306 Stoner Loop, Suite 9 - Lakeside, MT 59922 - phone: 406-407-9245 - fax: 406-407-9249

Riverbend Intake Form

Last Name: ____________________________First Name: _________________________Date:_______________________

Address:____

City: _______________________________________State: _______________________Zip:_______________________________

Telephone (Home): ____________________________________Telephone (Work):_______________________________

Email Address: ____Do you want email reminders? Y___N___

Age: ______________ Date of Birth: ________________________________ Gender:__________________________________

Married: ______Separated: ______Divorced: _______Widowed:_______Single:_________Partnership:__________

Live with: Spouse: _______ Partner: ______Parents: _______Children:_________Friends: _______Single: _______

Do you have any children? Y / N if yes please list their ages: ____

Occupation: _____________________________Hours per Week:____

Employer name and address: ____

____

How did you hear about this clinic/referred by? ____

If internet: Our website _____Google_____AANP website_____WANP website______Other: _____________________

Emergency Contact: _________________________________Relationship:____

Phone: ____________________________________ Address:____

Have you ever been treated by a Naturopathic physician before? Y / N

Are you currently receiving healthcare? Y / N, if yes where and from whom? ____________________________

What was the reason?____

Present Health Concerns: Please list important health concerns in their order of significance.

1.____

2.____

3.____

4.____

5.____

What do you believe is causing your most important health concerns?____________________________________

____

What goals do you have for your visit today?____

____

Do you have any contagious diseases at this time? Y / N If yes, what?_______________________________

Past Medical History:

Hospitalizations/Surgeries/injuries:

____Year: ____________

____Year: ____________

____Year: ____________

____Year: ____________

Allergies: Please include mild to severe or life-threatening allergies and reactions (symptoms)

1.) Medications:____

____

____

2.) Food: ____

____

____

3.) Environment: ____

____

____

General:

Height:___________________ Weight:_________________ Weight 1 year ago:____________________________

Maximum Weight:_______________________________When:____

Exercise: Y / N If so, what kind and how often:____

Personal Habits:

Coffee? Y/ N If yes how often and how much?____

Drink alcohol? Y / N If yes how often and how much?____

Smoke? Y / N If yes, how often and how much? ____

Notice of Privacy Practices

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.

Understanding your Health Information
Each time you visit your healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, diagnosis, treatment, and a plan for future care of treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health or medical professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- Understanding of what is in your record and how your health information is used to help you to: ensure its accuracy; better understand who, what, when, where, and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights
Although your health information is the physical property of your healthcare provider, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of the "Notice of Privacy Practices" upon request
- Inspect and copy your health records
- Request an amendment of your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities
The physicians and staff at this office are required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a request restriction
- Accommodate reasonable requests you may have to communicate health information by alternative locations

How We Use your Health Information

- We will use your health information for TREATMENT

  Example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding

- We will use your health information for PAYMENT

  Example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

- We will use your health information for HEALTH CARE OPERATIONS

  Example: Members of the medical staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

Other Ways That We May Use your Health Information

- Business Associates: There are some services provided in our organization through contracts with Business Associates, including: diagnostic services and laboratory tests. When these services are contracted, we may disclose your health information to our Business Associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associates to appropriately safeguard your information.
- Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- Worker's Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.
- Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
- **Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.**

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

To Report a Problem

If you believe your privacy rights have been violated, you can file a complaint. We will investigate all complaints and there will be no retaliation for filing a complaint. You may also file a written complaint with the Secretary of Health and Human Services.

Effective Date: September 1st, 2009
Version: I

Carla Brook NP-C

Riverbend Integrative Medicine, LLC
306 Stoner Loop Rd, Suite 9
Lakeside, Montana 59922

Acknowledgment of receipt of notice of privacy practices.

I acknowledge that I have received a copy of Riverbend Integrative Medicine Notice of Privacy Practices. I understand that the Notice of Privacy Practices describes how Carla Brook NP-C may disclose and use my protected health information.

Patient printed name: ____

DOB: ______________________

Signature: ____

If acknowledgment is not signed, indicate reason:

____

Riverbend Integrative Medicine

BILLING AND PAYMENT POLICY

Please initial on the line next to each paragraph to validate that you understand each policy.

1. I am financially responsible for all charges, whether covered by my insurance provider. This includes office visits, phone consults, IV therapies, and all labs. We do our best to be upfront with all costs regarding lab costs and appointments, however, in some circumstances pricing is subject to change depending on what insurances decide to cover. If you think this may be an issue, please call your insurance company to check what they may cover and/or get pre-authorization for a lab test or appointment. X __________

2. Any charges or billing regarding labs are to be negotiated with that specific lab company, not the office of Riverbend Integrative Medicine. We will do our best to answer any questions or address your concerns, however, if we are unsure, it will be your responsibility to acquire more information unless other arrangements have been made in advance with the office manager. X __________

3. I realize that full payment is expected the day of service, including phone consults. We accept cash, check, Visa, Mastercard, Amex or Discover card. As a small clinic, we unfortunately cannot hold negative balances, and we appreciate your understanding. X __________

4. If you need to reschedule or cancel your appointment for any reason, please call the office as soon as possible or within 24 hours of your appointment. If we are out of the office, please leave a voicemail or send us an e-mail. Our goal is to provide quality individualized medical care in a timely manner. No-shows and late cancellations inconvenience those individuals who also need access to our care. If you forget or do not show up to your appointment we will apply a No Show/Late Cancellation fee of $75 to your account that must be paid before rescheduling; it is your responsibility to attend an appointment you scheduled. X __________

5. Be on time for your appointment; this includes phone consults. If you are late to your appointment, please realize that it cuts into your appointment time and that is time you will be charged for and is subject to our hourly wage. If you are more than 10 minutes late, we reserve the right to reschedule your appointment in order to stay on schedule for the benefit of our other patients. X __________

6. Please remember that phone consults are appointments too. They are subject to the same hourly rate as an in-office appointment and it is the patient's responsibility to call the office at their scheduled time. No Show and Late Cancellation fees apply to phone consults. X ___________

I HAVE READ THE BILLING AND PAYMENT POLICY AND I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

X ____ X ____________________

Patient Signature **Date**