NEW ENGLAND NATUROPATHIC MEDICAL CENTER, LLC
Lesa Werner, ND

New Patient Profile

Date:_____

Last Name:_____ First Name:_____ Birth date:____/____/____

Address:_____ Home Phone:_____

City:_____ State:_____ Zip:_____ Work Phone:_____

Email Address:_____

Emergency Contact:_____ Drivers License:_____ OK to call work? Y / N

Insurance Information

Insurance Company:_____ Policy ID #_____ Group #_____

Name of Insured:_____ Insured's Employer_____

Insurance Authorization

Authorization to Pay Doctor

I hereby authorize the _____insurance company to pay, by check made out to and mailed directly to:

New England Naturopathic Medical Center, LLC
Dr. Lesa Werner, ND
PO Box 370513
West Hartford, CT 06137-0513

Print Name:_____ Signature:_____ Date:_____

Authorization to Release Information to Insurance Company

I hereby request and authorize the disclosure, whenever requested to do so, either verbally or in writing, any information which you may deem appropriate concerning my physical condition with respect to any illness or injury, medical history, consultation or treatment. I hereby release Dr. Lesa Varnagy from all legal responsibility, liability or consequence thereof, which may arise from the act that I have authorized above.

Print Name :_____ Signature :_____ Date :_____

New Patient Profile

Date:_____

Last Name:_____ First Name_____ M / F_____ Birth date:_____/____/____

A note to our patients: Please complete this questionnaire as thoroughly as possible to assist the doctor in your treatment. This information is *confidential* and will not be released without your expressed written consent.

PRESENT HEALTH CONCERNS

Please list health concerns in order of their significance.	Has this problem been previously diagnosed? If so, what was the diagnosis?
1.	1.
2.	2.
3.	3.

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

_____ _____

_____ _____

_____ _____

_____ _____

Bring all prescriptions and supplements in original bottles to your office visit.

LIST ALL SUPPLEMENTS, HERBS, AND HOMEOPATHICS YOU ARE CURRENTLY TAKING:

_____ _____

_____ _____

_____ _____

_____ _____

LIST ALL ALLERGIES TO MEDICATIONS: _____

_____

LIST ALL PREVIOUS SURGERIES_____

Medical Diagnostic Exams/Labs/Screenings: Please list approximate dates and results below

PAP Smear	Date: _____	Result: _____
EKG/ Stress Test	Date: _____	Result: _____
Blood Work	Date: _____	Result: _____
Mammogram	Date: _____	Result: _____
Chest X-ray	Date: _____	Result: _____
Urinalysis	Date: _____	Result: _____
DEXA / Bone / Density Scan	Date: _____	Result: _____
Colonoscopy	Date: _____	Result: _____
Last Menstrual Period	Date: _____	

Please bring a copy of all recent labs and imaging studies with you to your appointment

Family Medical History: Please indicate if any family members have had any of the following conditions:
(**M**= mother; **F**= father; **S**=sister; **B**=brother, **GM-M**= maternal grandmother; **GM-P=** paternal grandmother; **GF-M=**maternal grandfather, **GF-P=** paternal grandfather; **C=** your children))

Allergies_____	Diabetes_____	Hypoglycemia_____
Alcoholism_____	Endocrine/hormone _____	Kidney disorder_____
Asthma_____	Genetic/ Congenital / Inherited condition_____	Liver problems_____
Bleeding tendency_____	Heart disease_____	Neurological disorder_____
Cancer /Type_____	High Blood Pressure_____	Tuberculosis_____
Depression/Anxiety_____	High Cholesterol_____	Other_____

Patient Symptoms Checklist: Please indicate if you currently **(C)** suffer from any of the following, or if you have suffered from a condition in the past **(P):**

Alcoholism_____	Diabetes_____	Hemorrhoids_____	Shakiness if hungry_____
Acne_____	Diarrhea_____	Hot flashes_____	Sciatica_____
Asthma_____	Dizziness_____	Insomnia_____	STD history_____
Anemia_____	Dry skin_____	Interrupted sleep_____	Sinus problems_____
Anxiety_____	Dry/ Brittle nails_____	Irregular Menses_____	Skin problems_____
Arthritis_____	Ear pain/ringing_____	Joint pain_____	Stroke_____
Back pain_____	Eye pain_____	Kidney/pain/infection_____	Spine problems_____
Bad breath_____	Visual changes_____	Leg pain_____	Tremor_____
Bloating/Gas_____	Fatigue_____	Lumps in breast_____	Tuberculosis_____
Bruise easily_____	Fluid/water retention_____	Mood Swings_____	Ulcers_____
Bursitis_____	Foot pain_____	Nausea_____	Vaginitis_____
Bloody stools_____	Forgetfulness_____	Neck pain_____	Varicose veins_____
Cancer_____	Frequent colds_____	Night sweats_____	Weight gain_____
Chest pain_____	Frequent urination_____	Nosebleeds_____	Weight Loss_____
Chronic fatigue_____	Hay fever_____	Numbness/tingling_____	Yeast infections_____
Cold hands/feet_____	Headaches	Mucus/Phlegm_____	Other_____
Constipation_____	HIV_____	Poor Circulation_____	_____
Cough_____	Herpes/cold sores_____	PMS_____	_____
Cramps_____	Heartburn/GERD_____	Poor digestion_____	_____
Decreased Sex drive_____	Heart palpitations_____	Prostate issues_____	_____
Depression_____	High Blood Pressure_____	Shortness of Breath_____	_____

Diet: Please describe a typical Breakfast, Lunch and Dinner.

Breakfast:
Snack:
Lunch:
Snack:
Dinner:
Snack:

How much water do you drink per day?_____

How much coffee do you drink per day?_____

How much alcohol do you drink per day/week?_____

Exercise: Describe the amount and type of exercise you participate in on a weekly basis?

Sleep: Describe your sleep. (Hours per night, interrupted sleep, sound sleep, difficulty falling asleep, etc.)

Environmental: Please list any chemicals, fumes, dust particles, pesticides or other toxins to which you are exposed.

Smoking: Do you smoke or are you exposed to smoke? If so, how much and for how long?

Stress: Are you frustrated by your current situation (home, work, family, relationships)?

Sex: Are you currently in a committed relationship?

Do you practice safe sex?

Spiritual:

Do you have a religious/spiritual orientation/practice that is important to you? Are there any products that the doctor might suggest that may be against your beliefs (e.g. Non-Kosher products, animal-based vs. vegan products, digestive enzymes derived from pork?). Please elaborate freely (note: our office can accommodate various food/religious concerns that you might have):

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS EXTENSIVE FORM. YOUR EFFORT WILL ASSIST THE DOCTOR IN DETERMINING AN ACCURATE DIAGNOSIS AND APPROPRIATE INDIVIDUALIZED TREATMENT PLAN.

New England Naturopathic Medical Center, LLC

Lesa Werner, N.D.

Policy Statement and Consent for Treatment

Introducing Dr. Werner

As a Naturopathic Doctor (N.D.) and graduate of Bastyr University, an accredited Naturopathic Medical School, Dr. Werner is trained as a general practitioner with a specialty in science-based natural medicine. Whereas some states permit Naturopathic Physicians to prescribe certain pharmaceuticals, Connecticut law prohibits this, and therefore, Naturopathic physicians in Connecticut cannot fully *function as Primary Care Physicians.*

Dr. Werner maintains her license to practice naturopathic medicine in Connecticut and offers a wide variety of natural / non-pharmaceutical treatments for various medical conditions.

Treatment may include, but is not limited to, herbal medicines, nutritional supplements, dietary and exercise recommendations, homeopathy; physical modalities including hydrotherapy, craniosacral therapy, massage, Bowen therapy, ultrasound, counseling and lifestyle modification.

Fees

Payment is due in full at the time of each visit and is payable via cash, check, or credit card. The fee for service is $250.00 for the first office visit. Return office visit fee schedules are available upon request. Dispensary items are charged at an additional fee and vary depending on the products prescribed. Dr. Werner will issue a prescription when necessary through FullScript and/or Wellevate, online dispensaries. FullScript and Wellevate will offer Dr. Werner's patients a 15% discount on all products on their websites. You may also fill your prescriptions at any website or health store of your choosing. Phone consultations lasting longer than 10 minutes are also subject to charges.

Insurance

While many Connecticut-based insurance companies cover Naturopathic care, Dr. Werner currently participates in only CT Anthem, Cigna, and Oxford Freedom health insurance plans. Please check with your insurance carrier regarding your specific policy prior to scheduling an appointment. For insurances where Dr. Werner is a provider, our office will submit your claims directly and you will only be responsible for your co-pay (if necessary) at the time of your visit.

Many other insurance companies will cover a percentage of "out-of-network" services for Naturopathic Physicians. In these instances, you will be required to pay the full appointment fee at the time of your office visit. Our office will provide you will a detailed superbill that you may submit directly to your insurance carrier. If you do not have insurance coverage for Naturopathic Medicine, you are expected to pay in full at the time of your office visit.

Medicare

Full payment is required at the time of each visit, as Medicare **does not** cover naturopathic services and products.

Senior Citizen Discount

Non-insured Senior citizens (age 60 and older) receive a 10% discount on office visits when paying with cash or check. This ***does not*** apply to lab fees or shipping fees.

Cancellations

Please allow 24 hours notice for cancellation of a scheduled appointment. Cancellations made with less than 24 hours notice will be billed a fee of $50.00.

Consent for treatment

By signing below, I agree to the above stated policies and consent to treatment by Dr. Werner. I understand that I maintain the right to refuse treatment and/or discontinue treatment at any time. I also understand that my records are kept confidential and will not be released without my expressed written consent except as deemed necessary under Connecticut law.

Signature_____ Date_____

Signature_____ Date_____

Signature of parent or guardian if under 18 or otherwise unable to sign for oneself.