Tahoe Center of Natural Medicine
600 N. Lake Blvd
Tahoe City, California, US - 96145

Dr. Campbell Naturopathic Form

Date: *

First Name *

Last Name *

Age *

Date of Birth *

Birth Sex * ☐ Male ☐ Female ☐ Decline to answer

Marital Status * ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Registered Partnership ☐ Widowed

Occupation

Employer

Primary Contact Details

Caregiver First Name

Caregiver Last Name

Email *

Home Phone

Mobile Phone

Work Phone

Fax

Primary Phone * ☐ Mobile Phone ☐ Home Phone ☐ Work Phone

Address Line1 *

Address Line2

City *

Country *

State *

Zip code *

Tahoe Center of Natural Medicine
600 N. Lake Blvd
Tahoe City, California, US - 96145

Postbox No _____

Emergency Contact Name _____

Emergency Contact Number _____

Extn _____

Emergency Contact Relationship _____

Who referred you, so we may thank them! _____

FINANCIAL AGREEMENT: I agree to full financial responsibility for services rendered at Tahoe Center of Natural Medicine and
understand that payment is required in full at time of service unless prior arrangements were agreed to in advance. Notice of 24 hours is necessary for cancelled appointments. We reserve the right to charge for a missed appointment.

Signature (Patient / Parent / Guardian) _____

History Questionnaire

When did you last receive medical care? _____

Where did you last receive medical care? _____

What were you seen for? _____

What are your most important health problems that you want to discuss today? _____

Medications

Medication Name	Intake Details

Supplements

Supplement Name	Intake Details

Allergies

Allergies	Type	Severity	Reactions

What hospitalizations and or surgeries have you had and when:

What x-rays, CAT scans, MRI's, EKG's have you had and when

Have you or your family members had any of the following?

- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Problems
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Asthma, Hay fever, Hives
- ☐ Osteoporosis

Height _____

Weight _____

Weight 1 year ago _____

Maximum Weight _____

When? _____

Please note past or present conditions by marking the appropriate box

Neck

Swollen	☐ Past	☐ Present
Goiter	☐ Past	☐ Present

Skin

Rashes	☐ Past	☐ Present
Eczema, Hives	☐ Past	☐ Present
Acne, Boils	☐ Past	☐ Present
Itching	☐ Past	☐ Present
Color Change	☐ Past	☐ Present
Night Sweats	☐ Past	☐ Present

Head

Headaches	☐ Past	☐ Present
Head Injury	☐ Past	☐ Present

Eyes

Eye Pain	☐ Past	☐ Present
Tearing or Dryness	☐ Past	☐ Present
Changing Vision	☐ Past	☐ Present
Glaucoma	☐ Past	☐ Present
Cataracts	☐ Past	☐ Present

Ears

Ringing	☐ Past	☐ Present
Earache	☐ Past	☐ Present
Dizziness	☐ Past	☐ Present

Nose and Sinuses

Frequent Colds	☐ Past	☐ Present
Stuffiness	☐ Past	☐ Present
Nose Bleeds	☐ Past	☐ Present

Mouth and Throat

Sore Throat	☐ Past	☐ Present
Sore Tongue	☐ Past	☐ Present
Gum Problems	☐ Past	☐ Present
Hoarseness	☐ Past	☐ Present
Difficulty Swallowing	☐ Past	☐ Present

Respiratory

Cough	☐ Past	☐ Present
Spitting Blood	☐ Past	☐ Present
Bronchitis	☐ Past	☐ Present
Pleurisy	☐ Past	☐ Present
Emphysema	☐ Past	☐ Present
Wheezing	☐ Past	☐ Present

Asthma	☐ Past	☐ Present
Shortness of Breath	☐ Past	☐ Present
Pain of Breathing	☐ Past	☐ Present
Pneumonia	☐ Past	☐ Present
Tuberculosis	☐ Past	☐ Present

Bowel Movements

How Often? _____

Is this a change? _____

Urinary

Pain or Urination	☐ Past	☐ Present
Increased frequency	☐ Past	☐ Present
Inability to hold urine	☐ Past	☐ Present
Frequent infections	☐ Past	☐ Present
Kidney stones	☐ Past	☐ Present

Cardiovascular

Chest Pain	☐ Past	☐ Present
Angina	☐ Past	☐ Present
High Blood Pressure	☐ Past	☐ Present
Murmurs	☐ Past	☐ Present
Rheumatic fever	☐ Past	☐ Present
Anemia	☐ Past	☐ Present

Endocrine

Fatigue	☐ Past	☐ Present
Hypothyroid	☐ Past	☐ Present
Heat or Cold intolerance	☐ Past	☐ Present
Excessive Thirst	☐ Past	☐ Present

Excessive Hunger	☐ Past	☐ Present

Musculoskeletal

Joint Pain and Stiffness	☐ Past	☐ Present
Arthritis	☐ Past	☐ Present
Broken Bone	☐ Past	☐ Present
Muscle Spasms/cramps	☐ Past	☐ Present
Weakness	☐ Past	☐ Present
Cold hands/feet	☐ Past	☐ Present
Varicose veins	☐ Past	☐ Present

Habits

Do you exercise?	☐ Yes	☐ No
Eat 3 meals per day?	☐ Yes	☐ No
Sleep well?	☐ Yes	☐ No
Awaken rested?	☐ Yes	☐ No
Average 6-8hrs of sleep?	☐ Yes	☐ No
Use Tobacco?	☐ Yes	☐ No
Use alcoholic beverages?	☐ Yes	☐ No
Sexually Active	☐ Yes	☐ No

Gastrointestinal

Nausea	☐ Past	☐ Present
Vomiting	☐ Past	☐ Present
Gallbladder disease	☐ Past	☐ Present
Liver disease	☐ Past	☐ Present
Change in Thirst	☐ Past	☐ Present
Change in appetite	☐ Past	☐ Present
Belching/passing gas	☐ Past	☐ Present

Heartburn	☐ Past	☐ Present
Ulcer	☐ Past	☐ Present

Emotional

Depression	☐ Past	☐ Present
Mood Swings	☐ Past	☐ Present
Anxiety or nervousness	☐ Past	☐ Present
Tension	☐ Past	☐ Present

Neurological

Fainting	☐ Past	☐ Present
Seizures	☐ Past	☐ Present
Paralysis	☐ Past	☐ Present
Muscle weakness	☐ Past	☐ Present
Numbness or tingling	☐ Past	☐ Present
Loss of memory	☐ Past	☐ Present

Male reproductive

Hernia	☐ Past	☐ Present
Testicular masses	☐ Past	☐ Present
Prostate disease	☐ Past	☐ Present
Sexual difficulties	☐ Past	☐ Present
Discharge of sores	☐ Past	☐ Present
Venereal Disease	☐ Past	☐ Present
Number of Children?	_____	

Female Reproductive

Length of Cycle	_____
# of menstrual days	_____
Are cycles regular?	☐ Yes ☐ No

Number of Abortions _____

Number of live births _____

Number of Miscarriages _____

Number of Pregnancies _____

Bleeding between periods ☐ Past ☐ Present

Painful menses ☐ Past ☐ Present

Excessive Flow ☐ Past ☐ Present

Menopausal Symptoms ☐ Past ☐ Present

Venereal disease ☐ Past ☐ Present

Difficulty Conceiving ☐ Past ☐ Present

Sexual difficulties ☐ Past ☐ Present

Pain during intercourse ☐ Past ☐ Present

Do you use birth control? ☐ Yes ☐ No

If so what kind? _____

Breasts

Lumps ☐ Yes ☐ No

Pain or tenderness ☐ Yes ☐ No

Nipple Discharge ☐ Yes ☐ No

Do you do self exams? ☐ Yes ☐ No

Patient Care Financial Policy

We are a cash-based practice. Currently, we are unable to accept insurance for any of our in-house services. FULL PAYMENT OF ALL CHARGES IS REQUIRED AT THE TIME OF SERVICE. We accept payment by cash, check, and credit/debit cards.

*2.5% will be added to the subtotal for credit card payments. Initial _____

Checks denied for insufficient funds will incur a fee of $35.00. We are NOT recognized providers for Medicare, Medicaid or MediCal.

We are NOT contracted with any insurance providers; our services are not covered by insurance in CA. As a courtesy, we can
provide you with a “Superbill” for services rendered. This can be submitted to your insurance company for review of possible benefits. The provided “Superbill” and any insurance submission for possible reimbursement are the sole responsibility of the patient.

The following are general guidelines to patient fees, final charges are determined based upon both time and complexity of the appointment. We reserve the right to adjust pricing without notification.

First Office Visit: $425.00 (This does not include required tests or supplements)

Chiropractic ONLY: $165

Return Office Visit:

15 min $ 125.00 - $150.00

30 min $195.00 - $250.00

45min $250.00 - $295.00

60 min $295.00 - $325.00

Chiropractic ONLY Return Visit: $85

Annual Prescription Renewal Appt: $275 (30 min)

Venipuncture: $25

Intramuscular Vitamin Injection: $35

Re-establishing Care: Patients not receiving care for a period greater than 3 years will require a more comprehensive return office visit to re-establish healthcare baseline.

Phone Appointments: Charged accordingly with in-office visits. If you have any questions or concerns regarding this charge, feel free to ask at the time of your call. Phone consults are not reimbursed by insurance.

Emails: Communication through email will be subject to charges based on complexity and time.

Cancellations: We require a minimum of 24 hours for any changes to your scheduled appointment. We reserve the right to charge for missed appointments, or appointments cancelled with less than 24 hours’ notice.

Supplements: Nutritional supplements, herbs, and homeopathic remedies are often recommended as a part of your treatment plan. We do carry most of the products we recommend at competitive prices, although you are free to purchase from any source you choose. However, most products available to health care providers are often of a higher quality not found in many over-the-counter brands. Most supplements are NOT FDA approved for treatment of any condition.

Other Tests: We do not mark-up any outsourced testing services offered through our office.

Patient/Guardian Signature _____

Date _____

INFORMED CONSENT FOR NATUROPATHIC TREATMENT

I acknowledge that I am accepting treatment from a licensed Naturopathic Doctor (N.D) at the Tahoe Center of Natural Medicine. I understand that there are intrinsic differences between the care of Naturopathic Doctors (N.D.'s) and Medical Doctors (M.D.'s).

Dr. Christina Campbell holds a Naturopathic License in the state of California. Dr. Campbell is also a licensed Chiropractor in California. In the State of California, Naturopathic Doctors are licensed to diagnose and treat disease and have limited prescriptive rights.

I hereby authorize Dr. Christina Campbell to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g. venipuncture, Pap smears, urine analysis.

Minor office procedures: e.g. ear lavage or skin scraping

Medicinal use of nutrition: e.g. therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.

Botanical medicine: e.g. botanical substances may be prescribed as teas, tinctures, capsules, tablets, creams, plasters, or suppositories.

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: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.

Physical medicine: e.g. massage, hot and cold therapy, stretching, manipulation, electrical muscle stimulation, and therapeutic ultrasound.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks include but are not limited to: allergic reactions and other side effects to prescribed herbs and supplements; aggravation of pre-existing symptoms; discomfort, pain, infection, burns, nausea, light headedness; inconvenience of lifestyle changes, injury from injections, venipuncture, or other procedures. Please notify Tahoe
Center of Natural Medicine if you experience any symptoms which may be secondary to the above procedures.

Potential benefits include but are not limited to: restoration of health and the body's maximal functional capacity without the use of drugs or surgery; relief of pain and symptoms of disease; assistance in injury and disease
recovery; and prevention of disease or its progression.

Notice to pregnant women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

At this time, it is my decision to pursue Naturopathic treatment. I do understand that, as with any medical treatment, there is no guarantee that this treatment will offer complete resolution to any or all of the conditions I may have. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the Tahoe Center of Natural Medicine, or any of its personnel, regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures/treatments at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself, or my representative, or as required by law.

Patient/Guardian Signature _____

Date _____

FINANCIAL DISCLAIMER

I claim full responsibility for services rendered at the Tahoe Center of Natural Medicine (TCNM). I understand that payment is required at the time of service, unless other arrangements have been made.

Naturopathic care is not recognized by Medicare or Medicaid. We are not contracted providers with either system. Any care provided through our offices can NOT be billed to either Medicare or Medicaid.

A Super Bill with diagnostic and procedural information is provided for you to submit to your insurance company for possible reimbursement. Again, this does not apply to either Medicare or Medicaid. At this time I understand there is no official insurance reimbursement for naturopathic care. TCNM does not submit to insurance on the behalf of the patient, it is the sole responsibility of the patient. The Super Bill is provided at the time of service, they can not be reproduced later and should be maintained for your own records.

It is our policy we receive 24-hour cancellation notice. If we do not, we reserve the right to charge the full fee for a missed appointment.

Patient Signature _____

Date _____

PRIVACY RULE CONSENT

By signing this form, you are giving Tahoe Center of Natural Medicine permission to use and disclose your protected health information for the purposes of treatment and payment associated with your care.

We have a “Notice of Privacy Practices” that provides more detailed information regarding how we may use and disclose your health information. You have the right to review this document detail at any time. You have the right to request restrictions on how we may use and disclose your health information. We are not required by law to agree with your request, but we will do whatever we can to accommodate requests that are reasonable. You also have the right to revoke this consent in writing at any time, unless your health information has already been used or disclosed in reliance on this consent for the diagnosis, treatment or payment for the medical services for which you sought treatment.

A copy of our “Notice of Privacy Practices” may be obtained by contacting our offices at 530-583-0002, or in writing at POB 6869, Tahoe City, CA 96145. Please note that our “Notice of Privacy Practices” may be changed as needed to comply with Federal Law.

Printed Name _____

Patient Signature _____

Date _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment.

I (specify name), hereby acknowledge that The Tahoe Center of Natural Medicine has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. | understand that if I have questions or complaints I may contact the office’s Privacy Officer: _____

Christina Campbell

(530) 583-0002

I also understand that I am entitled to receive updates upon request if the Tahoe Center of Natural Medicine amends or changes it Notice of Privacy Practices in a material way.

Signature Relationship to Patient- if signed by someone other than the patient _____

THIS SECTION IS TO BE COMPLETED BY THE TAHOE CENTER OF NATURAL MEDICINE IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above named patient, but was unable to because:

☐ Patient declined to sign this Written Acknowledgement

Name and title of employee _____

Date _____