Patient Information

Last Name: ________________________________ First Name: ___________________________ Middle Name: _____________________

Date of Birth: ___/____/_______ Age: _____________ Gender: F__ M___

Address: ____ City: ______________________ State: ______ Zip Code: __________

Home Ph:(______)______-_________ Work Ph:(______)______-__________ Cell Ph:(______)______-__________

Email Address: ____ Would you like to receive our email newsletter *(circle one)* Yes No

Preferred Method of Contact: ☐ Home ☐ Work ☐ Cell ☐ Email

Employer: ____ Occupation: ____

Referred by: ____

Mother's Name (minors only): ________________________________ Father's Name (minors only): ________________________________

Emergency Contact: ____ Relationship to Emergency Contact: __________________________

Contact's Phone #: (_______)_____________________ ☐ Home ☐ Work ☐ Cell Marital Status ***(circle one):*** Single Married Other

How did you hear about us? ____

Primary Insurance Carrier Information

Policy Holder Last Name: ________________________________ First Name: ___________________________ Middle Initial: _________

Date of Birth: ___/____/_______ Age: _____________ Gender: F__ M___

Address: ____ City: ______________________ State: ______ Zip Code: __________

Home Ph:(______)______-_________ Work Ph:(______)______-__________ Cell Ph:(______)______-__________

Patients Relationship to Policy Holder: ______________________________ Policy Holder Employer: _______________________________

Insurance Company: _________________________________ ID #: ____________________ Policy / Group Number:___________________

Secondary Insurance Carrier Information

Policy Holder Last Name: ________________________________ First Name: ___________________________ Middle Initial: _________

Date of Birth: ___/____/_______ Age: _____________ Gender: F__ M___

Address: ____ City: ______________________ State: ______ Zip Code: __________

Home Ph:(______)______-_________ Work Ph:(______)______-__________ Cell Ph:(______)______-__________

Patients Relationship to Policy Holder: ______________________________ Policy Holder Employer: _______________________________

Insurance Company: _________________________________ ID #: ____________________ Policy / Group Number:___________________

Responsible Party (Custodial Parent / Legal Guardian / Other legally Authorized Representative)

Last Name: __________________________________ First Name: _____________________________________ Middle Initial: _________

Address: ______________________________ City: _______________ State: _______ Zip: ___________ Phone: (____)______-________

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X ____ _____________________

Guarantor's Signature Date

(OVER)

Terms of Admission, Insurance Authorization / Release of Information & Notice of Privacy Practices

Terms of Admission: I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.

Insurance Authorization: I understand that some third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Dr. Nathan Spencer and Lakeside Naturopathic Clinic to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

Notice of Privacy Practices: Lakeside Naturopathic Clinic keeps a record of the services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. By my signature, I acknowledge the Notice of Privacy Policy Statement has been made available to me.

X ____ ____________________
Patient's Signature Date

X ____ ____________________
Guardian/Representative's Signature Date

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Relationship to Patient/Representative Authority

Consent for Treatment

I hereby authorize Dr. Nathan Spencer to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

General Diagnostic Procedures (including but not limited to venipuncture, pap smears, radiography, and blood and urine labwork, general physical exams, neurological and musculoskeletal assessments)
Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions
Herbs/Natural Medicines (prescribing of various therapeutic substance including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical cremes, pastes, plasters washes; suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.)
Dietary Advice and Therapeutic Nutrition (use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.)
Soft Tissue and Osseous Manipulation (use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy)
Electromagnetic and Thermal Therapies (includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and infrared and ultraviolet therapies or moxa—warming or indirect burning of an acupuncture point and hydrotherapies.)

Potential Risks*:* Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.
Potential benefits*:* Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
Notice to Pregnant Women*:* All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Spencer.

X ____ ____________________
Patient's Signature Date

X ____ ____________________
Guardian/Representative's Signature Date

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Relationship to Patient/Representative Authority