NEW PATIENT PACKET

• welcome to our clinic •

First Visit Checklist:

☐ **Completed Intake Form**
Please bring the completed intake forms with you to your appointment. If you would like to send us your forms *before the day of your appointment*, you may scan and email them to: **info@thegolgiclinic.com**.

☐ **Bring Lab or Imaging Reports**
If you have notes or reports from previous doctors visits that you feel might help us in treating you, please bring them to your first appointment.

☐ **List of Current Medications/Supplements**
This includes over-the-counter and prescription medication, herbs, vitamins, supplements & homeopathics.

☐ **Parking**
Parking is available in the Caras Park Lot behind our building or on Front Street.

☐ **Don't Go Upstairs**
When you enter our building, **don't** go upstairs. Upon entering our building, we're located on the main level (second floor) of 113 W. Front Street. Upstairs is actually the third floor.

☐ **Plan to Arrive on Time for Your Appointment**
There is complimentary tea available in our reception area.

☐ **Payment is Expected at the Time of Service**
Cash, check, Mastercard, Visa and Discover are all accepted. Please see our insurance billing policies attached.

Adult Health Intake

Patient Information

Name: ____
First Middle Last

Date of Birth: ______________ Age: ______ Social Security Number: ______________

Street Address: ____
apt/unit

City: ______________ State: ________ Zip: ________

Email: ____
☐ (check box to receive clinic newsletter)

Phone: (home): ____________ (mobile): ____________ (work): ____________
Please circle number(s) where we may leave messages

Employer: ______________________ Occupation: ______________________

Number of hours worked per week? ______

How did you hear of us? ____

Emergency Contact

Contact Name: ______________________ Relationship: ______________

Phone (home): ____________ (mobile): ____________ (other): ____________

Adult Health Intake
Context of Care Review

Successful *health care* and *preventive medicine* are only possible when the physician has a complete understanding of the patient, physically, mentally, and emotionally. The nature of your responses to the following questions, as well as your thoughtfulness and honesty, will go a long way toward improving our understanding of you and will greatly aid us in addressing your health needs.

Why did you choose to come to this clinic?

What do you know about our approach?

What three expectations do you have from your visit to this clinic?
1)
2)
3)

What long term expectations do you have from working with this clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment toward addressing the underlying cause(s) of your symptoms?
Rate from 0 to 10 (10 being 100% committed).

0% 0 1 2 3 4 5 6 7 8 9 10 100%

In what behaviors or lifestyle habits do you regularly engage, which you believe *support* your health?

In what behaviors or lifestyle habits do you currently engage, which you believe are *self-destructive*?

What potential *obstacles* do you foresee in addressing the lifestyle factors that are undermining your health?

What obstacles might you see in adhering to the therapeutic protocols that I will be sharing with you?

Who do you know that will sincerely and consistently *support you* with the beneficial lifestyle changes you will be making?

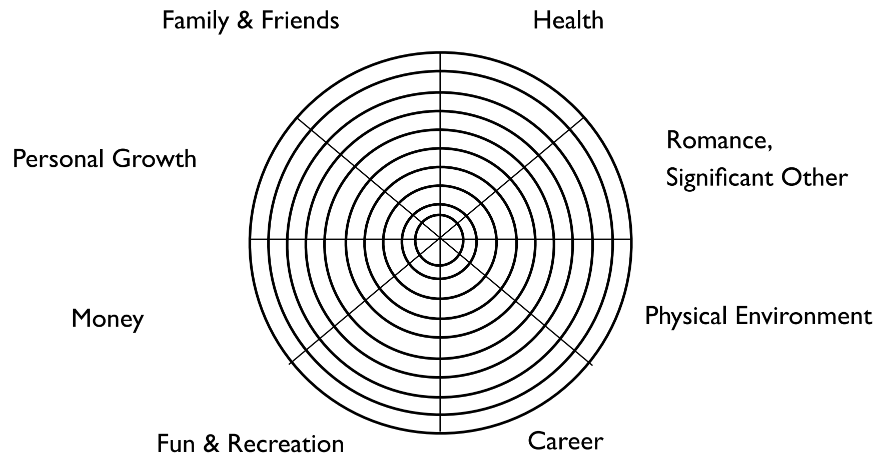
What do you love to do?

Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, starting from the center point.



Are you currently receiving healthcare? ☐ No ☐ Yes

If **yes**, where and from whom? ______________________________

If **no**, when and where did you last receive health care? ______________________________

What was the reason? ______________________________

What are your most important health problems? List as many as you can, in order of importance.

1) ______________________________
2) ______________________________
3) ______________________________
4) ______________________________
5) ______________________________
6) ______________________________
7) ______________________________

Personal Medical History: Please *circle* any that apply to you; *now or past.*

Diabetes (type I or II)	High Blood Pressure	Heart Disease	Breast Cancer	Other Cancer
Mental Illness	Epilepsy	Stroke	Kidney Disease	Hypo/Hyperthyroid
Glaucoma	Asthma	Anemia	Arthritis	Cysts (breast/ovarian)
Hay Fever	Eczema	Fibroids	Inflammatory Bowel Disease	

Other Recurrent, Chronic, or Severe Illness(es):

____

Please list any **surgeries, hospitalizations, imaging** (CT, MRI, EEG, EKG), include **dates**:

____

____

Do you have allergies to medications? ☐ No ☐ Yes
If yes, list medication & reaction: ____________________

Do you have **food allergies** or **environmental sensitivities?** ☐ No ☐ Yes
If **yes**, please list allergy and reaction:

____________________ Reaction: ____________________
____________________ Reaction: ____________________
____________________ Reaction: ____________________

Vaccines: please list name & date of the most recent ____________________

Childhood Illnesses: please *circle* any that apply.

Chicken Pox	Mononucleosis	Rubella	Mumps	Measles
Tuberculosis	Strep Throat	Diphtheria	Rheumatic Fever	Typhoid Fever
Scarlet Fever	German Measles			

Preventative Screening Test: please list the *most recent* date and test's *result.*

☐ Routine Blood Tests: Date__________ Results: ☐ Normal ☐ Abnormal
☐ Sigmoidoscopy or ☐ Colonoscopy: Date(s)__________ Results: ☐ Normal ☐ Abnormal
Women: ☐ Pap smear: Date__________ Results: ☐ Normal ☐ Abnormal
☐ Mammogram: Date__________ Results: ☐ Normal ☐ Abnormal
☐ Dexascan (osteoporosis): Date __________ Results: ☐ Normal ☐ Abnormal
Men: ☐ PSA (prostate): Date__________ Results: ☐ Normal ☐ Abnormal

Social History

Home

With whom do you live? ____________________ Pet(s): __________
Do you have a religious or spiritual practice? ☐ No ☐ Yes, explain: ____________________
Watch TV? ☐ No ☐ Yes, # hours per week: __________
How often do you take vacations? ____________________
Read? ☐ No ☐ Yes, # hours per week: __________
Exercise? ☐ Never ☐ Yes, current ☐ Yes, past
What type: ____________________ minutes/day: __________ times/week __________

Tobacco Use

Cigarettes: ☐ Never ☐ Quit, date: __________ ☐ Current, packs/day: __________ for _____ yrs
Other: ☐ exposed to 2nd hand smoke ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use

Do you drink alcohol? ☐ Never ☐ Past, # drinks/wk _____ ☐ Current, # drinks/wk _____

Drug Use

Have you ever used recreational drugs? ☐ No ☐ Yes, explain: ____________________

Caffeine Intake

☐ Never ☐ Quit ☐ Yes, I drink (circle) coffee/caffeinated tea/soda/cocoa: _____ c/day

Mental Health

Have you had any times of major psychological trauma? ☐ No ☐ Yes
Age: _____ Explain: ____________________
Age: _____ Explain: ____________________
Age: _____ Explain: ____________________
Have you received mental health counseling? ☐ No ☐ Yes

Toxic exposure

Have you had daily or prolonged exposure to toxic chemicals, pesticides, paints, lead, mercury? ☐ No ☐ Yes

If **yes**, what type & when: ______

General

What time of day is your energy the best: ______ worst: ______ Is this a change? ☐ No ☐ Yes

Current height: ______ Current weight: ______

As an adult, what has been your (women: non-pregnant) **maximum weight**: ______

minimum weight: ______

Diet

Do you follow a specific diet? ☐ No ☐ Yes

If **yes**, please *circle*:

Vegetarian Vegan Paleolithic Anti-inflammatory Blood-type Atkins Low-fat/low calorie Gluten-free Dairy-free

Other ______

What do you **typically** eat?

Breakfast: ______

Lunch: ______

Dinner: ______

Snacks: ______

To drink: ______

What is your heritage? (please *circle*)

Caucasian Black Hispanic Native American Asian Other: ______

Family History: Please indicate any ***known*** health conditions; and ***age at death*** if applicable.

mother: ______

father: ______

siblings: ______

siblings: ______

siblings: ______

siblings: ______

grandparents (maternal) ______

grandparents (paternal) ______

Thank you. We look forward to helping you in any way we can.

Please **initial** in the spaces provided after reading the following:

Consent to Treatment

_________ I authorize The Golgi Clinic to treat me/my child. I understand methods of treatment used in this practice may include, but are not limited to: homeopathic, herbal, craniosacral, and/or physical medicine, as well as others deemed appropriate. I am at liberty to seek alternate opinions or care, and may discontinue treatment at any time. I will not hold The Golgi Clinic responsible for treatment outcomes should I choose to disregard the doctors medical advice and treatments.

Pharmacy Policy

_________ Your health care provider may prescribe medication, which may only be purchased at The Golgi Clinic. Most insurance companies *do not* cover the medicinary items that we prescribe and dispense. We can provide paperwork for reimbursement from medical savings plans (FSA or HSA) as well as help billing insurance for reimbursement of the cost. Patients are responsible for payment at the time of order. We do not accept returns on homeopathic medicines or probiotics.

After Hours Appointments Policy

_________ The Golgi Clinic doctors may provide contact information for use in situations where you/your child requires urgent care outside regular office hours. For these appointments, as well as email/phone correspondence from patients, after hours, requiring more than a brief discussion, the clinic reserves the right to charge for the visit based on time and complexity.

Credit Card Policy

The Golgi Clinic asks that active patients keep a valid credit card on file. Please initial the spaces below once you have read the ways in which your card may be used.

_________ I authorize the Golgi Clinic to keep a secure, digital copy of my credit card on file for office visits (via phone, email or Skype) and other appointment-related costs, including missed appointment fees, pharmacy purchases and shipping costs.

_________ All new appointments require a credit card to hold the appointment. This ensures we keep no-shows to a minimum and enables our scheduling process to run seamlessly.

Cancellation Policy

_________ To help us better serve our patients, the Golgi Clinic requires 24 hours notice to cancel or reschedule your appointment. Any appointment changes made with less than 24 hours notice will incur a $50 fee for established patients and $100 for new patients. Please call our office to change or cancel your appointment. *Email is not a valid form of communication.*

Golgi Insurance Policies

__________ As a courtesy to you, we will bill your insurance company for your visit. We are participating with BlueCross BlueShield and PacificSource. For other insurance companies, we are considered out-of-network.

__________ We bill insurance using contracted rates, which are higher than fees charged to patients who pay at the time of service. We offer a Same Day Discount for patients who pay at the time of service and submit their own insurance claims.

Keep in mind, if your insurance benefits do not cover the visit, you're responsible for the contracted rate. The patient is responsible for any balance not covered by their insurance company.

__________ If you would like us to bill your insurance, please be ready with co-pay amount, deductible met to-date, and subscriber information when scheduling. It is the patient's responsibility to know their covered benefits before each appointment.

__________ Payment for non-covered services, copay/coinsurance and medicinary is required at the time of service and may be paid by cash, personal check, VISA or MasterCard. When out-of-network claims and pharmacy claims are paid directly to the clinic, instead of the patient, those payments will be credited to the patient's account. This credit may be used for future visits and/or supplements.

PLEASE READ AND SIGN:

I certify that I have read and understand the above information to the best of my knowledge. I agree to be responsible for payment of all services rendered on my behalf or my dependents, including fees above those designated as "usual and customary" by my insurance carrier.

____

Name (or responsible party name)

____

Signature of responsible party

____

Date

Notice of Privacy Practices

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your healthcare.

It is important that you understand that your information can be used and shared in the following ways:

- To give you medical treatment or other types of health care, multiple providers may be involved in your treatment, both directly and indirectly
- To bill you or a third party for payment for services provided to you
- To assist law enforcement officials in response to criminal activities and to avert a threat to an individual or to public health safety (as in outbreaks of communicable disease)
- In response to a court or administrative order
- We may share your health information with a person(s) that *you have named* to be involved with your health care: **I hereby authorize privileged, confidential information about my treatment to be shared with the following people:**

____

print name(s) of authorized people

You have the following rights relating to the medical records we keep about you:

- Right to inspect your health record and to receive a copy of your health record upon request
- Right to amend information in your health record you believe is inaccurate or incomplete
- Right to know to whom we have disclosed your health information
- Right to ask for limits on the health information data we give out about you
- Right to receive communication from us about your health information in alternate ways
- Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge having received and read all the above-stated policies of The Golgi Clinic and will comply with them in all respects. If my insurance company requires the release of medical records, I hereby give my permission by signing this form.

____

Print Name (*or* name responsible party if patient is a minor)

____ ____ /____/_______

Signature (responsible party signature if minor) Date

How Do I Check My Insurance Benefits*?

The Golgi Clinic is contracted (in-network) with **BlueCross** and **PacificSource** insurance companies. If you have insurance and would like us to bill them for the cost of your office visit, please use this helpful questionnaire to assist you in determining what will be paid. If we are *not* in-network with your plan, you may have out-of-network benefits with your PPO and may be reimbursed a portion of your expenses at our clinic.

Insured Patient Name: ______________________ Insurance ID# ______________________
Insured DOB: ____________________

Call the number on your insurance card listed for patient customer service. Then follow steps 1-6 when calling to find out benefits and eligibility.

1. When did my coverage begin and when is it valid thru?

   Beginning Date of Coverage____________ Ending Date of Coverage____________

   Does my insurance plan follow a Fiscal or Calendar Year Schedule? ____________

2. Do I need a referral from my primary care physician (PCP) for alternative services? Y N

3. What are my benefits for the following services? *Be sure to find out whether your plan includes Out-of-Network coverage for the following benefits.

   Specialties:

   Naturopathic: # of Visits____________ ; Co-pay/ Co-Insurance ____________;Year Max ____________

   Physical Therapy: # of Visits ____________; Co-pay/ Co-Insurance ____________;Year Max ____________

   Lab work/X-rays: % Coinsurance ____________; Year Max ____________

   Female Annual Exam/Well-Woman Exam or Male Annual Exam: Subject to Deductible? Y N; # used to date ______

4. What is the insured person's **individual** deductible for the year and has any or all of it been met?

   Deductible $ ____________; Amount of Deductible met so far $ ____________ Date today ____________

5. Does the insured person's plan have a **family** deductible? Y N

   Deductible $ ____________; Amount of Deductible met so far $ ____________ Date today ____________

6. Are the specialties listed above subject to either deductible? Y N

   If so, which specialties? ____

What was the name of the representative I spoke with? ____

Please bring this form with you to your appointment. If you have trouble getting the information you need, please feel free to call the clinic for assistance.

***Please be aware that this is not a guarantee of payment, if an insurance company gives you inaccurate information they may not honor the benefits that were quoted.**