



NEW PATIENT PACKET

• welcome to our clinic •

First Visit Checklist:

- Completed Intake Form**
Please bring the completed intake forms with you to your appointment. If you would like to send us your forms *before the day of your appointment*, you may scan and email them to: **info@thegolgiclinic.com**.
- Bring Lab or Imaging Reports**
If you have notes or reports from previous doctors visits that you feel might help us in treating you, please bring them to your first appointment.
- List of Current Medications/Supplements**
This includes over-the-counter and prescription medication, herbs, vitamins, supplements & homeopathics.
- Parking**
Parking is available in the Caras Park Lot behind our building or on Front Street.
- Don't Go Upstairs**
When you enter our building, **don't** go upstairs. Upon entering our building, we're located on the main level (second floor) of 113 W. Front Street. Upstairs is actually the third floor.
- Plan to Arrive on Time for Your Appointment**
There is complimentary tea available in our reception area.
- Payment is Expected at the Time of Service**
Cash, check, Mastercard, Visa and Discover are all accepted. We do not bill insurance.

Adult Health Intake
Patient Information

Name: _____ Date of Birth: _____ Age: _____

Social Security Number: _____

Address: _____

City: _____ State: _____^{apt/unit} Zip: _____

Email: _____

(check box if you would like to receive our free clinic newsletter)

Phone: (home): _____ (mobile): _____ (work): _____

Please circle number(s) where we may leave messages.

Employer: _____ Occupation: _____

Number of hours worked per week? _____

How did you hear of us? _____

Emergency Contact

Contact Name: _____ Relationship: _____

Phone (home): _____ (mobile): _____ (other): _____

Adult Health Intake
Context of Care Review

Successful *health care* and *preventive medicine* are only possible when the physician has a complete understanding of the patient, physically, mentally, and emotionally. The nature of your responses to the following questions, as well as your thoughtfulness and honesty, will go a long way toward improving our understanding of you and will greatly aid us in addressing your health needs.

Why did you choose to come to this clinic?

What do you know about our approach?

What three expectations do you have from your visit to this clinic?

- 1)
- 2)
- 3)

What long term expectations do you have from working with this clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment toward addressing the underlying cause(s) of your symptoms?
Rate from 0 to 10 (10 being 100% committed).

0% 0 1 2 3 4 5 6 7 8 9 10 100%

In what behaviors or lifestyle habits do you regularly engage, which you believe *support* your health?

In what behaviors or lifestyle habits do you currently engage, which you believe are *self-destructive*?

What potential *obstacles* do you foresee in addressing the lifestyle factors that are undermining your health?

What obstacles might you see in adhering to the therapeutic protocols that I will be sharing with you?

Who do you know that will sincerely and consistently *support* you with the beneficial lifestyle changes you will be making?

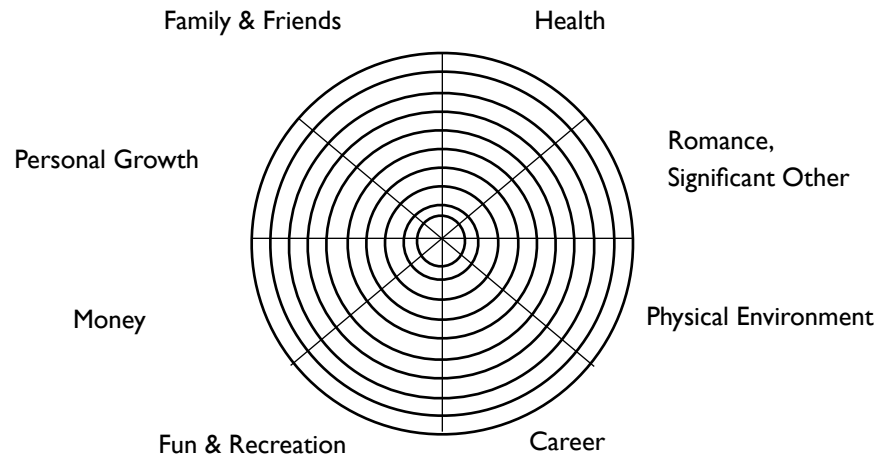
What do you love to do?

Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, starting from the center point.



Are you currently receiving healthcare? No Yes

If **yes**, where and from whom? _____

If **no**, when and where did you last receive 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) _____
- 7) _____

Personal Medical History: Please *circle* any that apply to you; *now or past*.

- | | | | | |
|-------------------------|---------------------|---------------|----------------------------|------------------------|
| Diabetes (type I or II) | High Blood Pressure | Heart Disease | Breast Cancer | Other Cancer |
| Mental Illness | Epilepsy | Stroke | Kidney Disease | Hypo/Hyperthyroid |
| Glaucoma | Asthma | Anemia | Arthritis | Cysts (breast/ovarian) |
| Hay Fever | Eczema | Fibroids | Inflammatory Bowel Disease | |

Other Recurrent, Chronic, or Severe Illness(es):

Please list any **surgeries, hospitalizations, imaging** (CT, MRI, EEG, EKG), include **dates**:

Do you have allergies to medications? No Yes

If **yes**, list medication & reaction: _____

Do you have **food allergies** or **environmental sensitivities**? No Yes

If **yes**, please list allergy and reaction:

Reaction: _____

Reaction: _____

Reaction: _____

Vaccines: please list name & date of the most recent _____

Childhood Illnesses: please *circle* any that apply.

Chicken Pox Mononucleosis Rubella Mumps Measles
Tuberculosis Strep Throat Diphtheria Rheumatic Fever Typhoid Fever
Scarlet Fever German Measles

Preventative Screening Test: please list the *most recent* date and test's *result*.

Routine Blood Tests: Date _____ Results: Normal Abnormal
 Sigmoidoscopy or Colonoscopy: Date(s) _____ Results: Normal Abnormal
Women: Pap smear: Date _____ Results: Normal Abnormal
 Mammogram: Date _____ Results: Normal Abnormal
 Dexascan (osteoporosis): Date _____ Results: Normal Abnormal
Men: PSA (prostate): Date _____ Results: Normal Abnormal

Social History

Home

With whom do you live? _____ Pet(s): _____

Do you have a religious or spiritual practice? No Yes, explain: _____

Watch TV? No Yes, # hours per week: _____

How often do you take vacations? _____

Read? No Yes, # hours per week: _____

Exercise? Never Yes, current Yes, past

What type: _____ minutes/day: _____ times/week _____

Tobacco Use

Cigarettes: Never Quit, date: _____ Current, packs/day: _____ for _____ yrs

Other: exposed to 2nd hand smoke Pipe Cigar Snuff Chew

Alcohol Use

Do you drink alcohol? Never Past, # drinks/wk _____ Current, # drinks/wk _____

Drug Use

Have you ever used recreational drugs? No Yes, explain: _____

Caffeine Intake

Never Quit Yes, I drink (*circle*) coffee/caffeinated tea/soda/cocoa: _____ c/day

Mental Health

Have you had any times of major psychological trauma? No Yes

Age: _____ Explain: _____

Age: _____ Explain: _____

Age: _____ Explain: _____

Have you received mental health counseling? No Yes

Toxic exposure

Have you had daily or prolonged exposure to toxic chemicals, pesticides, paints, lead, mercury? No Yes

If **yes**, what type & when: _____

General

What time of day is your energy the best: _____ worst: _____ Is this a change? No Yes

Current height: _____ Current weight: _____

As an adult, what has been your **maximum weight**: _____ **minimum weight**: _____

Diet

Do you follow a specific diet? No Yes

If **yes**, please *circle*:

Vegetarian Vegan Paleolithic Anti-inflammatory Blood-type Atkins Low-fat/low calorie Gluten-free Dairy-free

Other _____

What do you **typically** eat?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

What is your heritage? (please *circle*)

Caucasian Black Hispanic Native American Asian Other: _____

Family History: Please indicate any **known** health conditions; and **age at death** if applicable.

mother: _____

father: _____

siblings: _____

siblings: _____

siblings: _____

siblings: _____

grandparents (maternal) _____

grandparents (paternal) _____

THANK YOU. WE LOOK FORWARD TO HELPING YOU IN ANY WAY WE CAN.

Please **read** and **initial** the following statements:

Please initial in the spaces provided after reading the following:

Consent to Treatment

_____ I authorize The Golgi Clinic to treat me. I understand methods of treatment used in this practice may include, but are not limited to: homeopathic, herbal, craniosacral, and/or physical medicine, as well as others deemed appropriate. I am at liberty to seek alternate opinions or care, and may discontinue treatment at any time. I will not hold The Golgi Clinic responsible for treatment outcomes should I choose to disregard the doctors medical advice and treatments.

Payment & Insurance Policy

_____ Payment for all services and pharmacy items is due at the time of the visit. We accept cash, check, Visa, MasterCard or Discover. The doctors at The Golgi Clinic are not contracted providers with any insurance plan. If your plan has coverage for out-of-network naturopathic care we will provide you with the appropriate paperwork and coding to submit your own insurance claim.

_____ During your visit, your health care provider may prescribe medication, which may be purchased at The Golgi Clinic or elsewhere. Most insurance companies *do not* cover the pharmacy items that we prescribe and dispense.

_____ I understand that no refunds are offered for services rendered or pharmacy items purchased.

_____ Returned checks are subject to a \$22 non-sufficient funds charge from The Golgi Clinic.

Appointment Cancellation Policy

_____ I recognize that scheduling an appointment involves the reservation of time specifically for set aside for me, consequently The Golgi Clinic requires that a valid credit card be placed on file to hold your appointment. To avoid being charged, a minimum of **24 hours notice** is required to cancel or reschedule an appointment. *We do not recommend appointment cancellations by email as we check it infrequently.*

Credit Card Form

I authorize my credit card to be placed on file at The Golgi Clinic.

_____ I understand that the above card will be charged for appointment-based fees incurred via phone or Skype and/or for any medication I wish to order from the clinic.

_____ I understand that on the day of my appointment I may use another credit card to pay for my visit. I further understand that while I must keep a card on file at The Golgi Clinic, I may change the credit card on file at any time.

_____ For missed appointments or those cancelled with less than 24 hours notice, **I understand that my card will be charged the full cost of my office visit (for in-office, phone, Skype, and craniosacral visits).**

_____ I understand that my credit card information will be kept in a secure, digital format once I've submitted it and that should I cease to be a patient, The Golgi Clinic will destroy my credit card information immediately.

Name on Credit Card _____

Credit Card Number _____ - _____ - _____ - _____

Expiration Date _____

Security Code (3 digits on back of card) _____

Billing Address Zip Code _____

Signature of Cardholder _____

Notice of Privacy Practices

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 healthcare.

It is important that you understand that your information can be used and shared in the following ways:

- To give you medical treatment or other types of health care, multiple providers may be involved in your treatment, both directly and indirectly
- To bill you or a third party for payment for services provided to you
- To assist law enforcement officials in response to criminal activities and to avert a threat to an individual or to public health safety (as in outbreaks of communicable disease)
- In response to a court or administrative order
- We may share your health information with a person(s) that *you have named* to be involved with your health care: **I hereby authorize privileged, confidential information about my treatment to be shared with the following people:**

_____ print name(s) of authorized people

You have the following rights relating to the medical records we keep about you:

- Right to inspect your health record and to receive a copy of your health record upon request
- Right to amend information in your health record you believe is inaccurate or incomplete
- Right to know to whom we have disclosed your health information
- Right to ask for limits on the health information data we give out about you
- Right to receive communication from us about your health information in alternate ways
- Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge having received and read the above-stated policies of The Golgi Clinic and will comply with them in all respects. If my insurance company requires the release of medical records, I hereby give my permission by signing this form.

_____ Print Name (or name responsible party if patient is a minor)

_____ Signature (responsible party signature if minor)

____/____/____ Date

How Do I Check My Insurance Benefits*?

The Golgi Clinic is not contracted (in-network) with any insurance company. Many insurance plans reimburse a portion of their member’s out-of-pocket expenses at our clinic. If you have insurance and would like to bill them for the cost of your office visit, we’ve attached this helpful questionnaire to assist in determining what will be paid.

Insured Patient Name _____ Insurance ID# _____

Call the number on your insurance card listed for patient customer service. Then follow steps 1-6 when calling to find out benefits and eligibility.

1. When did my coverage begin and when is it valid thru?
 Beginning Date of Coverage _____ Ending Date of Coverage _____
 Does my insurance plan follow a Fiscal or Calendar Year Schedule? _____
2. Do I need a referral from my primary care physician (PCP) for alternative services? Y N
3. What are my benefits for the following services? *Be sure to find out whether your plan includes Out-of-Network coverage for the following benefits.

Specialties:

Naturopathic: % Covered; Co-pay/ Co-Insurance _____; Year Max _____

Chiropractic: % Covered _____; Co-pay/ Co-Insurance _____; Year Max _____

Lab work/X-rays: % Covered _____; Year Max _____

4. What is the insured person’s **individual** deductible for the year and has any or all of it been met?
 Deductible \$ _____; Amount of Deductible met so far \$ _____ Date today _____
5. Does the insured person’s plan have a **family** deductible? Y N
 Deductible \$ _____; Amount of Deductible met so far \$ _____ Date today _____
6. Are the specialties listed above subject to either deductible? Y N
 If so, which specialties? _____

What was the name of the representative I spoke with? _____

Please bring this form with you to your appointment. If you have trouble getting the information you need, please feel free to call the clinic for assistance.

***Please be aware that this is not a guarantee of payment, if an insurance company gives you inaccurate information they may not honor the benefits that were quoted.**