Lavender Fields Wellness, LLC
Laurel West, N.D., PA-C
P.O. Box 194
Jesup, GA. 31598
(912) 294-9955

New Patient Intake Form

Patient Information / Profile

Name:	Date of Birth:	Gender: M F Other
Address:	☐ Single ☐ Married	☐ Divorced ☐ Other
(zip)	Employer / School:	
Occupation:		

Contact Information

Phone Numbers:	Work:	Home:	Cell:
Which number may be used to leave a private message with confidential health information?			
E-mail Address:	☐ Do Not Send Me Wellness Education and Event Updates		
Emergency Contact :		home phone:	
Relationship to patient:		work phone:	

Referrals and Adjunctive Care

Are you currently under medical care? ☐ No ☐ Yes For:				
Please list other health care professionals from whom you receive care (name, specialty, contact # if possible)				
How did you find Lavender Fields Wellness?	☐ Patient Referral:	☐ Internet:	☐ Other:	☐ Physician Referral:
Referring Physician or Patient Name:				

Health Concerns (please list in order of importance to you)

1.	4.
2.	5.
3.	6.
Are you currently pregnant? ☐ No ☐ Yes Months?	
What goals do you have from your visit today and overall?	

What expectations do you have of your provider?

Medications and Supplements

Medications & dose:	
1.	4.
2.	5.
3.	6.
Supplements (vitamins, herbs, etc):	
1.	4.
2.	5.
3.	6.

Health History / Review of Systems

Allergies or Reactions to:	☐ Iodine	☐ Penicillin / antibiotics	☐ Sulfa Drugs	☐ Local anesthetics
☐ Aspirin	☐ Nuts	☐ Scents	☐ Other:	
Serious illnesses:				
Accidents:				
Hospitalizations / operations:				

Family History

Mother:	☐ Living	☐ Deceased	Cause	Age:
Father:	☐ Living	☐ Deceased	Cause	Age:
Siblings:	Number living:	Number deceased:	Causes / Ages:	
Children:	Number living:	Number deceased:	Causes / Ages:	

Has any family member had:	**Yes**	**Which Relative(s) & Age of Onset**	**Physician's Notes**
Diabetes	☐		
Stroke	☐		
Heart Disease	☐		
Heart Attack	☐		
High Blood Pressure	☐		
High Cholesterol	☐		
Kidney Disease	☐		
Osteoporosis	☐		
Hepatitis	☐		
Thyroid problems	☐		
Breast Cancer	☐		
Colon Cancer	☐		
Ovarian Cancer	☐		

Client Signature: _____ Date: _____

Lavender Fields Wellness
A Natural Path to Healing
Laurel West, ND, PA-C
P.O. Box 194
Jesup, GA. 31598
(912) 294-9955
www.Lavenderfieldswellness.com

Treatment Authorization and Payment Policy:
(Please print)

I, _____ authorize the practitioners, and staff of Lavender Fields Wellness, LLC. to provide alternative medical care and treatment for (check one)

_____ Myself

_____ My dependent or minor child, named _____
in accordance with the policies stated below:

Notice as to Nature of Services: I understand that care received at Lavender Fields Wellness, LLC. may be nontraditional or unconventional. Such services are commonly referred to as complementary or alternative medicine (CAM), holistic, or innovative services. This can include nutritional and herbal consultation, including alternative approaches to hormonal difficulties, and innovative laboratory testing and diagnosis. Many of these services may not be recognized as standard medical practice, and while long-practiced may still be considered investigational or experimental by the conventional medical community.

No Guarantees: I am aware that no practice of medicine is an exact science, and acknowledge there are and can be no guarantees as to accuracy or outcomes of any diagnoses or treatments I receive at Lavender Fields Wellness, LLC.

Financial/Insurance Responsibility: The physicians and practitioners at Lavender Fields Wellness, LLC. do not participate in any insurance plans. I understand and agree that payment is required in full at each visit unless an alternative is agreed upon in advance; neither Lavender Fields Wellness, LLC. nor any of its physicians/practitioners take assignment. I am responsible for charges incurred for all treatment rendered, and agree that I am responsible for payments for services my insurance carrier may determine non-covered or excluded or to be unreasonable or not medically necessary. I understand my responsibility to pay includes fees for laboratory or other clinical services requested by my treating practitioner(s). I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Lavender Fields Wellness, LLC. to take action to secure payment of an outstanding balance owed.

Notice Regarding Insurance Reimbursement for Non-Participating Providers: I also understand that, if my plan provides reimbursement for services provided by nonparticipating providers, I may submit a claim myself to request reimbursement. I understand that it is my responsibility to know my plan benefits and that Lavender Fields Wellness, LLC. will not be responsible for determining or assisting me with collecting insurance benefits.

Credit/Debit Card On File: Lavender Fields Wellness, LLC. may require a valid credit or debit card be kept on file. I understand my card information will be encrypted and secured as part of my confidential chart in compliance with both HIPAA and credit card industry security standards. I agree to promptly update my credit/debit card information should it change or expire. I understand and agree that Lavender Fields Wellness, LLC. will apply charges to my credit/debit card on file for fees that occur as a result of my treatment – such as labwork, shipping, medical courier, processing, bank service, etc. – and that Lavender Fields Wellness, LLC. will notify me in such cases.

Accepted Methods of Payment: Lavender Fields Wellness, LLC. accepts credit cards, debit cards, and pre paid checks as payment. This includes any health savings account (HSA) card containing a Visa or MasterCard logo. Lavender Fields Wellness, LLC. cannot currently accept the Care Credit program as payment.

Reservation, Reschedule, and Cancellation Policy: Lavender Fields Wellness, LLC. may require a valid credit card on file to reserve an appointment. I acknowledge that this card on file will not be charged until my appointment has concluded, and that I may use another accepted form of payment at that time. If I do not attend an appointment, or if I am unable to provide 24 hours notice of cancellation, I understand Lavender Fields Wellness, LLC. will charge my card on file for up to 50% of the office visit, including the cost of any materials used in preparation for the appointment.

Outstanding Balances, Returned Checks, and Chargebacks: Lavender Fields Wellness, LLC. may refuse to see patients with balances greater than $60.00 and/or over 30 days overdue, and who are not making regular payments on the balance. Outstanding balances greater than 90 days overdue may be referred to a collection agency. In the event of a returned check or credit card chargeback, Lavender Fields Wellness, LLC.will add a fee of $30.00 for each occurrence.

I have read, understand, and agree to the above terms and conditions.

_____ _____

Signature of Patient (or legal guardian) Date

Lavender Fields Wellness,LLC.
Laurel West, ND, PA-C
P.O. Box 194
Jesup, GA. 31545
Phone: (912) 294-9955
FAX: (912) 545-2823

Authorization to Disclose Protected Health Information

Name of Patient _____ Date of Birth _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care	Military	Social Security/Disability
Insurance	Personal Use	Other: _____
Legal Purposes	School	_____

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical	Consultation Report	ER Record
Operative Reports	Discharge/Death Summary	Face Sheet
Lab/Path Reports	X-Ray Reports/Images	Other: _____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO: Lavender Fields Wellness- Laurel West, N.D., PA-C **(912) 294-9955**

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

P.O. Box 194, Jesup, GA. 31598

Address (Street, City, State and ZIP)

FROM:

_____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____

Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will not expire, unless I revoke the authorization in writing.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

_____
Printed Name of Patient or Legally Authorized Representative

_____
Relationship to Patient