Champion
naturopathic health

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

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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**

Champion
naturopathic health

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: _____

Champion naturopathic health

Name: _____ Date: _____

What are your most important health concerns? List in order of importance:

1. _____

2. _____

3. _____

4. _____

5. _____

Family History

	Father	Mother	Siblings	Mat/Paternal Grand M/F				Spouse	Children
				MGM	MGF	PGM	PGF		
Age if living									
Age when died									
Reason for death									

Place an X in the appropriate location below if it applies.

Allergies									
Alzheimer's Disease									
Anxiety Disorder									
Arthritis									
Asthma									
Auto-Immune Disease									
Crohn's Disease									
Cancer _____									
Cancer _____									
Celiac Disease									
Depression									
Diabetes Type 1									
Diabetes Type 2									
Gallbladder Disease									
Heart Attack									
High Blood Pressure									
Liver Disease									
Mental Illness									
Migraines									
Osteoporosis									
SIBO									
Stroke									
Thyroid Disease									
Ulcerative Colitis									

Doctor, Hospitalization, Surgery, Imaging

Please Note When & Why You Have Had Each of the Following:

X-Rays: _____ MRI/CT Scans: _____

Ultrasounds: _____ EKG: _____

Last Dental Visit: _____ Last Eye Exam: _____

List any other major illness, trauma, medical interventions not yet mentioned:

_____

Allergies

Please list any medication, food, environmental, or other allergies: _____

_____

Medications (Prescription & Over-the-Counter)

Medication Name	Condition Treated	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Supplements

Name	Brand	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

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Habits/Lifestyle

Exercise	Activity Type	# Mins	Frequency		Soda	Y N	#Ounces/day:	regular / diet
Cardio					Coffee	Y N	#Ounces/day:	regular / decaf
Weights					Sweet Tooth	Y N	Amt/day:	Type:
Stretching					Cigarettes	Y N Past	#Pack/day	#years:
Other					Water	# Ounces/day _____		
					Alcohol	#____ Drinks every_____		

Active Spiritual Practice? Y N	**Type:**		
Main Interests & Hobbies?			
Hrs of Sleep per night? ___	**Awake Rested?** Y N	**Need Naps?** Y N	**How often?**
History of Abuse? Y N	**Type of Abuse:**		
Eat 3 meals/day? Y N	**Diet often?** Y N	**Current Weight?**	**Ideal Weight?**
Recreational Drugs? Y N	**Rehab?** Y N	**Type of Recreational Drug(s):**	

REVIEW OF SYSTEMS

Mental / Emotional

Now	Past		Now	Past	
		Treated for emotional problems			Depression
		Mood Swings			Anxiety or Nervousness
		Considered/Attempted suicide			Tension
		Poor Concentration			Memory problems

Immune

Now	Past		Now	Past	
		Reactions to immunizations			Reactions to vaccinations
		Chronic Fatigue Syndrome			Chronic infections
		Chronically swollen glands			Slow wound healing

Endocrine

Now	Past		Now	Past	
		Hypothyroid			Heat Intolerance
		Hypoglycemia			Cold Intolerance
		Excessive Thirst			Excessive Hunger
		Fatigue			Diabetes

Neurologic

Now	Past		Now	Past	
		Seizures			Paralysis
		Muscle Weakness			Numbness or Tingling
		Loss of Memory			Easily Stressed
		Vertigo or Dizziness			Loss of Balance

Skin

Now	Past		Now	Past	
		Rashes			Eczema, Hives
		Acne			Itching
		Color Change			Perpetual Hair Loss
		Lumps			Night Sweats
		Nails weak			Athlete's foot
		Cuts heal slowly			Dry Skin

Head

Now	Past		Now	Past	
		Headaches			Head Injury
		Migraines			Jaw Pain/TMJ problems

Eyes

Now	Past		Now	Past	
		Spots in eyes			Dry, Burning, or Itchy
		Impaired vision			Eye Pain/Strain
		Blurry eyes			Cataracts
		Color Blindness			Glasses/Contacts
		Bloodshot, Red, or Puffy			Mucus or Discharge

Ears

Now	Past		Now	Past	
		Impaired Hearing			Ear Discharge
		Earaches			Excessive Earwax
		Ringing			Dizziness

Nose and Sinuses

Now	Past		Now	Past	
		Frequent Colds			Post Nasal Drip
		Stuffiness			Loss of Smell or Taste
		Sinus Problems			Difficulty Swallowing
		Nose Bleeds			Allergies, Runny Nose

Mouth and Throat

Now	Past		Now	Past	
		Frequent Sore Throat			Copious Saliva
		Teeth Grinding			Sore Tongue/Lips
		Gum Problems			Hoarseness
		Dental Cavities			Jaw clicks

Neck

Now	Past		Now	Past	
		Lumps			Swollen Glands
		Goiter			Pain or Stiffness

Respiratory

Now	Past		Now	Past	
		Cough			Pneumonia
		Spitting up Mucus or Blood			Bronchitis
		Wheezing			Emphysema
		Asthma			Chest Pain
		Shortness of Breath			Shortness of Breath Lying Down

Cardiovascular

Now	Past		Now	Past	
		Heart Disease			Angina
		High Blood Pressure			Murmurs
		Low Blood Pressure			Chest Pain
		Blood Clots			Fainting
		Swelling in Ankles			Heart Beats Fast or Irregularly

Urinary

Now	Past		Now	Past	
		Pain on Urination			Increased Frequency
		Frequency at night			Inability to Hold Urine
		Frequent Infections			Kidney Stones
		Blood in Urine			Incomplete Urination or Dribbling

Gastrointestinal

Now	Past		Now	Past	
		Trouble Swallowing			Heartburn (Reflux or GERD)
		Change in Thirst			Frequent Belching/Burping
		Change in Appetite			Frequent passing gas
		Nausea			Abdominal discomfort (cramps, pain)
		Vomiting			Abdominal Bloating/Distension
		Ulcer			Constipation
		Jaundice/Yellow Skin			Diarrhea
		Gallbladder Disease			Black Stools
		Liver Disease			Blood in Stool or On Toilet Paper
		Hemorrhoids			Floating Stool
		Bad Breath			Undigested Food in Stool
		Rectal Pain or Itching			Foul odor of Stool of Gas
		Heaviness after eating			Straining/Difficulty having a Bowel Mov't
		Indigestion			# Of Bowel Movements per day:

Musculoskeletal

Now	Past		Now	Past	
		Joint Pain or Stiffness			Arthritis
		Broken Bones			Weakness
		Muscle Spasms or Cramps			Sciatica
		Joint Swelling			Numbness or Tingling

Blood / Peripheral Vascular

Now	Past		Now	Past	
		Easy Bleeding or Bruising			Anemia
		Deep Leg Pain			Cold Hands/Feet
		Varicose Veins			Inflammation/Swelling of Vein

Male Reproduction

Now	Past		Now	Past	
		Hernias			Testicular Masses
		Testicular Pain			Prostate Disease
		Sexually Transmitted Diseases			Discharge or Sores
		Impotence			Premature Ejaculation
		Sexually Active			Sexual Orientation?

Female Reproduction / Breasts

Now	Past		Now	Past	
		Irregular Periods			Heavy Periods
		Pain Prior To or With Periods			Hot Flashes
		Depressed or Irritable Around Periods			Diminished or Excessive Sex Drive
		Painful or Swollen Breasts			Difficulty Reaching Orgasm
		Lumps in Breast			Miscarriages (How Many?)
		Nipple Discharge			Abortions (How Many?)
		Vaginal Discharge			Pelvic Pain
		Vaginal Pain or Itching			Difficulty Conceiving
		Sexually Active			Pain With Intercourse
		Cervical Dysplasia			Number of Pregnancies?
		Endometriosis			Number of Live Births?
		Abnormal PAP			Menopausal Symptoms
		Ovarian Cysts			Length of Cycle?
		Sexually Transmitted Diseases			Length of Period?
		Age of Last Period (if menopausal)?			Date of Last Annual Exam/PAP?

Is there anything else you would like to add or comment on? _____