



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.

Teen Health Intake (13 - 17 years)
Patient Information

Name: _____

Date of Birth: _____ Age: _____ Gender: Male / Female Year/Grade in school: _____

Parent/Guardian's Name: _____

Address: _____

City: _____ State: _____ apt/unit _____ Zip: _____

Parent/Guardian's 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.

Name of doctor's office/hospital/clinic where your health records are kept: _____

Has any other family member been a patient at our clinic? Yes / No (if yes who?: _____)

Reason for referral or today's chief complaint: _____

How did you or your parent/guardian hear of our clinic? _____

Emergency Contact

Contact Name: _____ Relationship: _____

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

Thank You For Your Time & Effort

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

Health History

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

- 1) _____
- 2) _____
- 3) _____

Do you have a primary care doctor? No Yes

Name: _____ Location: _____ Phone: _____

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) _____

Do you have a contagious condition at this time? No Yes

If **yes**, what? _____

Personal Medical History

Childhood Illnesses: please *circle* any that apply, now or in the past

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

Ear Infections No Yes Approximate number of times: _____

Tonsillitis No Yes Approximate number of times: _____

Number of colds each year _____

Number of flu each year _____

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

Immunization History

Polio No Yes Tetanus No Yes Measles/Mumps/Rubella No Yes

Pertussis No Yes Diphtheria No Yes Chicken pox No Yes

Hepatitis _____ type No Yes HiB Shot No Yes Flu Shot No Yes, date: _____

Other Immunizations _____

Adverse Reactions? No Yes

If **yes**, to what and what type of reaction: _____

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: _____

Hobbies and Lifestyle

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

What do you **love to do**? What motivates you in life?

What behaviors or lifestyle habits do you currently engage in regularly that you believe **support your health**?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are **unhealthy or self-destructive**?

Please rate your **stress** on a scale from 1 to 10. (10=most)

1 2 3 4 5 6 7 8 9 10

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

How often do you take **vacations**? _____

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

Read? No Yes, # hours per week: _____

Exercise? Never Yes, current Yes, past

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

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

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: _____

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

Please rate your energy on a scale from 1 to 10. (10=most)

1 2 3 4 5 6 7 8 9 10

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

Height: _____ Weight: _____ Weight 1 year ago: _____

Maximum weight: _____ When? _____

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? (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) _____

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.**