N8ture Calls

NATUROPATHIC MEDICINE INFORMED CONSENT TO TREAT

I, _____(Patient/Parent or guardian), hereby authorize Dr. Tiffani Alwazan to perform the following procedures as necessary to facilitate my health and vitality:

- Common or specific diagnostic procedures: e.g. physical exams, laboratory testing using blood, saliva or other bodily fluids
- Medicinal use of nutrition and nutritional supplementation
- Botanical medicine: may be prescribed as teas, alcohol-based tinctures, capsules, tablets, creams, plasters, or suppositories
- Homeopathic medicine: the use of highly diluted quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses
- Naturopathic counseling
- Lifestyle and hygiene counseling: diet therapy, promotion of wellbeing including recommendations for exercise, sleep, stress reduction, and balancing work and social activities
- Therapeutic massage and naturopathic manipulative techniques
- Hydrotherapy: the use of water applications to achieve physiologic changes I recognize the potential risks and benefits of the procedures as described below:
  - Potential risks: Unforeseen allergic reactions to prescribed herbs, supplements and medications, side effects of natural medication, inconvenience of lifestyle/diet changes, emotional release/catharsis/ emotional distress, healing crisis.
  - Potential benefits: enhanced health and vitality, relief of pain and symptoms of disease, decreased injury recovery time, 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.

I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure. I understand that **I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter**).

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Tiffani Alwazan regarding cure or improvement of my condition. I understand Dr. Tiffani Alwazan has the right to refuse treatment or make referrals to outside physicians and/or emergency medical services if she feels that they may be of service to my case. 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 to the best of my provider's 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.

_____ _____

Patient Signature Date

_____

Print patient name here

If the patient is a minor or unable to consent:

_____

Signature of person legally responsible for the patient

_____

Date

_____

Print name of person legally authorized here

N8ture Calls

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.
The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication.

You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ____YES ___NO

May we leave a message on your answering machine at home or on your cell phone? ___YES __NO

May we discuss your medical condition with any member of your family? ___YES ____NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

N8ture Calls

N8ture Calls PLLC Financial Policy

N8ture Calls PLLC maintains a financial policy that seeks to make services affordable and accessible to all.

Appointment fee – to make a reservation online or by phone the client will pay $35 for immediate care visit or $150 for extended visit. The *appointment fee* will be applied to the cost of the telehealth visit. The appointment fee is non-refundable.

Late cancellation fee – to make sure clients may be seen promptly and as soon as possible, we respectfully request cancellations be made 24 hours in advance. Clients who fail to cancel in a timely manner will be charged *$30 late cancellation fee*.

Refunds – Due to the nature of the services that we provide, we do not provide refunds. We ask that if you will be late, 5 minutes or more for any appointment or if you need to cancel, please call our office beforehand to make sure your appointment is rescheduled. The appointment will be available for you to use at another time.

Declined payments – When an electronic payment is subsequently declined by a financial institution, the amount charged by the financial institution will become the responsibility of the client.

By reserving an appointment and signing below, you agree to our cancellation policy. You agree to reschedule your appointment if you will be absent or more than 5 minutes late. You agree you will be liable for any chargeback fees. By reserving this appointment, you hereby agree that you have read all the contents of this cancellation refund policy thoroughly and that you understand your appointment will be rescheduled and not refunded. **If you do not understand or have questions about the information above, please contact us before making an appointment.**

I _____ agree to the above financial policy.

_____ _____

Signature Date

_____

Print name here

N8ture Calls

Date _____

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Age: _____ DOB: ____/____/____ Number of Children: _____ Martial Status: S M Other

Sex: M F Occupation: _____

Name of emergency contact: _____

Emergency Contact Phone: _____

HEALTH HISTORY

Have you ever suffered from (please check yes or no):

	Yes	No		Yes	No
Dizziness			Asthma		
Backaches			Neuritis		
Heart trouble			Digestive Disorders		
Diabetes			Nervousness		
Tuberculosis			Sinus trouble		
Arthritis			Anemia		
Headaches			Cancer		

Purpose of Appointment: _____

Other doctors seen for this condition: _____

Referred by: _____ Date of Last Physical Exam: _____

Have you been treated for any health condition by a physician in the past year? Yes / No

Describe: _____

Current/Past Conditions: _____

_____

Current Medications: _____

_____

Current Supplements: _____

_____

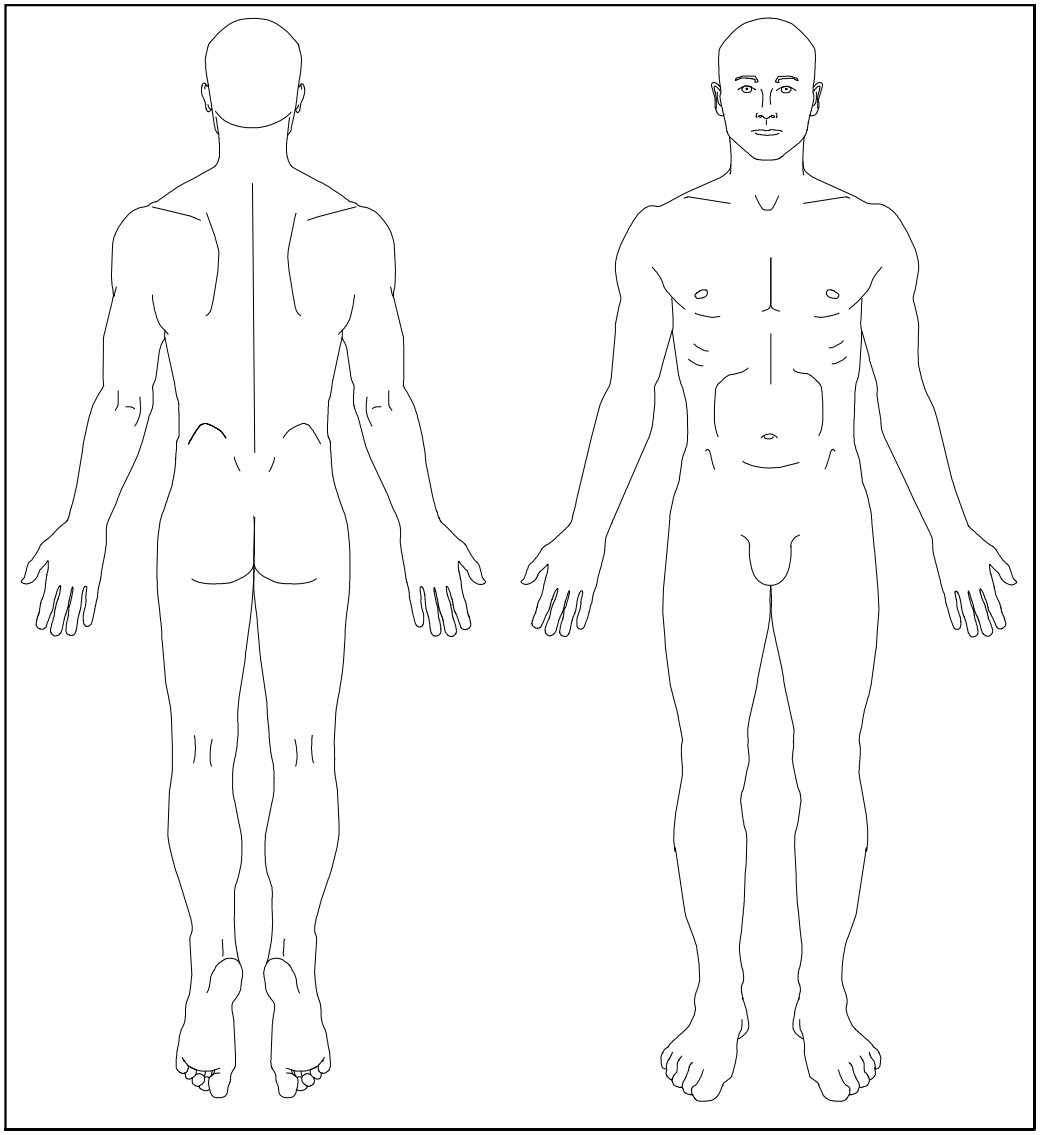
Patient Initials: _____

N8ture Calls

Please shade in on the picture above your symptoms at the current time.

Circle any symptoms: Pain, numbness, tingling.

Please estimate the intensity at the time on a 0 (Min) - 10 (Max) scale: _____



N8ture Calls

HEALTH HISTORY: *check all that apply*

Patient Initials: _____

Conditions you have had

☐ AIDS / HIV
☐ Alcoholism
☐ Allergies
☐ ALS (Lou Gehrig's)
☐ Alzheimer's
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Birth Defects
☐ Bleeding Disorder
☐ Breast Cancer
☐ Colitis / Crohn's / IBS
☐ Colon Cancer
☐ COPD
☐ Depression
☐ Diabetes
☐ Drug Abuse
☐ Epilepsy
☐ Glaucoma
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Herpes / Shingles
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Disease
☐ Liver Disease
☐ Mental Illness
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Parkinson's
☐ Pneumonia
☐ Prostate Cancer
☐ Sickle Cell Anemia
☐ Stroke
☐ Suicide
☐ Thyroid / Goiter
☐ Tuberculosis
☐ Ulcers
☐ Other:

Devices Currently Used

☐ Pacemaker
☐ Implants of any kind
☐ Joint Replacement
☐ Braces (neck, back, knee)
☐ Orthotics

Current Past **General**

☐ ☐ Pain not relieved by rest
☐ ☐ Fever
☐ ☐ Chills
☐ ☐ Night Sweats
☐ ☐ Fatigue
☐ ☐ Weight Loss or Gain
☐ ☐ Headaches
☐ ☐ Tremors
☐ ☐ Dizziness
☐ ☐ Numbness / Tingling
☐ ☐ Loss of Sensation
☐ ☐ Change in Memory

Last Physical Exam: ____/____
☐ Normal ☐ Abnormal

Skin

☐ ☐ Dryness
☐ ☐ Itching
☐ ☐ Bruise Easily
☐ ☐ Change in Mole(s)
☐ ☐ Nail Changes
☐ ☐ Hair Changes
☐ ☐ Acne

Eye, Ear, Nose, Throat

Last Eye Exam: ____/____
☐ ☐ Eye Pain
☐ ☐ Glaucoma
☐ ☐ Change in Vision
☐ ☐ Ear Pain
☐ ☐ Ear Ringing
☐ ☐ Change in hearing
☐ ☐ Change in smelling
☐ ☐ Change in taste
☐ ☐ Change in voice
☐ ☐ Trouble Swallowing
☐ ☐ Hoarseness

Gastrointestinal

☐ ☐ Bowel Incontinence
☐ ☐ Change in Bowel Habits
☐ ☐ Abdominal Pain
☐ ☐ Nausea
☐ ☐ Bloating
☐ ☐ Belching / Gas
☐ ☐ Heartburn
☐ ☐ Indigestion
☐ ☐ Constipation
☐ ☐ Diarrhea
☐ ☐ Undigested Food
☐ ☐ Hemorrhoids
☐ ☐ Poor appetite
☐ ☐ Change in appetite

Current Past
☐ ☐ Bloody Stool
☐ ☐ Black / Tarry Stool
☐ ☐ Diverticulitis
☐ ☐ Vomiting
☐ ☐ Vomiting Blood
☐ ☐ Ulcers

Last Colonoscopy: ____/____
☐ Normal ☐ Abnormal

Respiratory

☐ ☐ Difficult Breathing
☐ ☐ Chronic Cough
☐ ☐ Phlegm
☐ ☐ Cough up Blood
☐ ☐ Wheezing

Cardiovascular

☐ ☐ Pain over heart
☐ ☐ High blood pressure
☐ ☐ Low blood pressure
☐ ☐ Irregular Heartbeat
☐ ☐ Murmur
☐ ☐ Palpitations
☐ ☐ Previous Heart trouble
☐ ☐ Cold or blue hands / feet
☐ ☐ Swelling of ankles
☐ ☐ Varicose veins

Last Cholesterol Test: ____/____
☐ Normal ☐ Abnormal

Genitourinary

☐ ☐ Bladder incontinence
☐ ☐ Frequent Urination
☐ ☐ Overnight more than twice
☐ ☐ Painful urination
☐ ☐ Difficulty starting flow
☐ ☐ Blood in urine
☐ ☐ Urinary infection
☐ ☐ Kidney stones
☐ ☐ Discharge
☐ ☐ STD

Men Only

☐ ☐ Testicular swelling / pain
☐ ☐ Prostate problems

Last Prostate Exam: ____/____

Current Past **Women Only**

☐ ☐ Infertility
☐ ☐ Hot flashes
☐ ☐ Lumps in breast
☐ ☐ Vaginal discharge

Last PAP: ____/____
☐ Normal ☐ Abnormal

Last Mammogram: ____/____
☐ Normal ☐ Abnormal

Menstrual Periods
Age Onset: _____
Avg. Days of flow: ____
Avg. Cycle: _____ days

Menstrual Flow
☐ Reg. ☐ Irreg.
☐ Pain / cramps

Menopause – age: ____
Are you pregnant?
☐ No ☐ Yes: ____ Months:_____

Birth control Method: _____

Number of Children
_____ Born alive
_____ Cesarean
_____ Premature
_____ Stillborn
_____ Miscarriages

Childhood Diseases

☐ ☐ Chicken Pox
☐ ☐ Measles / Mumps
☐ ☐ Polio
☐ ☐ Rheumatic Fever

Immunizations (dates)

Polio: ____/____
Tetanus: ____/____
Hepatitis: ____/____
Flu: ____/____
Pneumonia: ____/____

Patient Initials: _____

Please describe your average daily diet. *Be specific.*

Morning:

_____-

_____

Lunch:

_____

_____

Dinner:

_____

_____

Snacks: _____ How Often? _____

Lifestyle

Water: cups/day ___
Exercise: x/week___
Sleep: hours/night ___
Alcohol: drinks/day ____
Smoke: packs/day ____
☐ Previous Smoker
Start Date: ____/____
End Date: ____/_____