NATUROPATHIC
MEDICAL SPECIALISTS

Patient Name:_____ Date:_____

MEDICAL HISTORY

DATE	CONDITION	TREATMENT	FOLLOW- UP

SURGICAL HISTORY

DATE	CONDITION	SURGERY	FOLLOW- UP

8960 W. Cheyenne Ave. Suite 190
Las Vegas, NV 89129
www.naturopathicmedicalspecialists.com
Phone: 702.656.0016
Fax: 702.933.8690

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Full Name: _____	**DOB**: __/__/__ Sex: M F **Marital Status:** S M D W
Home Address: _____ _____ **City/State**: _____ **Zip code**:_____	**Home Phone**: _____ **Cell Phone**: _____ **I allow Text Messages / Emails**: _____/_____

Email Address:
How did you hear about us? Website: Friend/Family/Who:

PATIENT EMPLOYER

Employer:			**Hours per wk:**	**Phone:**
Address:				
City/State:				**Zip**:
N/A	Lt Labor	Mod Labor	Heavy Labor	Office/Clerical

GUARANTOR

Guarantor Name:						
Relationship to Guarantor:	Spouse	Parent	Sibling	Child	Aunt/Uncle	Legal Guardian	Other: _____
Address:			**City/State**:			**Zip**:
Phone:			**Cell**:			

SPOUSE NAME and EMERGENCY CONTACT

Spouse Name:	**Cell:**	
Spouse Place of Work:		**Work Phone:**
Emergency Contact:	**Relation:**	**Phone:**

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INSURANCE INFORMATION

Primary Insurance:			**Phone:**
ID#:	**Group#:**		
Insured's Name:		**Relationship:**	**Spouse** **Parent**
Insured's DOB:			
Primary Insurance:			**Phone:**
ID#:	**Group#:**		
Insured's Name:		**Relationship:**	**Spouse** **Parent**
Insured's DOB:			

Race (Please select one or more): African American/Black American Indian Asian Hispanic/Latino

Italian Non-Hispanic/Latino Pacific Islander White Other: _____ Decline Unknown

_____

REASON for VISIT

What is your main complaint(s):

When did they begin:

HEALTH MAINTENANCE **When was the last time you had the following tests performed?** (Please check all that apply):

	Past Year	2 Years	10 Years	Never
Colonoscopy				
Routine Physical				
Eye Exam				
Breathing Test				
Bone Density				
Cholesterol Check				
DTP				
Flu Shot				
Mammogram				
Pap Smear				
Pneumonia Vaccine				

NATUROPATHIC MEDICAL SPECIALISTS

PAST MEDICAL HISTORY

Do you have or have you been diagnosed with the following? (If yes, please mark all that apply.):

	Yes	No	0-12 months	1-3 yrs	3-5yrs	5-10yrs	10+yrs
Cancer							
Diabetes							
Glaucoma							
Heart Disease							
High Blood Pressure							
High Cholesterol							
HIV							
Lung Disease - Asthma, COPD, etc							
Seizures							
Stroke							
Other:							

Have you been hospitalized in the past year? **Yes** **No** (If yes, please specify below.)

Date	Hospital	Reason

Are you currently seeing any specialists? **Yes** **No** (If yes, please provide the name and reason below.)

Specialist Name	Reason

FAMILY HISTORY

	Yes	No	Relation
Cancer			
Diabetes			
Glaucoma			
Heart Disease			
High Blood Pressure			
High Cholesterol			
HIV			
Lung Disease - Asthma, COPD, etc			
Seizures			
Stroke			
Other:			

SOCIAL HISTORY

What is your smoking status? Never Past Smoker Current Smoker How many packs per day? Years?
Do you drink alcoholic beverages? Yes No If yes, approximately how many drinks per week?
Have you or do you use drugs for recreational use (confidential)? Yes No If yes, please explain:
Have you ever been exposed to any conditions/events that could potentially be damaging to your health (i.e. Military combat, occupational hazards, chemicals, etc)? Yes No If yes, please explain:

ALLERGIES

Do you have any **FOOD OR DRUG ALLERGIES**? Yes No If yes, please list below.

Food or Drug	Reaction

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MEDICATIONS

Please list all medications including over-the-counter medications, and herbal supplements that you are currently taking:

Supplement	Dose	Treatment Purpose

I confirm that I am 18 years or older. I confirm that all information is correct to the best of my knowledge. I hereby consent to and authorize all services.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

NATUROPATHIC MEDICAL SPECIALISTS

ADULT HEALTH HISTORY FORM

Symptoms: (Check symptoms that you currently have or have had in the past year.)

General
- ☐ Anxiety
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Sweats
- ☐ Weight gain
- ☐ Weight loss

Cardiovascular
- ☐ Chest pain
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

Men only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore penis
- ☐ Other

Gastrointestinal
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Skin
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

Muscle/Joint/Bone

Pain, weakness, numbness in:
- ☐ Arm
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

Eye, Ear, Nose, Throat
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - flashes or halos

Genito-Urinary
- ☐ Blood in the urine
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Frequent urination

Women only
- ☐ Abnormal Pap Smear
- ☐ Bleed between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

I confirm all information is true to the best of my knowledge. I will notify the Naturopathic Medical Specialist if anything changes.

Patient Signature:_____Date:_____

NATUROPATHIC
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GENERAL POLICY

Patient Name: _____ Date of Birth: _____Age: _____

Welcome! We look forward to working with you on your healthcare needs. This document contains important policy information that pertains specifically to you. Please read over the entire document, initial where indicated, and sign at the bottom. If you have any questions please feel free to ask the staff members at Naturopathic Medical Specialists.

Payment

All Naturopathic Medical Specialists require payment in full at the time services are rendered. For your convenience we accept Cash, Check, Visa, Discover, American Express, and MasterCard. There will be a $40.00 fee for all returned checks. _____ please initial

Insurance

All Naturopathic Medical Specialists are not a recognized provider for any insurance companies nor do they submit claims to insurance companies on your behalf. We will, however, provide you with the information necessary for you to submit your claim to your insurance company excluding Medicare. This does not ensure any coverage from your insurance company. If you do have Medicare please see the receptionist. _____ please initial

Emergencies

If you have a true medical emergency or serious medical concern you are to call 911 immediately. If you have an urgent medical concern please call the office; if it is after regular business hours (9am to 5pm) please leave a message at (702)656-0016 and someone will return your call the next business day. If you feel you can not wait until the next business day it is your responsibility to seek appropriate medical care. _____ please initial

I am a consenting adult of at least 18 years or older. I have read this document completely and I understand and agree with all of its contents demonstrated by my signature below.

Patient Signature: _____ Date: _____

NATUROPATHIC MEDICAL SPECIALISTS

INFORMED CONSENT FOR NATUROPATHIC MEDICINE

Patient Name: _____ Date: _____ Date of Birth:_____

I,_____, understand that the evaluation, diagnosis and treatment by a naturopathic physician and specifically by Dr. Alexandra Reimann, ND may include, but is not limited to:

- Interview (history taking)
- Physical examination
- Common diagnostic procedures such as diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva.
- Dietary advice and therapeutic nutrition such as the therapeutic use of foods, diet plans/lifestyle changes, nutritional supplements, intravenous and intramuscular injections.
- Wellness protocols including exercise recommendations, stress reduction, sleep enhancement, counseling and balancing of work and social activities.
- Botanical medicines and nutraceuticals [also referred to as supplements] such as the prescribing of various therapeutic substances including plant, mineral and animal materials. Substances may be given in the form of teas, pills, creams, powders, tinctures-which may contain alcohol, suppositories, topical creams or other forms.
- Homeopathic remedies.
- Over the counter medications
- Referral to a prescribing doctor for prescription medications when indicated.
- Referral to doctors of other specialties when indicated.

I am informed that in the practice of Naturopathic Medicine there are risks and benefits including, but not limited to the following:

- Potential risks: pain, discomfort; allergic reaction to prescribed herbs, supplements, prescription medications; aggravation of pre-existing symptoms.
- Potential benefits: restoration of the body's optimal functioning capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery and prevention of disease or its progression.

By signing below I acknowledge that I have been provided ample opportunity to read this form. I understand that it is my responsibility to request that the provider explain therapies and procedures to my satisfaction. I further acknowledge that no guarantees have been given to me concerning the results intended from the treatment. This consent form is to cover the entire course of treatments for my present condition and any future conditions for which I am seeking treatment. I will notify the doctor of any changes in my medical history, medications and risk for potential pregnancy.

Signature: _____ Date: _____

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PATIENT ACKNOWLEDGEMENT FORM

Date:_____

How would you like to be addressed in the front lobby area?

- ❑ First name
- ❑ Surname
- ❑ Other _____

I authorize this office to confirm appointments and/or communicate with me about my health care via:

- ❑ Cell phone
- ❑ Home phone
- ❑ Email
- ❑ Any of the above

The undersigned acknowledges receipt of a copy of the Notice of Privacy Practices for this healthcare facility.

Print Name: _____ Sign Name:_____

NATUROPATHIC
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APPOINTMENT POLICY

Patient Name: _____ Date of Birth: _____ Age: _____

Due to the length and demand for new patient appointments, a $100 deposit is required to schedule a new patient appointment. This deposit is non refundable if the appointment is not canceled one week prior. We consider an appointment to be an agreement between our patients and our practice.

Our practice takes pride in scheduling and keeping appointments in the time frame agreed upon between our patients and our practice.

We are responsible to be available to provide patients with our services, during scheduled appointment times.

Patients are responsible to keep and meet the agreed upon appointment times or to give our practice a 48 hour notice of cancellation.

If you are unable to keep the new patient appointment for any reason, without giving a week's notice will result in loss of deposit.

If you are unable to keep follow up appointments for any reason, without giving the appropriate 48 hour notice, a $50 cancellation fee will be applied to the next visit fee.

please initial:_____

NATUROPATHIC
MEDICAL SPECIALISTS

PAYMENT POLICY

General:

Our practice requires payment in full at the time services are rendered. For your convenience we accept Cash, Check, Visa, Discover, American Express, and MasterCard payments. A $40.00 fee will be charged for all returned checks.

please initial:_____

Insurance:

Our physicians and Naturopathic Medical Specialists are not providers for any insurance networks. Our practice does not submit claims to insurance companies on patients' behalf. Our practice will, however, provide patients with the information necessary to submit claims to their insurance companies on their own behalf. This does not ensure any coverage from the individual patient's insurance company.

If you have Medicare please see the receptionist for additional paperwork.

please initial:_____

Emergencies:

If you have a medical emergency or serious medical concern, call 911 immediately. For other medical concerns please call our practice to schedule an appointment. If your medical concern arises after our practices' regular business hours (9am to 5pm, Monday through Friday) please leave a message at 702.656.0016 and our staff will return your call the next business day. If the medical concern cannot wait to be addressed until the next business day it is your responsibility to seek appropriate medical care immediately.

please initial:_____

I am a consenting adult of 18 years or older. I have read this document completely and I understand and agree with all of its contents.

Patient signature:_____ Date:_____

HIPAA Omnibus Notice of Privacy Practices
Effective as of September 13, 2013

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred, DME vendors, specialist referrals, diagnostic centers, surgery centers/hospitals, referring physicians, family practitioners, physical therapists, home health providers, laboratories, workers comp adjusters and nurse case managers, etc to ensure that the healthcare provider has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for an MRI or other diagnostic tests, specialist referral, physical therapy, etc.may require that your relevant protected health information be disclosed to the health plan to obtain approval for the procedure.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500. Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your

protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

Your Rights: The following are statements of your rights with respect to your protected health information. You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality. You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically. You have the right to request an amendment to your protected health information – If we deny your request for 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.

You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request. You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically.

We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

NATUROPATHIC MEDICAL SPECIALISTS

Fax:702.933.8690

Request for Records

To: ____

Specialty: ____

Phone:____________________ **Fax:** ____________________

Requesting:

❏ All medical records	❏ Blood work from the last _____ months	❏ All radiology reports
❏ Ultrasound reports	❏ Pathology reports	❏ Other ______________

To: ____

Specialty: ____

Phone:____________________ **Fax:** ____________________

Requesting:

❏ All medical records	❏ Blood work from the last _____ months	❏ All radiology reports
❏ Ultrasound reports	❏ Pathology reports	❏ Other ______________

To: ____

Specialty: ____

Phone:____________________ **Fax:** ____________________

Requesting:

❏ All medical records	❏ Blood work from the last _____ months	❏ All radiology reports
❏ Ultrasound reports	❏ Pathology reports	❏ Other ______________

I, ________________________ hereby authorize the release of the above records to the office of Naturopathic Medical Specialists.

______________________________ ______________________________

Patient, Parent or Guardian Signature **Date of Birth**

______________________________ ______________________________

Relationship to Patient **Today's Date**