Alpine Valley Wellness Center

Pediatric Intake Form

Our practice is dedicated to providing the best possible care for your child. In order for us to serve you better, please take a few minutes to answer the following questions. Your answers will be kept strictly confidential.

Child's Name_____ **Age**_____ **Birth Date**_____ **Sex: M/F**

Caregiver's Name_____ **Social Security #**_____

Caregiver's Home Phone_____ **Work Phone** _____ **Cell Phone**_____

Are you the child's: ❑ Birth Parent ❑ Foster parent ❑ Grandparent ❑ Other relative ❑ Other
Besides you, does anyone else take care of the child? ❑ Yes ❑ No If yes, who? _____
Has child received health care elsewhere? ❑Yes ❑No If yes, where? _____
Does the child have any allergies to any medications? ❑ Yes ❑ No If yes, what? _____
Has the child received any immunizations? ❑ Yes ❑ No If yes, where? _____
Which ones? _____
Has the child ever been hospitalized? ❑ Yes ❑ No If yes, when? _____
Where? _____ Why? _____
Any history of head injury? ❑ Yes ❑ No If yes, when? _____
Has this child ever been unconscious? ❑ Yes ❑ No If yes, why? _____
How would you rate this child's health in general? ❑. Excellent ❑. Good ❑. Fair ❑ Poor
Do you have any concerns about your child's behavior or development? ❑ Yes ❑ No
If yes, what? _____
Reason for visit to the doctor:_____
_____
Duration of complaints/symptoms:_____
What has been done so far?_____
_____
Current medications and their doses:_____
_____

What pets live with you-indoors or/and outdoors_____
_____
When and where have you traveled outside the country? _____
_____
_____
What is your religion and how important is religion/spirituality in your family's life?
_____ _____

Early childhood illnesses :
First illness at _____ months First antibiotic at _____ months

Number of ear infections in the first 2 years: _____

Number of other infections in the first 2 years: _____ Which ones?_____

How many times on antibiotics in the first 2 years?_____ Which ones?_____

PREGNANCY HISTORY OF PATIENT:

Duration of pregnancy: _____ Birth Weight:_____ Total weight gained in pregnancy:_____
Any complications during pregnancy?_____
Any drugs taken during pregnancy? (include over-the-counter medications): _____
Any alcohol?_____ How much?_____
Any tobacco?_____ How much?_____
High blood pressure?_____
Illnesses/Infections during pregnancy?_____

Difficulty getting pregnant (>6mo) ❑ Yes ❑ No Infertility drugs used ❑ Yes ❑ No
In vitro fertilization ❑ Yes ❑ No Drink alcohol ❑ Yes ❑ No Smoke tobacco ❑ Yes ❑ No
Take progesterone ❑ Yes ❑ No NOT Take prenatal vitamins ❑ Yes ❑ No
Take antibiotics ❑ Yes ❑ No Take other drugs ❑ Yes ❑ No If yes, which?_____
Have a viral infection ❑ Yes ❑ No Have a yeast infection ❑ Yes ❑ No
Amalgam fillings put in teeth ❑ Yes ❑ No Have any amalgams removed from teeth ❑ Yes ❑ No
Have bleeding ❑ Yes ❑ No If yes, which months?_____ Group B strep infection ❑ Yes ❑ No
Have an x-ray ❑ Yes ❑ No Have Rhogam ❑ Yes ❑ No If yes, how many? _____
High blood pressure ❑ Yes ❑ No Have house exterminated ❑ Yes ❑ No
Have house painted ❑ Yes ❑ No Chemical exposure ❑ Yes ❑ No

LABOR AND DELIVERY:

How long was labor? _____ Breech or unusual presentation?_____
Cesarean Birth? ❑ Yes ❑ No If yes, why?_____
Pain medication used? ❑ Yes ❑ No If yes, which?_____
Pitocin used? ❑ Yes ❑ No Forceps used? ❑ Yes ❑ No Delay in respiration or cry? ❑ Yes ❑ No
Was oxygen administration necessary? ❑ Yes ❑ No Apgar Score, if known?_____

NEWBORN:

Jaundice? ❑ Yes ❑ No Cyanosis? ❑ Yes ❑ No Infection? ❑ Yes ❑ No Anemia? ❑ Yes ❑ No
Other important medical conditions: _____

Your Child's Medical History

Please circle or fill in where indicated if your child has ever had any of the following :

AIDS/HIV +
Allergies_____
Anemia
Asthma
Back pain
Bladder/urinary problems
Cancer_____
Cerebral palsy
Chest pain
Chickenpox
Colitis/irritable bowel
Diabetes ❑ Type I
Ear or hearing problems
Epilepsy
Eye problems
Fatigue, chronic
Frequent antibiotic use
Gall bladder/ Liver problems
Gastrointestinal problems_____
Gum/teeth problems
Hair loss
Hayfever
Headaches/Migraines
Heart problems_____
Hepatitis ❑ A ❑ B ❑ C ❑ Other
Hypoglycemia
Jaundice
Joint problems
Kidney/ Urinary problems
Measles
Mental Health Issues_____
Mononucleosis / Epstein Barr virus
Movement Disorders_____
Mumps
Neurological conditions_____
Parasites _____
Rheumatic fever
Seizures
Sexual abuse
Sinusitis
Skin problems/rashes_____
Stroke
Tuberculosis
Thyroid problems
Other _____

Vaccination History
Please provide a listing of vaccinations and dates for your child

Vaccination	Date Given

Family Medical History

*For each person below, complete those that are appropriate. Place a **check** in the appropriate column for relevant diseases*

	Father	Mother	Brother (s)	Sister (s)
Age if Living:				
Age at Death:				
Cause of death				
Cancer				
Diabetes				
Depression				
Heart Disease				
High blood pressure				
Stroke				
Epilepsy				
Mental illness				
Asthma				
Kidney Disease				
Glaucoma				
Tuberculosis				
Endocrine Disease (				
Multiple Sclerosis				
Neurological Diseas				
Autoimmune Diseas				
OTHER (please list)				

Finance/Insurance Form

PLEASE PRINT AND COMPLETE ALL ENTRIES				
Patient Name (Last, First, MI)	Date of Birth	Age	Marital Status	Today's Date
Address (Street, City, Zip)	Home phone:			
	Work phone:			
	Cell phone:			
Social Security #	Who is financially responsible for this bill?			
Spouse/Parent Name (Last, First, MI)	Date of Birth	Home Phone.	Work phone	
Emergency contact	Relationship	Phone number		
Email address:				
INSURANCE				
Insurance Primary Subscriber Name	Primary Subscriber SS#	Primary Subscriber Date of Birth		

Note: Medicare does **not cover Naturopathic services at this time.*

I agree to make payments according to the policies of Alpine Valley Wellness Center (AVWC), including all payments due at the time of visit. I agree to allow AVWC to charge my credit card or utilize my deposit if I fail to follow the cancelation policy for my first visit.

By accepting services at AVWC, I am agreeing to pay for that service even if my insurance company denies payment. I understand that the restrictions imposed by my insurance company are constantly changing and that the staff of AVWC are not responsible to track these changes. I understand that it is my responsibility to ensure that my insurance policy covers all treatments I am receiving. I agree to call my insurance company and verify benefits if I have any concerns. I understand that AVWC does collect co-payments at the time of my visit. I give permission for the release of information requested by my insurance company to assist in processing my insurance claims and assign directly to AVWC all appropriate payments from my insurance company for health care services rendered to me by AVWC.

_____

Patient Name (Please Print)

_____ _____

Patient Signature Date

OFFICE POLICIES

Welcome to the Alpine Valley Wellness Center (AVWC)! If you have any questions or comments about our policies, please feel free to share them with us. For more information, please see our website: www.alpinebewell.com

1. Responding To Your Needs
Our main way of communicating with you is by phone. Please ensure that your voice mail is operational and that you check your phone messages if you are expecting a call from us. We are constrained from responding by text message or social media (e.g. Facebook, etc.) because of state and federal privacy laws. The costs involved in setting up a HIPAA compliant server and electronic medical records (EMR) have limited our ability to communicate via email.

2. Missed Appointments, Cancelations, Deposits

- For new patients, a deposit or credit card number is necessary to secure an initial visit with our physicians. If you do not have a credit card, a deposit of $60 via check or money order can be sent to our office. You will only be charged a $60 fee if you cancel your appointment with less than 24 hours notice. Deposits will be returned and credit card numbers will be destroyed at the first visit.
- For established patients, we require a minimum of 24 hours notice, received during our normal business hours, for canceled or rescheduled visits. Cancelations made with less than 24 hours notice will incur a $60 fee for a missed half hour appointment, a $75 fee for an hour missed appointment, and a $15 fee for a missed blood draw. Your insurance company will not cover this charge – it will need to be paid out of pocket. Extenuating circumstances or emergencies are exceptions that will not be billed.

4. Treatment Limitation

- There are limitations to what any physician is able to accomplish without actually seeing you. The most important limitation is that ***we cannot diagnose and/or treat medical conditions over the telephone***. This constraint is imposed by state and federal government guidelines, insurance companies, and the boundaries of medical ethics.
- We cannot discuss a condition over the phone if it is an illness for which you have not been previously evaluated.
- We cannot prescribe supplements or medications over the telephone for someone who we have not seen previously as a patient, including family members who are not established patients of the clinic.

4. Phone Consultations
Telephone consultations are provided for established patients under special circumstances determined by your doctor. There is a charge of ***$75 for each 30 minute segment***, which will need to be scheduled with your doctor. Your insurance company will not cover this expense. Clarification of on-going therapy or any discussion with the doctor under five (5) minutes is not considered a phone consultation and will not be charged.

5. Emergency Contact and After Hours Services
For all critical, psychiatric, or life-threatening emergencies, please call 911 or proceed immediately to your local hospital. An emergency is defined as a health problem which you feel requires immediate attention. The clinic is not set up to do these kinds of emergency interventions. After business hours, please limit calls to urgent matters only. Our pager number is always available by calling our office number, listed above. There is a charge of $25 per page unless one of the doctors specifically asks you to page them. Your insurance company will not cover this expense. While telecommunication technology is generally quite stable, there are a number of reasons it can fail. For this reason, it is **very important** that you proceed to an Emergency Room in a serious situation if you do not hear back from your physician after a short period of time.

7. Payments and Non-Sufficient Funds (NSF)

- For those without insurance coverage, complete payment is expected at the end of each office visit unless some other payment plan is created. Cash or personal checks are preferred. Please note that, in order to keep costs

down, we only accept credit cards in person. Items not covered by insurance, such as supplements, need to be paid at the time of the visit.

- Checks or credit card payments that are denied for lack of funds (NSF) will incur a fee of $20. Upon receipt of an NSF issue, we will contact you and arrange for payment to be made in cash within the current business week.

8. Non-medical services

Because of escalating labor and material costs, we reluctantly have begun charging for some non-medical services. Requests for medical records by other providers is a service we continue to provide for free. However, personal requests for medical records will incur a charge based on the number of pages requested. Special requests that are not reimbursed by your insurance company, such as letter writing, medical leave document processing by the doctors, health saving account letters, etc. will be billed at the regular rate of $75/hour. Our ability to provide such services is limited and typically requires a minimum of 7 business days to process. Please check with the front desk for more information.

9. Dispensary Items

- All dispensary items are "cash and carry." That is, payment is due at the time they are picked up from the clinic. If you do not have the funds available at the time, we will be happy to hold them for you for one week.
- If an item is not available during your visit, we will call you when it becomes available. Items are held for one week.
- Please be aware that we can no longer offer refunds on dispensary items that have been opened or are special orders. The only exception is that a partial refund may be given if it is determined by the doctor that there is a medical reason you cannot take a particular supplement. Unopened supplements may be returned for a full refund within four (4) weeks of purchase.
- Prescriptions for tinctures or other items that require our attention during the business day typically require ***24 to 48 hours*** to be filled. If you are refilling a tincture, please bring your old bottle to refill to avoid being charged the cost of a new bottle (first one is free) and to help us with our recycling efforts.
- We can mail supplements to you. In addition to the retail price, there is a handling fee of $5.00 if the price is under $100 and $7.50 if the price is over $100 that covers shipping and handling. No refund can be made if the items fail to reach you.
- It is best to call ahead before picking up dispensary items to ensure they are available. Because the particular item may need to be ordered, try to plan to pick up the needed item before you run out. ***Special order items need to be pre-paid at time of order.***
- Nutritional supplements are not typically covered by insurance plans. However, supplements are not subject to sales tax if they are prescribed by a doctor. Health savings accounts can be used to pay for the supplements prescribed at our clinic.

1. Waiting Room Etiquette: Chemical Sensitivity, Children, and Cell Phone use

Many of our patients are chemically-sensitive or are struggling with various kinds of allergies. For this reason, **please do not bring pets or wear perfumes, colognes, or other scented products to the clinic.** If your child is not coming to the clinic as a patient, please consider that all clinics have a variety of sick patients who your child may be exposed to. We ask that our patients turn off their cell phones prior to going into an exam room and that they step outside the waiting room if they are going to answer a call. This will help us to keep the clinic space relaxing, therapeutic, and enjoyable for all our patients.

10. Test Results and Prescriptions Refills

For prescription refills, please call the pharmacy where the medication will be filled and have them fax our office a prescription refill request. Prescriptions refills typically take between 6 to 48 hours to address. As a general rule, most lab results are received within 7 days except for Pap smears, biopsies, and special testing such as food allergy panels, which can take between 10-14 days. Please note that because of the complexity of some results that are positive, an appointment will be required to discuss them. Labs that are not urgent are discussed at the next follow up visit. If you would like the results sooner, please call us.

I have read, understood, and agree to follow the policies of Alpine Valley Wellness Center.

_____

Patient Name (Please Print)

_____ _____

Patient Signature Date

Informed Consent for Treatment

This form is part of our effort to inform you about your diagnosis and/or treatment options, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon. Please read it carefully.

Your physicians at the Alpine Valley Natural Health Clinic (AVNHC) will take a thorough case history and may perform various appropriate physical examinations that can include laboratory testing. The following are procedures that may be performed to facilitate your diagnosis and treatment:

Common diagnostic procedures: e.g. venipuncture, Pap smears, laboratory tests, etc.
Minor office procedures: e.g. dressing a wound, ear cleansing, etc.
Prescription drugs: as medically necessary and allowed under naturopathic prescriptive rights
Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, and vitamin injections.
Botanical medicine: botanical substances may be prescribed as teas, alcohol-containing tinctures, capsules, tablets, crèmes, plasters, or suppositories.
Chinese medicine: Chinese medical interventions may include the use of acupuncture, electro-acupuncture, moxibustion, or Chinese herbs.
Electrotherapy: the use of electrical stimulation devices such as ultrasound or microcurrent devices.
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.
Lifestyle counseling and hygiene: education and discussion concerning the promotion of wellness (e.g. recommendations for exercise, sleep, stress reduction, diet, etc.) as well as addressing obstacles to quality of life and health (e.g. smoking, poor lifestyle choices, food allergies, etc.)
Naturopathic psychological counseling: addressing minor mood and psychological problems; assessing for possible psychiatric referral based on protecting the safety of self and others.
Contraception

I recognize the potential risks and benefits of these procedures, which include but are not limited to:

Potential risks: allergic reactions to herbs and/or supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injection, venipuncture, or procedures.
Potential benefits: restoration of health, return of maximal functional capacity, relief from symptoms including pain, injury and prevention of disease or its progression.

I agree to inform my AVNHC clinician of any disease process that I am suffering from and any medications/over the counter drugs that I am currently taking. I will also advise my doctor immediately if I am pregnant, suspect that I am pregnant, or if I am or will begin breast-feeding.

Having read and fully understood the items described above, I hereby authorize the AVNHC to perform the described medical procedures, as necessary to facilitate my diagnosis and treatment. I understand that no guarantees have been given to me by AVNHC regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I am also free to ask question about my care that my clinician will answer to the best of their ability.

I further understand that a medical record will be kept of the health services provided for me and that this record will be kept confidential unless otherwise directed by myself, my representative, or as required by law. I acknowledge that I can request to view my medical record at any time and can request a copy of it by paying a copying fee. My medical record will be kept for a minimum of three but no more than ten years after the date of my last visit. I understand that the clinicians at AVNHC may be constrained in their activities by the rules and laws of the State of Washington, my insurance company, and the federal government.

_____ _____

Date Signature of Patient or Patient Representative

Non-Covered Services: Consent for Treatment

The following services may or may not be covered by your insurance plan.

❑ **Wellness services and counseling.** I understand that Dr. Piscopo and Dr. Thomas are licensed to provide counseling and wellness services but they are not psychologists or psychiatrists. Counseling services are focused on lifestyle issues, relationship issues, and wellness – not to treat or diagnose major mental illnesses. Wellness and counseling services may fall outside the guidelines for medically necessary treatment and therefore may not be covered by your insurance plan. I request and agree to pay for these services regardless of the insurance company's determination of benefits.

❑ **Nambudripad's Allergy Elimination Techniques (NAET)**. This service is typically billed as a regular office visit, though it could be considered a contract exclusion by some insurance plans.

❑ **Maintenance/ Palliative Care.** Services in this category, which include many treatments for chronic conditions, are not considered curative. They therefore may not be deemed medically necessary by your insurance company and may not be a covered service.

❑ **Laboratory Testing.** Some laboratory tests may not be covered by your insurance plan. These may include candida testing, cancer screening, blood typing, food allergy panels, digestive analysis, heavy metal testing or any laboratory testing not specifically approved by your insurance company.

❑ **Other** _____

I _____ hereby request and personally agree
to accept full financial responsibility for the medical care received from the Alpine Valley Wellness Center, which many include non-covered services as determined by my current insurance benefits.

_____ Date _____
(Patient's Signature or Signature of Legal Guardian)

_____-_____-_____ OR _____-_____-_____
(Patient's Social Security Number) *(Legal Guardian's Social Security Number)*

Alpine Valley Wellness Center

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Alpine Valley Wellness Center (AVWC) we are committed to maintaining the confidentiality of your personal financial and health information. As part of providing care and services to you, we are required to maintain *Protected Health Information* or PHI. about you. State and federal law protects this kind of information by limiting its use and disclosure. A more extensive version of our Privacy Practices is available for viewing at our clinic.

Our legal obligations, based on Federal and State Laws, include:

- making certain that your protected health information is protected;
- giving you this Notice, which describes our legal obligations and privacy practices concerning your medical information;
- following the terms of this Notice, as is currently in effect;
- explaining how we can use and disclose your protected health information
- ensuring that privacy of information regarding billing/payment for your health care services is maintained;
- obtaining your written authorization to use or disclose your protected health information for reasons other than those listed below and permitted by law.

Our Uses and Disclosures of PHI for Treatment, Payment, and Healthcare Operations

1. For treatment:
We may use and disclose your protected health information (PHI) to provide you with medical treatment and services, and to coordinate or manage your health care and related services. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

2. For Payment:
We may use and disclose your protected health information (PHI) so that treatment and services you receive from AVNHC can be billed to the appropriate party (e.g. you, an insurance company, or a third party) and payment can be obtained. For example, we may need to contact your insurance company to see if your health plan covers a certain laboratory test we would like to do.

3. For Health Care Operations:
We may use and disclose your protected health information (PHI) as necessary for our clinic operations. These uses and disclosure are made for a variety of reasons that include, but are not limited to: quality of care, medical staff activities, legal or regulatory concerns, employee evaluation, contractual or governmental obligations, health care contracting, business management or administration activities, insurance activities, or the sale or merging of any part of AVNHC.

Uses and Disclosures That Do Not Require Your Authorization or Opportunity to Object

1. As Required by Law:
We may disclose your protected health information when required to do so by federal, state, or local law as well as other judicial or administrative proceedings.

2. Emergencies:
We may use or disclose protected health information as necessary in emergency treatment situations.

3. Public health reporting.
Your protected health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

4. Reporting Victims of Abuse or Neglect:
We may use and disclose your protected health information to notify a government authority when authorized by law, or if you agree to the report, if we believe that you have been a victim of abuse or neglect.

5. Individuals Involved in Your Care or Payment for Your Care:
We may disclose protected health information about you to a family member, relative, close personal friend or any other person you identify, including clergy, who is involved in your care.

6. Research:
In limited situations, your protected health information may be used for research purposes, subject to the confidentiality provisions of state and federal law, provided that the privacy and safety aspects of the research have been reviewed and approved by an institutional review board or a privacy board.

7. Health Oversight Activities:
We may disclose your protected health information to governmental, licensing, auditing, and accrediting agencies as authorized or required by law. A health oversight agency is a state or federal agency that oversees the health care system.

Uses and Disclosures of PHI with Your Written Permission

Except for those circumstances listed above, we will use and disclose your protected health information only with your written authorization. You may revoke your authorization, in writing, at any time. If you revoke an authorization, we will no longer use or disclose your protected health information for the purposes covered by that authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

The medical information generated about you within our clinic in the course of providing medical services for you is the property of AVNHC. However, you have the following rights regarding your personal health information we maintain about you:

1. The Right to Access Your Protected Health Information. With certain exceptions, and upon written request, you have the right to inspect and obtain a copy of your protected health information (PHI). We may charge a reasonable, cost based fee for copies.

2. The Right to Request an Amendment or Addendum. If you feel that medical information, billing records, or other protected health information maintained by us is incorrect or incomplete, you may ask us to amend the information or add an addendum for as long as the information is kept by us.. Your request must be made in writing and must explain the reasons for the requested amendment.

3. The Right to Request Restrictions. You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to your request.

4. The Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

5. The Right to An Accounting of Disclosures. You have the right to request an accounting of certain disclosures of your protected health information made after April 14, 2003.

6. The Right to a Paper Copy of This Notice. You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time by contacting our office in writing or by phone.

7. Right to provide an authorization for other uses and disclosures. Our clinic will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with AVNHC or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

1. To file a written complaint with AVWC, please contact us in writing at:
   Alpine Valley Natural Health, Privacy Officer
   430 Elva Way
   East Wenatchee, WA 98802

2. To file a complaint with the federal government, you may contact:
   Office of Civil Rights
   U.S. Department of Health and Human Services
   200 Independence Avenue, S.W., Room 509F
   HHH Building
   Washington, D.C. 20201

Acknowledgement of Receipt of Notice of Privacy Practices

Changes to this Notice

We reserve the right to revise this notice. A revised notice will be effective for medical information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect.

Consent

I have received a copy of the **Notice of Privacy Practices** from Alpine Valley Wellness Center (**AVWC**). I hereby give my consent for **AVWC** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **AVWC** may decline to provide treatment to me.

Signature of Patient _____

Signature of Patient Representative (If the patient is a minor or an adult who is unable to sign this form)

_____

Name of Patient (Print or Type) _____

Date _____

Relationship of Patient Representative to Patient _____

Getting the Most from Your Medical Visit

An office visit with a naturopathic doctor (ND) is somewhat different from a visit to a conventional medical doctor. Since one of the main principles of naturopathic medicine is getting to the root of your medical issues, naturopathic physicians typically spend more time with you.

Ironically, the fact that your ND spends more time with you can lead to some misunderstandings. For example, there is the misperception that all visits with the doctor will be as long as the first one or that the doctor has unlimited time for each visit. This is not the case and, to understand why, we need to touch upon insurance reimbursement.

It is useful to understand that the medical care you receive is heavily influenced by what your insurance company is willing to pay for. Insurance companies impose many constraints and reimburse only if there is enough documented justification based on complexity of your case, amount of physical exam done, number of symptoms, time spent, etc. just like an MD. For example, they typically pay for a 60-minute first office visit and a 15 or 20-minute follow up. The rest of the time is essentially donated to you by your naturopathic physician in order for them to secure a good understanding of your medical situation. It is a sad reality that our doctors are constrained in this way by the dictates of the insurance companies and cannot spend as much time with you as they would like or that you feel you may need.

Insurance companies will also only reimburse the doctors for certain medical conditions. A good example of this is mental health issues. While your ND may speak to you about depression, stress, anxiety, and grief because it is important, they are typically not reimbursed for this. Also, these issues cannot be the focus of the visit unless you have specific mental health benefits or there is a physical manifestation of the mental health issue such as insomnia.

Insurance reimbursements are structured to reward practitioners who see a large number of patients in a short amount of time. Part of the success of naturopathic medicine, on the other hand, is that we take the time to get to the root of the problem and time to do educational, preventative, and lifestyle-intensive interventions. However, your insurance company does not reimburse for much of this. We absorb the cost of doing these interventions without charging you because we believe they have a tremendously positive impact on your health. But there are limits to what we can do in any one visit. To help us provide optimum care, we suggest the following:

- Please prioritize a maximum of **two** health issues per visit for best results. This will ensure that these issues will get maximal attention. If you feel you have multiple urgent issues or need more time with the doctor, please discuss this with the front desk when scheduling your appointment. We can then be in a better position to schedule your time with the doctor most appropriately.
- Follow up visits are usually 20 or 40 minutes – again, based on the constraints discussed above. In some instances, such as acupuncture or electrotherapy, you may be in the treatment room longer, but generally the doctor will only be available for the allotted time.
- Please present questions and concerns as early as possible in the visit so we can ensure they will be addressed. If you wait till the end of the visit to mention the issue, or have multiple issues that are not prioritized, **we cannot ensure that the issue or issues will be addressed**.
- Please be diligent about following through on directions that will impact your treatment. For example, it is important to be well hydrated for your electrotherapy sessions or to complete requested lab work.

In closing, please be aware that if you ever have any questions or concerns about your health care, please do not hesitate to talk to us about them. The main reason our clinic exists is to be of service to our patients – in other words, to you. Thank you for allow us to assist you with your medical care.