Dear Patient,

Welcome to our office!

Thank you for allowing Champion Naturopathic Health to partner with you in your journey towards optimal health! Naturopathic medicine approaches health from a holistic perspective and provides safe, effective, natural medicine tailored specifically to you.

The following pages are the start of our comprehensive discussion to learn about you. This form is somewhat long, but we appreciate your time to thoughtfully answer these questions.

The first office visit is where we gather the largest amount of information. This visit will be a thorough assessment of your health and you will need to allow approximately 1 to 1.5 hrs (depending upon the complexity of your health concerns).

In order for us to prepare for this visit, we require that this form be emailed or faxed to Champion Naturopathic Health at least 2 business days prior to your first appointment. If we do not receive your intake on file at least 2 business days prior to your scheduled appointment, we will cancel your appointment. This is to allow another patient who already has their intake form on file and is on our waiting/cancellation list to have that appointment time.

Additionally, if you have any recent bloodwork results, other laboratory testing, or pertinent medical records; please also email/fax these along with your intake form.

We understand that life happens but if you do need to reschedule your appointment, we kindly request you **please let us know at least 2 business days prior to your scheduled time** so that we may allow other patients to have your appointment time.

We are excited to work with you and look forward to meeting you!

Sincerely,

Dr’s Nate & Nita Champion

Champion Naturopathic Health
10505 Wayzata Boulevard, Ste 202 • Minnetonka, MN 55305 • tel (952) 417-1912 • fax (952) 417-1913 • www.championnh.com

Confidential Patient Information

Today's Date: ___________________

Patient Name: ____

Age: ___________ **Date of Birth:** ________________________ **Height:** ______________ **Weight:** ____________

Address: _________________________________ **City:** ______________ **State:** __________ **Zip**: ____________

Home Phone: ___________________ **Cell Phone**: ____________________ **Phone Work**: ___________________

Sex: Female / Male **Marital Status**: Single / Married / Divorced

Who referred you or how did you hear about us?

Other practitioner____ **who?** _______________________ **Friend** ____ **who?** _____________________________

Internet search (specify website): **Other**:

Employment Status: Retired / Full time / Part time / Not employed **Student:** Full time / Part time

Name of Employer: ______________________________________ **Occupation:** __________________________

Name of Spouse (or parent for minor child): ____

Emergency Contact: **Relationship to you**: **Phone**:

Insurance Company: ______________________________ **Name of Insured**: _____________________________

Relationship to the Insured: __________________________________ **Date of Birth**: ______________________

Employer: **Policy/ID #**: **Group #**:

We are excited to keep in touch with you! Please provide us with an email address to receive our office emails regarding clinic announcements, office hours, referral programs, office specials, etc.

Email Address: (you may opt-out anytime you wish)

Clinic Policy requires payment at time of services.

_______________________________ _______________________________ _____________

Patient's Signature **Parent or Guardian's Signature** **Date**

_______________________________ _______________________________

Please Print Name **Please Print Name**

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Consent to Treatment (Informed Consent)

I, ____, hereby voluntarily consent to outpatient care at Champion Naturopathic Health, encompassing, but not limited to the following:

- Interview (history taking)
- Physical Examination
- Routine Diagnostic procedures
- Routine Laboratory work (blood, stool, urine, saliva, etc.)
- Homeopathic medicines (highly dilutes substances)
- Botanical medicines/Nutraceuticals (supplements)
- Dietary Advice & Clinical Nutrition

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including their designees as is necessary in the medical staff's judgment.

I understand that the treatment suggestions provided are not all accepted by the United States FDA and therefore should not be taken as such.

I understand that this consent form will be valid and remain in effect as long as I receive medical care at Champion Naturopathic Health.

Notice to pregnant women: all female patients must alert the provider if they know or suspect that they are pregnant, since some of the therapies could present a risk to the pregnancy.

I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I also 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. I intend that 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.

Signature of Patient or Person Authorized to consent for patient:

____ Date: ___________________________

****

If the patient is a minor or is unable to consent, please complete the following:

Patient is a minor and is ______ years of age.

Name of Father: ____________________________ Name of Mother: ______________________________

Financial Policy (effective 1/1/18)

Please read the following regarding your financial obligations while under the care of Dr. Nate Champion and/or Dr. Nita Champion at Champion Naturopathic Health.

- **Payment is due at the time of service.**
- We accept cash, check, debit and credit cards including Visa, Master Card, American Express, and Discover.
- We do not accept insurance, however:
  - Out of courtesy to our patients we will prepare a health insurance claim form and submit it to your insurance company requesting reimbursement for your appointment charges.
  - We may also bill your insurance company for particular labs, bloodwork, breath testing, and/or imaging. The majority of specialized labs will not be billed through insurance.
- ***All new patients are required to provide a valid credit card number, security code, expiration date and billing zip code in order to schedule a new patient appointment.***
- **New patient appointments:**
  - We require 48 hours (2 business days) notice for cancelations for new patient appointment. If you fail to cancel/reschedule or do not show for your appointment without notification, your credit card will be charged a fee equal to the cost of your appointment (For example, if you are scheduled for a 90 minute new patient intake, you will be billed at a rate of $300 per hour (i.e. $450).
- **Initial homeopathic intake appointments:**
  - Same as the above policy for new patient appointments
- **Follow up appointments:**
  - We require 24 hours notice for cancelations for follow up appointment. If you fail to cancel or reschedule within 24 hours of your appointment or do not show for your appointment, your credit card will be charged for the full cost of your appointment, based upon the allotted scheduled time. For example, if you have a 30 min follow up scheduled and our rate is $300 per hour, you will be charged $150 for that appointment.
- **Phone appointments:**
  - We bill for phone appointments with our doctors. They often require the same time and expertise as in-office appointments.
  - Phone appointments are billed at the same rate as in-office appointments ($300/hour).
- **Email policy:**
  - Email correspondence is not to take the place of a scheduled follow up appointment (in-office or phone). It is always best to schedule an in-office appt. or phone appt. if you have questions pertaining to your care, that cannot be answered by a simple yes or no.
  - If your email pertains to a simple clarification regarding your current treatment sheet that has been previously discussed, and requires a simple yes or no answer, there will likely be no charge for this.

  - If your email questions are of a more complex nature, you will likely be told your questions are best addressed at a future follow up appt. (phone appt. or in-office appt.).
  - If an email response is more involved and requires more than 1-2 sentences to answer, you will likely be billed at the same rate as our billable appointments (i.e. prorated at $300/hour).

- **Lab results:**
  - We do not release laboratory results (bloodwork, stool, breath test, saliva, etc.) to patients before we have had the opportunity to review them and appropriately discuss them with you during your follow up appointment. This is so we can provide the best care to you by being able to properly review your labs, answer your questions, and discuss next steps/treatment strategies.
  - We understand that some of you may be used to accessing your lab results (i.e. My Chart) outside of having an appointment with your doctor. But, please note we do not practice this way and we request you refrain from calling/emailing our office in between appointments to request them ahead of time.

- **Please note there are no refunds for services or labs.**

- **Rationale for the above policies**
  - We would like to share with you briefly why we have implemented this cancellation policy. We spend a great amount of time and energy with each and every one of our new patients because we are committed to providing the highest quality of care. In order for us to do so, our new patient appointments require us to block off large time slots, which creates scheduling problems when canceling or rescheduling appointments at the last minute. We have a large cancelation/waiting list of patients who have their paperwork on file and desire to have an earlier appointment time as appointments become available. We ask that as a courtesy to us and to patients who are waiting, that you let us know as soon as you know you are unable to keep your scheduled appointment time. We have implemented this policy for us to be able to continue providing this level of individualized care for you, and for each and every patient.

By signing this agreement you are indicating that you understand and agree to the terms of service explained above. You are also indicating that you give permission to us to charge your credit card for missed appointments, phone consultations, or any of the above stipulations that may apply to you. ***We will automatically charge this card as described by the terms above***. If you request, phone consultations or other services may be paid with another card or account at the time of service. Your card on file can also serve as a convenient way to pay for supplements or services without having to wait in line at check out. As a courtesy, our front desk staff will call on the workday prior to your appointment to remind you of your scheduled time.

Name of patient or legal guardian: ____

Signature: ____ **Date:** ______________________

Type of card: Visa MC Disc Amex **Card number:** ______________________________________

Expiration date: _________________ **Security Code:** ______ **Billing zip code:** ______________

Confidentiality Statement (HIPAA)

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

Outlined below is a brief summary of your rights and protections under the Health Insurance Portability & Accountability Act (HIPAA). You can learn more details regarding your rights by visiting the following website: http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html or by calling 1-866-627-7748.

Your rights regarding your health information

1. Ask to see and get a copy of your health records.
2. Have corrections added to your health information.
3. Receive a notice that tells you how your health information may be used or shared.
4. Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
5. Request where you would like to be contacted.
6. Ask that your information not be shared. For example, you could ask your doctor not to share your medical record with other doctors in the office.
7. If you believe your rights are being denied or your health information isn't being protected, you can:
    a. File a complaint with your doctor
    b. File a complaint with the U.S. Government

Shared information within Champion Naturopathic Health

In order to provide you with the best quality health care we do at times consult with our colleagues. Information regarding your medical history or current treatment plan may be shared with the other doctors/practitioners at Champion Naturopathic Health.

If you have any questions regarding this notice or our health information privacy policies, please contact the Office Manager at Champion Naturopathic Health.

Name of Patient or Legal Guardian: ____

Signature: ________________________________ **Date:** ____________________________

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Name of Patient or Legal Guardian: ____

Signature: ________________________________ **Date:** ____________________________

Pediatric Intake Form

Health Concerns
What are your child's most important health concerns? List in order of importance:
1.______________________________ Length of time: ______________
2.______________________________ Length of time: ______________
3.______________________________ Length of time: ______________
4.______________________________ Length of time: ______________

Hospitalizations or Surgeries
1.__________________________ When they occurred:______________
2.__________________________ When they occurred:______________
3.__________________________ When they occurred:______________

Medications (drugstore or prescription)
1.________________ Condition Treated: ____________ Dosage: __________
2.________________ Condition Treated: ____________ Dosage: __________
3.________________ Condition Treated: ____________ Dosage: __________
4.________________ Condition Treated: ____________ Dosage: __________

Supplements
1.________________ Condition Treated: ____________ Dosage: __________
2.________________ Condition Treated: ____________ Dosage: __________
3.________________ Condition Treated: ____________ Dosage: __________
4.________________ Condition Treated: ____________ Dosage: __________

Any known Allergies to food, drugs, environment, animals or other allergies (please describe):
____
____

Vaccination History: check if applies	**Testing**
□ MMR □ DPT □ Hep B	**Hearing test normal**: □ Yes □ No □ Not tested
□ Hib: □ Polio: □ Chickenpox:	
□ Other: ________________	**Vision test**: □ Yes □ No □ Not tested
Adverse reactions? (please explain)	**Speech impediments:** □ Yes □ No □ Past
______________________________	
______________________________	**Learning impediments**: □ Yes □ No □ Don't know

Any particular household stressors child has witnessed or gone through:
1.____
2.____
3.____

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<table>
<tr><th colspan="2">Birth History</th></tr>
<tr><td>Prenatal
Previous # pregnancy ____ Previous # births _____
At time of conception:
Mother's age ______
Father's age ______
Did you use prenatal vitamins: □ Yes □No
Mother's Pregnancy History:
Please check all that apply
□ Alcohol □ High blood pressure
□ Anemia □ Nausea/vomiting
□ Bleeding □ Physical trauma
□ Caffeine intake □ Preeclampsia
□ Emotional stress □ Smoking
□ Gestational diabetes □ Recreational Drugs
□ Infection □ Thyroid condition
□ Prescription meds (please list) ________________
____</td>
<td>Birth
Please check all that apply:
□ Vaginal birth □ Cesarean
□ Traumatic birth (please explain) ___________
____
Weight at birth: ________ Length at birth: ________
Length of Labor: ____________________________
Health of baby at birth: ______________________
Delivered on time? □ Yes □ No
If no, + weeks _____, or – weeks _____
Any other complications: _____________________
____
____
____
____
______________________________________</td></tr>
</table>

Health History					
Now	**Past**		**Now**	**Past**	
		Anemia			Frequent colds: # of times __________
		Anxiety			Whooping Cough
		Asthma			Growing pains
		Bad foot odor			Headaches
		Bed-wetting			Hives
		Chicken pox			Hyperactivity
		Chronic sniffles/running nose			Jaundice
		Colic/gas			Mononucleosis
		Constipation			Mumps
		Cough/wheezing			Nightmares
		Cradle cap			Pneumonia
		Dental cavities			Rubella
		Diaper rash			Stomach aches
		Diarrhea			Strep throat/tonsillitis: # of times _____
		Disobedient			Sweats excessively
		Ear infections: # of times___________			Tantrums
		Early puberty			Teething difficulties
		Eczema or psoriasis			Thrush
		Epilepsy/seizures			Urinary tract infection
		Fears/phobias			Abdominal discomfort (cramps, pain)
		Finicky eating			Heartburn (reflux or GERD)
		Abdominal Bloating/Distension			Frequent Belching/Burping
		Nausea			Straining with bowel movements
		Vomiting			Undigested Food in stool
		Rectal Itching			Blood in stool
		Heaviness after eating			# Of Bowel Movements per day:

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General
Was child breastfed: ________
If yes, for how long: ______________________ If no, what formula: ______________________
When was solid food introduced: ________________
When did the following milestones occur:
Rolling over: __________________ First tooth: ___________________ Sitting: _________________________
Talking: _____________________ Walking: _____________________ Dressing self: ___________________

Family History				
	Mother	Father	Siblings	Grandparents
Allergies				
Asthma				
Eczema				
Diabetes				
Cancer				
Cardiovascular Disease				
Obesity				
Tuberculosis				
Mental illness				
Other: _______________________________				

Typical Day's Diet:

Breakfast: ____
Snack: ____
Lunch: ____
Snack: ____
Supper: ____
Snack: ____

Toxin Exposure:

Has the child ever lived near a refinery or other highly polluted area?___________________________________
Has the child ever lived in a house with lead paint?____
Has the child ever lived in a house that had new paint, cabinets, carpeting installed and did that seem to affect their health at all?____
Do you spray pesticides or herbicides around the house or use other toxic chemicals?
____
Does the child seem particularly sensitive to perfumes or other vapors?_________________________________

Anything else you would like to add that we haven't asked you about?

____
____
____