

Alpine Valley Wellness Center, PC
 430 Elva Way. East Wenatchee, WA 98802 (509) 886-9355

Note: The information you provide is confidential and will be secured via HIPAA regulations. Please complete this questionnaire as thoroughly as possible. Thank you.

Name: _____ Age _____ Birth Date _____ Sex: M F

Home phone: _____ Work phone: _____ Cell phone: _____

Allergies (medications, foods, etc.): _____

Emergency contact: _____ Phone number _____

Why did you choose our clinic? _____

Current Health Care Team

Primary Care physician: _____ Clinic _____

Specialist physician: _____ Specialty: _____ Clinic _____

Other health care professional (ex. massage therapist, nutritionist, physical therapist, chiropractor etc.):

Practitioner Name: _____ Specialty: _____

Practitioner Name: _____ Specialty: _____

Have you seen a Naturopathic Doctor before? Yes No Name: Dr. _____

Have you seen an acupuncturist before? Yes No Name: _____

Primary Health Concerns

Please list your top 3 primary health concerns in order of importance.

<u>Concern</u> <i>ex: Headache</i>	<u>Onset Date</u> <i>ex. June 1992</i>	<u>Severity</u> <i>Mild/Moderate/Severe</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any hospitalizations, surgery, or serious injuries with the date and type illness/operation/injury: _____

Please list the three most significant events in your life, beginning with the most recent.

List ANY Mental Health issues: _____

What are your top 2 therapeutic goals for your course of treatment with us? _____

What is your present level of commitment to your health? Rate from 10% to 100%: _____

What is your primary requirement for a successful therapeutic relationship with a physician?

What is your occupation? _____ Hours work/week: _____ Do you enjoy your work? Yes No

Are you currently in a relationship? Yes No Do you enjoy your current relationship status? Yes No

Active spiritual practice? Yes No Orientation (ex. Christian, Jewish, etc.) _____

What behaviors or lifestyle habits do you engage in regularly to support your health? (please list)

Your Medical History

Name: _____

Please circle or fill in where indicated if you have ever had any of the following :

- | | | |
|---|---|--|
| Alcohol abuse | Fibromyalgia | Mumps |
| Allergies _____ | Female gynecological problems | Panic Attacks |
| Anemia | Frequent antibiotic use | Parasites _____ |
| Arthritis | Gall bladder/ Liver problems | Prostate problems |
| Asthma | Gastrointestinal problems _____ | Rheumatic fever |
| Back pain | Gum/teeth problems | Sexual abuse |
| Bladder/urinary problems | Hair loss | Sexually transmitted diseases (herpes, chlamydia, gonorrhea, etc.) _____ |
| Cancer _____ | Hayfever | Sinusitis |
| Chest pain | Heart problems _____ | Skin problems/rashes _____ |
| Chickenpox | Hemorrhoids | Stroke |
| Colitis/irritable bowel | Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> Other | Tuberculosis |
| Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II | Hypoglycemia | Thyroid problems |
| Ear or hearing problems | Impotence/sexual problems | Ulcers |
| Eating Disorders _____ | Jaundice | Other _____ |
| Edema/water weight | Kidney/ Urinary problems | |
| Epilepsy | Measles | |
| Eye problems/cataracts/ glaucoma | Mental illness _____ | |
| Fatigue, chronic | Mononucleosis / Epstein Barr virus | |

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)	Children	Grandparents
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 (thyroid,						
Multiple Sclerosis						
Neurological Diseases						
Autoimmune Disease						
OTHER (please list)						

Review of Systems

Please check any of the following that you are experiencing now or have experienced in the past 3 months.

Energy

- Decreased libido
- Fatigue
- Poor memory
- Difficulty focusing
- Decreased motivation
- Tend to be warm
- Tend to be cold
- Abnormal sweating

Sleep

- Difficulty falling asleep
- Difficulty staying asleep
- Wakes in early AM and can't go back to sleep
- Wakes to use bathroom
- Disturbed sleep
- Need naps
- Night sweats
- Other _____

HEENT

- Dizziness/ Vertigo
- Fainting
- Headache/ Migraines
- Facial Pain
- Ringing in the ears
- Poor hearing
- Earaches
- Teeth grinding
- Teeth problems
- Gum problem
- Sores on mouth/lips
- Poor vision
- Blurred vision
- Spots floating in eyes
- Light bothers eyes
- Dry eyes
- Nose bleeds
- Nasal congestion
- Recurrent sore throat
- Other _____

Respiratory

- Daily cough
- Coughing with blood
- Difficulty breathing
- Shortness of breath
- Frequent colds/ flu
- Other _____

Cardiovascular

- High blood pressure
- Low blood pressure
- Irregular heartbeat
- Palpitations
- Chest pain/ pressure
- Varicose veins
- Swelling in hands/ feet
- Other _____

Psychology

- Irritability
- Depression
- Anxiety
- Mood swings
- Increased stress
- Recent loss
- Anger issues
- Fear
- Ongoing worry
- Hyperactivity
- Suicidal thinking
- Other _____

Gastrointestinal

- Nausea/ Vomiting
- Poor appetite
- Food cravings
- Indigestion
- Thirsty: Hot or cold drinks? _____
- Abdominal pain
- Flatulence
- Bloating
- Loose stools/ Diarrhea
- Constipation
- Blood or mucus in stool
- Black stool
- Rectal pain
- Other _____

Dermatology

- Acne
- Rashes/ Hives
- Itchy skin
- Dry skin

Genito-Urinary

- Pain/ Burning with urination
- Urgency to urinate
- Frequent urination
- Difficulty urinating
- Incontinence
- History of STD's

Men

- Last prostate exam _____
- Erectile dysfunction/Impotence
 - Penile sores/ Discharge
 - Other _____

Gynecology

- Pregnancies: _____
- Births: _____
- Premature/ Miscarry: _____
- Stillborn/ Abortion: _____
- First menses: _____
- Last Pap: _____
- Date of last menses: _____
- Duration of menses: _____
- Days between menses: _____
- Vaginal discharge
 - PMS
 - Breast soreness/ lumps
 - Vaginal sores

Musculoskeletal

- Joint pain/ stiffness
 - Muscle weakness
 - Bone problems
 - Pain
- Where: _____
- Better Worse with pressure
 - Better Worse with heat
 - Better Worse with cold
 - Other _____

Neurological

- Seizures
- Spasms
- Paralysis
- Numbness/ tingling
- Loss of consciousness
- Other _____

Name: _____

Diet/Nutrition

- 1) Do you eat five or more "fast food" meals per week? Yes No
- 2) Do you eat *less* than two portions of fruits and vegetables per day? Yes No
- 3) Do you react adversely to any food? Yes No
- 4) Do you address weight management by dieting? Yes No
- 5) Are you on any special diet (vegetarian, dairy-free, etc.)? Yes No
- 6) Do you have difficulties (e.g. weakness, nausea, etc) you miss a meal? Yes No
- 7) Do you use artificial sweeteners (e.g. NutraSweet, Sweet&Low) Yes No

Genetics

- 1) Were there medical problems at your birth? Yes No
- 2) Do you have any genetic diseases that you know of? Yes No

Environment

- 1) Do you react adversely when you consume caffeinated beverages? Yes No
- 2) In your work or home environment, are you exposed to chemicals, cigarette smoke, pesticides, or radiation? Yes No
- 3) Do you have a history of alcoholism? Yes No

Psycho-Social

- 1) Do you feel less happy than you did a year ago? Yes No
- 2) Do you feel your life has little meaning and/or purpose? Yes No
- 3) Do you believe stress is presently reducing the quality of your life? Yes No
- 4) Is your sex life less than satisfactory? Yes No
- 5) Have you ever been hospitalized for mental or emotional illness? Yes No
- 6) Is your primary relationship less fulfilling than it was a year ago? Yes No
- 7) Have you experienced major losses that are negative impacting you? Yes No
- 8) Do you feel you still have significant issues from your childhood? Yes No
- 9) Was there a history of alcohol or drug abuse in your family? Yes No

Exercise/Aerobic Conditioning

- 1) Are your symptoms better with exercise? Yes No

Women Only

- 1) Do you experience regular problems with PMS? Yes No
- 2) Do you regularly have problems with menstrual cramps? Yes No
- 3) Do you experience irregular menstrual cycles? Yes No
- 4) Do you experience heavy menstrual periods? Yes No
- 5) Have you entered menopause? Yes No

Men Only

- 1) Are you currently using anabolic steroids or growth hormone? Yes No
- 2) Do you have trouble with urination? Yes No
- 3) Any pain in the area of your prostate gland? Yes No

TREATMENT OPTIONS

In addition to the integrative care we offer, please check all additional options you are interested in and answer questions for each one.

Lifestyle Discussion/ Counseling/ Stress Management/ Life Planning

What are the top 3 issues you would like to address with Dr. Piscopo?

What are your goals for therapy? _____

Have you done counseling or psychotherapy before? Yes No

If yes, was it helpful? Yes No Counselor: _____

Is there a history of mood disorders, mental illness, or significant abuse? Yes No

Have you been hospitalized for a psychiatric illness? Yes No

If yes, details: _____

Are you taking psychiatric medications? Yes No

Injection Therapy/ Neural Therapy/ Biopuncture

Have you ever had injection therapy previously? If yes, please provide details _____

Any known allergies to anesthetics (e.g. Lidocaine, Procaine, etc.) or injectables? Yes No

Fainting or distress around injections? Yes No Bruise easily? Yes No

Are you taking any major pain medications or medications for neurological or psychiatric issues? Yes No

Have you been diagnosed with cancer? Yes No Are you currently pregnant? Yes No

Do you bleed easily? Yes No

Acupuncture/ Needless Acupuncture (Acutonics)/ Auriculotherapy

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Have you had acupuncture before?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have hepatitis, cancer, or HIV?
<input type="checkbox"/>	<input type="checkbox"/>	Do you bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a pacemaker?
<input type="checkbox"/>	<input type="checkbox"/>	Are you prone to bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty lying down for 30 minutes?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a tendency to faint?	<input type="checkbox"/>	<input type="checkbox"/>	Have you recently traveled outside the US?
<input type="checkbox"/>	<input type="checkbox"/>	Are you nervous about needles?	<input type="checkbox"/>	<input type="checkbox"/>	Women: are you pregnant?

Electrotherapy/ Magnetic Therapy

Have you have electrotherapy before? Yes No If so, have you had any negative reactions? Yes No

Are you taking any major pain medications or medications for neurological or psychiatric issues? Yes No

Have you been diagnosed with cancer? Yes No

Do you use a pacemaker? Yes No

Are you currently pregnant? Yes No



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 staffs of AVWC are unable 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, Cancellations, 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. Cancellations 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.
- All sales on dispensary items are final except for the rare instances that they have expired within 3 weeks of purchase, they are the wrong supplement, or a refund is approved by Dr. Thomas.
- 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 Wellness Center (AVWC) may perform the following procedures as part of the diagnosis and treatment of your health condition:

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.

Contraception Counseling and management

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 AVWC clinician of any disease process that I am suffering from and any medications or over the counter drugs that I am currently taking. I will also advise my doctor immediately if I am presented with a cancer diagnosis, 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 AVWC 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 AVWC 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 AVWC 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



Electrotherapy Consent

I, the undersigned, authorize the Alpine Valley Wellness Center to perform the medical treatment known as Frequency Specific Microcurrent therapy, a form of electrotherapy. This therapy is a non-invasive means of treating various somatic disorders, including chronic pain. The equipment that we use has been classified by the FDA as a TENS unit type device. TENS has not been shown to have any short or long term complications to date. However, the possibility that the device may affect some sensitive users in a presently unknown way cannot be overlooked.

I understand that Frequency Specific Microcurrent therapy involves the use of tiny amounts of electrical current (i.e. one millionth of an ampere) applied to the body. I understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. However, I recognize that the chances of success are enhanced by following the directives of my clinician (for example, to be well hydrated on the day of my treatment). There are some people who may not be able to receive Frequency Specific Microcurrent therapy, including women who are pregnant and patients using a demand type pacemaker. Please initial the following statements below:

I am not currently pregnant _____

I am not currently using a demand type pacemaker _____

Like all medical procedures, I recognize that Frequency Specific Microcurrent therapy has potential risks and potential benefits. These risks and benefits are as follows:

Potential Risks: Frequency Specific Microcurrent therapy has a history of safety and side effects are uncommon. If they do arise, they typically start during or about 90 minutes after treatment and lasting for a few minutes to a few hours. Side effects are similar to any use of electrical media when applied to the body, such as Ultrasound, EKG, etc., or to having a massage. These includes irritation at the site of stimulation, soreness, fatigue, light-headedness, drowsiness, or transient weakness. Symptoms may also worsen transiently before improving.

Potential Benefits: Microcurrent treatment is painless, increases speed of recovery, and often promotes healing in conditions that have not responded to other treatment. Microcurrent treatment can also lead to the resolution of the health concern being treated and the inducement of a greater sense of well being. The effects are long lasting and occur without the side effect of pharmaceutical drugs.

I hereby release Alpine Valley Wellness Center from all liability in connection with the Frequency Specific Microcurrent therapy I receive. I understand that I am free to discontinue treatment at any time.

Signature of patient

Date



What are Non-Covered Services?

Your medical insurance benefits are governed by a contract with your insurance company. In this contract, the insurance provider details those medical interventions and procedure that are allowed, which are called covered services. Those medical interventions and procedure that are not covered are called **non-covered services**.

In deciding what an insurance company considers covered and non-covered services, they are typically guided by a principle that assesses if a procedure is “medically necessary.” There is usually a code or legal definition that they ascribe to. For example, medically necessary could be defined as a procedure that is required to identify or treat a recipient’s illness, injury, or disability. Such a procedure would have to be warranted by the individual’s symptoms and be consistent with the defined standards of acceptable care by the conventional medical system. They may require that the procedure or intervention be supported by research and not be what they deem “experimental.” The following is a list of items that may be considered “non-covered services”:

- Dietary counseling, treatment and diagnostic procedures primarily for obesity or for weight reduction.
- Dental health services, particularly if preventative in nature.
- Treatment or removal of corns, callosities, or the cutting or trimming of nails.
- Fertility testing, diagnosis, evaluation and treatment.
- Artificial insemination, in vitro fertilization and embryo transfer procedures.
- Genetic testing, genetic treatment, or genetic engineering:
- Nutrition care, supplements, supplies or other nutritional substances.
- Services related to any surgical, laser or nonsurgical procedures or alterations of the refractive character of the cornea for correction of near-sightedness and/or astigmatism.
- Orthopedic shoes or orthotics for the feet.
- Food antigen and/or sublingual therapy.
- Mental health services, psychological or alcoholism and drug abuse counseling services.
- Cosmetic service or cosmetic surgery.
- Organ and tissue transplantation.
- Home health, skilled nursing care, skilled nursing facility and hospice services.

Another phrases that you often see in your contracts with your insurance company are these:

- “A medically necessary procedure cannot be solely for the convenience of the recipient and/or their family.”
- “If a non-covered service is provided to a covered person, the covered person has the responsibility for payment.”

This and other phrases like it are important for you to understand. The bottom line is that while you may think something is medically necessary or critical for your health, that has no bearing on whether the procedure will be covered by your insurance company. And if the insurance company has decided it is not covered, either that service is not available to you or you will have to pay for it out of pocket.

While many of the services provided by naturopathic physicians are covered by medical insurance, some of the services that naturopathic medicine strongly believes to be an important part of health care, such as prevention, lifestyle interventions, and nutritional counseling, may not be covered by your insurance company. We are providing this handout to you in order to educate you about the realities of your health care coverage so that you will be in the position to make informed choices, both concerning the insurance companies you do business with and about the services that may or may not be available to you.



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.

(Patient’s Signature or Signature of Legal Guardian) OR _____ Date _____

(Patient’s Social Security Number) OR _____
(Legal Guardian’s Social Security Number)



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509] 886-9355
www.alpinebewell.com

Physical Medicine Consent

The physicians at Alpine Valley Wellness Center (AVWC) perform a number of physical medicine interventions. These include, but are not limited to, electrotherapy, microcurrent therapy, and therapeutic ultrasound therapy.

Electrotherapy: The main type of electrotherapy used at AVWC is microcurrent therapy (for example Frequency Specific Microcurrent (FSM) therapy). Microcurrent therapy involves the use of tiny amounts of electrical current applied to the body. People who may not be able to receive electrotherapy include women who are pregnant, patients with cancer, or patients using a demand-type pacemaker.

Therapeutic Ultrasound: Therapeutic ultrasound (TS) is a treatment modality use to provide deep heating to soft tissues in the body. It is not the same as **diagnostic ultrasound**, which is a diagnostic imaging technique that is used to see the inside of the body. TS should not be used over a pregnant uterus, over a fracture, or over metal implants. Please let your ND know if you have these issues.

Potential Risks: physical medicine therapy has a history of safety and side effects are uncommon. Side effects can include irritation at the site of stimulation, soreness, fatigue, light-headedness, drowsiness, or transient weakness. Symptoms may also worsen transiently. I agree to contact my physician if any side effects do not subside in 24 hours.

Potential Benefits: Benefits may include an improvement in your symptoms and an increase in your ability to perform my daily activities. You may experience increased strength, awareness, flexibility and endurance in my movements. You may experience decreased pain and discomfort.

Release: Please initial below:

I am not currently pregnant _____

I am not currently using a demand type pacemaker _____

I am not aware of having an active cancer issue _____

Insurance: the physical medicine interventions done at AVWC are similar to interventions done by physical therapist and use the same insurance codes. **For this reason, your insurance company may decrease the number of physical therapy appointments available for the coming year if we use certain physical medicine interventions like electrotherapy and ultrasound.**

I hereby release AVWC from all liability in connection with the physical medicine interventions I may receive as part of my treatment. I understand that I am free not engage in physical medicine procedures if I chose, and I am free to discontinue these treatments at any time. I understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

Signature of patient

Date

Alpine Valley Wellness Center, PC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL 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.

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996(HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH Act), Omnibus Rule, and associated regulations and amendments.

If you have any questions about this notice or if you need more information, please contact

**Alpine Valley Wellness Center
Attn: Gary Piscopo, ND, LAc., HIPAA Privacy and Security Officer
430 Elva Way
East Wenatchee, WA 98802**

ABOUT THIS NOTICE

This Notice will tell you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to follow the terms of this Notice that is currently in effect. You may always obtain a copy of our current notice by any of the following means:

1. Accessing our website at www.alpinevalleywellnesscenter.com
2. Contacting our office
3. Asking for a copy at the time of your next visit

WHAT IS PROTECTED HEALTH INFORMATION (“PHI”)

PHI is information that individually identifies you. We create a record or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse that relates to:

- Your past, present, or future physical or mental health or conditions,
- The provision of health care to you, or
- The past, present, or future payment for your health care.

HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHI in the following circumstances:

Treatment.We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

Payment.We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

Health Care Operations.We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Minors.We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Research. We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may disclose PHI to be used in collaborative research initiatives amongst AVWC providers. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

As Required by Law. We will disclose PHI about you when required to do so by international, federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.
- **Business Associates.** We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your PHI.
- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, we may disclose PHI as required by military command authorities. We also may disclose PHI to the appropriate foreign military authority if you are a member of a foreign military.
- **Workers' Compensation.** We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- **Abuse, Neglect, or Domestic Violence.** We may disclose PHI to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.
- **Health Oversight Activities.** We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Data Breach Notification Purposes.** We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves in the event of a lawsuit.
- **Law Enforcement.** We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes.
- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your PHI to authorized officials so they may carry out their legal duties under the law.
- **Coroners, Medical Examiners, and Funeral Directors.** We may disclose PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- **Individuals Involved in Your Care.** Unless you object in writing, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

- **Payment for Your Care.** Unless you object in writing, you can exercise your rights under HIPAA that your healthcare provider not disclose information about services received when you pay in full out of pocket for the service and refuse to file a claim with your health plan.
- **Disaster Relief.** We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.
- **Fundraising Activities.** We may use or disclose your PHI, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

Your Written Authorization if Required for Other Uses and Disclosures

The following uses and disclosures of your PHI will be made only with your written authorization:

- Most uses and disclosures of psychotherapy notes;
- Uses and disclosures of PHI for marketing purposes; and
- Disclosures that constitute a sale of your PHI.

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your PHI

You have the following rights, subject to certain limitations, regarding your PHI:

- **Inspect and Copy.** You have the right to inspect, receive, and copy PHI that may be used to make decisions about your care or payment for your care. We have up to **30 days** to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. You can only direct us in writing to submit your PHI to a third party not covered in this notice. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.
- **Summary or Explanation.** We can also provide you with a summary of your PHI, rather than the entire record, or we can provide you with an explanation of the PHI which has been provided to you, so long as you agree to this alternative form and pay the associated fees.
- **Electronic Copy of Electronic Medical Records.** If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. If the PHI is not readily producible in the form or format you request your record will be provided in a readable hard copy form.
- **Receive Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured PHI.
- **Request Amendments.** If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **Accounting of Disclosures.** You have the right to ask for an “accounting of disclosures,” which is a list of the disclosures we made of your PHI. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. The first accounting of disclosures you request within any 12- month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the list. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.
- **Request Restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required by federal regulation to agree to your request. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Your request must state the specific restriction requested, whether you want to limit our use and/or disclosure; and to whom you want the restriction to apply.
- **Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you.

Paper Copy of This Notice.

You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may obtain a copy of this Notice by visiting our website: www.alpinevalleywellnesscenter.com/or by contacting our office.

Changes to This Notice

AVWC reserves the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Alpine Valley Wellness Center, Privacy and Security Officer, at the address listed at the beginning of this Notice. You can also file a complaint by contacting the Secretary of Health and Human Services. **You will not be penalized for filing a complaint.**

Alpine Valley Wellness Center, PC

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT NOTICE OF PRIVACY PRACTICES

I acknowledge that I read and/or received a copy of the Alpine Valley Wellness Center Patient Notice of Privacy Practices.

Signature of Patient _____ Date _____

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) _____

Please submit all requests for medical records in writing to our office to assist us in tracking your request. There may be a charge for transferring medical records.

This notice became effective on April 14th 2004.NPP updated 8/18/15

Alpine Valley Wellness Center

430 Elva Way, East Wenatchee, WA 98802
Business: [509] 886-9355 Fax: [509] 886-9354

HIPAA GENERAL CONSENT FORM

Patient Name _____ DOB ____ / ____ / ____

I hereby give my consent for the Alpine Valley Wellness Center (AVWC) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

AVWC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Gary Piscopo, ND, LAc, HIPAA Privacy and Security Officer.**

With this consent, AVWC may call my home or other alternative location and leave a message on voice mail or answering machine in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others. Yes No

With this consent, AVWC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.
 Yes No

Please check off who we may release your medical information to and write their names(s). If you do not wish to release your information to anyone, please check "only the patient".

- Only the patient
- Spouse _____
- Parent _____
- Other _____

By signing this form, I am consenting to allow AVWC to use and disclose my PHI to carry out TPO. I have the right to request that AVWC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. AVWC reserves the right to revise its HIPAA General Consent Form at any time.

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 or Legal Guardian Print Patient/Guardian Name Date



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 (MD). 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.

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, physical exam done, number of symptoms, etc. just like an MD. 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. This time is essentially donated to you by your naturopathic physician in order for them to secure a good understanding of your medical situation. 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.