitate insurance billing on your behalf.

4.) Payment shall be made in full at the time of the visit, unless, we are in-network with you insurance provider. Currently, Lifewise is the only insurance provider that we are contracted in-network. For these individuals we will accept your co-pay, and you will be responsible for payment to West Valley Naturopathic Center for any remainder of the bill that was not covered by Lifewise. For any service that is not covered by Lifewise we shall again take full payment at the time of the visit.

Your insurance provider should respond to the filed claim within **30 days** with an EOB (explanation of benefits), that will inform you if your claim has been either: accepted, denied, why it was denied, applied to your deductible or paid. West Valley Naturopathic Center shall in turn write a check to the patient for the portion of the visit that was covered by your insurance provider which can be verified on your EOB.

If you have any further questions please feel free to contact our insurance biller.

By signing below you agree to the above terms and conditions and that you will follow up with our office in the event that your insurance provider has not responded to the claim in **30 days**.

Patient's Signature/Date