Dr. Joshua Green ND
Dr. Courtney Bowers ND
Dr. Gabriella Petrelli ND

Vermont Natural Family Medicine, PLC
13 Kilburn Street
Burlington, VT 05401

P 802.238.8603 | F 855.886.6950
E: admin@vtnaturalfamilymedicine.com

Welcome, please complete the following paperwork so that we can best serve you.

Patient Name: ______________________________ Gender:_________ Preferred pronoun(s):_______

Date of Birth: _ ____ ______ Age ____ Social Security#:________

Address: ____ City:____________________

State:______________ Zip Code: ________________________ Home Phone:_______________

Mobile: ______________ Preferred method of contact: __________ Receive detailed voicemail:

Email:.________________________________

Emergency Contact:________________________ Phone :_______________ Relation:_____________

How did you find out about my practice?____

Primary Care Physician:_______________________ Location:_____________ Phone:_____________

Preferred Pharmacy name and phone:.____

Insurance:_______________ ID#: ________________ Group#:____________ Specialist co-pay: ___

Subscriber:_____________________ Subscriber DOB:__________ Relation to patient:____________

Please list any major medical diagnoses and past events (including dates):

1.____

2.____

3.____

Please list your surgical history, including dates and if there were any complications:

1.____

2.____

3.____

4.____

Reason (s) for appointment, in order of importance:

1. ____
2. ____
3. ____

Allergies:

___ No known drug allergies ___ No known food allergies _No known environmental allergies

If you have allergies please fill out below:

Allergen	Allergen Type (Drug, Food or Environment)	Severity (very mild, mild, moderate, or severe)	Reaction (rash, hives, etc)	Onset (childhood, adulthood, unknown)

Medications (all prescriptions including birth control):

Medication	Dosage	Date Started	Date Stopped	Indication	Prescribing Physician

Supplements (include all vitamins, minerals, herbs, amino acids, etc):

Supplements & OTC Including strength	Dosage	Date Started	Date Stopped	Indication	Prescribing Physician

Medical History (check all that apply):

□ Alzheimer's disease
□ Anxiety or Depression
□ Asthma
□ Autoimmune disease
□ Blood pressure problems
□ Cancer ____________________
□ Cholesterol problems
□ Chronic infection:__ __ __ __
Chronic bronchitis/emphysema
□ Diabetes
o Diverticular diz/colitis/ulcers
□ Heart disease
□ Inflammatory Bowel Disease

□ Irritable Bowel Syndrome
□ Kidney or bladder disease
□ Liver or gallbladder disease
□ Neurological problems (Parkinson's, paralysis, epilepsy, etc)
□ Recurrent infections: ______________________________
□ Seasonal Affective Disorder
□ Stroke
□ Suicidal thoughts and/or attempts
□ Thyroid trouble
□ Other:_ _ _ _ _ _ _ _ _ _ _

Reproductive:

□ BPH (enlarged prostate)
□ Erectile dysfunction
□ Sexually transmitted infection
□ Testicular pain and/or injury
□ Breast pain and/or cysts
□ Fibroids/ovarian cysts
□ Difficulty with pregnancy
□ Abnormal Pap: _ /_ /___
□ # of Vaginal births: ___
□ # of C-sections:
□ Last menses:_ _/___/____
□ Irregular/painful menses
□ Vaginal itching or infections

Preventative:

Colonoscopy	Date: ________	Normal / Abnormal
Mammogram	Date: ________	Normal / Abnormal
Pap Smear	Date: ________	Normal / Abnormal
Bone Density	Date: ________	Normal / Abnormal
Skin Exam	Date : ____________	Normal / Abnormal

Family History:

	Major medical problem(s)	Cause of death	Deceased at what age	Current age if living
Mother				
Father				
Siblings				
Children				

M. GrandM				
M. GrandF				
P. GrandM				
P. GrandF.				

Social History:

Occupation:______________________ Employer: ______________________How Long? __________

Jobs/Hobbies involving chemicals (ex: oil painting, woodworking):_______________________________

Sources of stress: _______________________________ Do you feel safe at home? ______________

Marital Status: ______________________________

# of children and ages: __________________ Who do you live with: _________________________

Tobacco use:

□Neversmoker □Heavy tobacco smoker □Unknown if ever smoked

□Former smoker □Smoker, current status unknown □Light tobacco smoker

□Current everyday smoker □Current some day smoker □Chew (circle one): former / current

Do you have any kind of addiction history? _______ I Current/ Recovering_________________

Comment: _____________________

Caffeine :

Coffee _ cups (6 **oz}/day**

Tea_ cups (6 **oz)/day**

Soda _ cans (12 **oz}/day**

Alcohol:

Wine____ (5 oz) **glasses/week**

Liquor___ **oz/week**

Beer ___ (12 oz) **glasses/week**

Water:

____ **oz/day**

Exercise:

Type:_________________________ Duration:___________________________ Frequency:_______________________

Type:_________________________ Duration:___________________________ Frequency:_______________________

Type:_________________________ Duration:___________________________ Frequency:_______________________

Nutrition History:

Do you have a history of an eating disorder?_________ II Current or Recovering?_________________

What are your favorite foods? ____

What is your typical breakfast: ____

typical lunch---

typical dinner: ____

typical snacks/desserts:____
Please list any and all dietary restrictions (i.e. salt, fat, calorie, gluten, corn, soy, etc):

____
____
____
____

Financial Policy:

The following information may be confusing and we have attached a supplementary glossary to help with any confusion. If you have further questions, please consult the customer service number on the back of your insurance card.

I authorize Vermont Natural Family Medicine PLC to bill my insurance and release information to my insurance as requested. This includes but is not limited to, chart notes, lab results, and imaging orders. _______initial

I understand that I may have a co-pay or deductible or co-insurance and will pay my balances in accordance with my insurance plan._______initial

If I don't have insurance, I understand that the Office Policy is a 15% discount offered ONLY at the time of service. If I leave the office without paying, I am forfeiting the time-of-service discount and agree to pay full price for the service. _________initial

I understand that returns are NOT accepted on any supplements or products sold at the office. Once a product is sold the sale is final. ________initial

To our valued patients,
We encourage you to call your insurance company to best understand your coverage as it pertains to care at our office. **Once your insurance is billed, you will be held liable for those services and charges, so it is in your best interest to consult your insurance to know what you will or won't be paying.**

This following section is provided in the best interest of you, the patient. It is advised that you answer the following questions prior to your visit so that there are no surprises for you at the time of service. Please sign at the bottom.

Choose the appropriate selection:

[ ] I have a co-pay which is______for specialists
[ ] I have a co-insurance of ________% for specialists
[ ] I have a deductible____________

Regarding Medicare:

[ ] I understand that Vermont Natural Family Medicine PLC is not a networked provider with Medicare and because Vermont Natural Family Medicine PLC is not a covered provider my supplemental insurance can NOT be billed and I will be paying out of pocket with a discounted rate if I pay at the time of service.

I have read the above information beginning at "Financial Policy" and confirm that the information I've given is true and consent to the office policies laid out in said section.

____

Signature of Patient　　　　　　　　Name　　　　　　　　Date

Privacy Practice:

I acknowledge that Vermont Natural Family Medicine PLC has provided me with a copy of its Notice of Privacy Practices (in the office or on the website) that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact Vermont Natural Family Medicine PLC at 802.238.8603. I also understand that I am entitled to receive updates upon request if there are amendments or changes to its Notice of Privacy Practices in a material way.

____ ______________________

Signature　　　　　　　　Date

This section is to be completed by the office if unable to obtain written acknowledgment from patient

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practice from the above named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment
[ ] Other (specify):____

____ _________________

Name and signature of employee　　　　　　　　Date

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Mandatory Disclosure of Information & Informed Consent for Treatment by Vermont Natural Family Medicine PLC

I understand that methods of treatment may include but are not limited to: diet and lifestyle therapies, nutritional counseling, therapeutic use of nutrients, herbal medicine, homeopathy, infrared, soft tissue manipulation, cranial sacral therapy, pelvic floor therapy and/or joint manipulation or prescription medications.

Naturopathic Dispensary:

- Herbal medicine: I understand that some herbs may need to be prepared. I understand that herbal tinctures are usually prepared with alcohol and will inform the physician if I cannot use them.
- I understand that some herbal medicines may have an unpleasant smell, taste or texture, which is not a reason for returning an item.
- I also acknowledge that unanticipated or unpleasant effects associated with a treatment are not cause for returning an item and should such a reaction occur I will immediately notify my doctor at Vermont Natural Family Medicine.

I do not expect Vermont Natural Family Medicine PLC to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on Vermont Natural Family Medicine PLC to exercise judgment during the course of treatment, which Vermont Natural Family Medicine PLC thinks at the time is in my best interest based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and to discuss with my doctor the nature, purpose, risk and benefits of treatments provided. I understand that not all of the above-named procedures may be utilized for my treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I understand that results are not guaranteed. I hereby request and consent to the treatment and use of the procedures listed above on me (or on the patient named below, for whom I am legally responsible).

____

Signature of Patient (or guardian)   Date   Printed Name

Terms and Conditions of Treatment

Consent for Treatment:
I understand that my care as a patient at Vermont Natural Family Medicine PLC is directed by a Naturopathic Doctor, and/or other health professionals. I consent to services rendered and provided to me under the instructions of these professionals assisting in my care _________ (initials)
I may be contacted by Vermont Natural Family Medicine PLC for voluntary participation in clinical research projects. I do, however, have the right to refuse these programs without jeopardizing my future care at Vermont Natural Family Medicine in any way.___________(Initials)

HIPAA Notice of Privacy Practices and Consent: I hereby consent to the use and disclosure of my protected health information by Vermont Natural Family Medicine PLC for the purposes of treatment, payment and healthcare operations, or as otherwise required by law.___________(Initials)

Statement of Financial Responsibility: I understand and agree to the following:
-Payment for services rendered and/or for missing an appointment with less than 2 business days' notice are my responsibility as the patient or patient's responsible party. I understand that the charge for a missed first appointment is more than the charge for a missed follow up appointment ___________ (Initials)
-I am solely responsible for paying for all services rendered at the time of service, and in the case of missing an appointment with less than 2 business days notice, payment will be rendered within 7 days' of scheduled appointment, by cash or check, unless Credit card services are available. In the event that I am unable to pay a missed appointment fee within 30 days I realize that I may be sent to a collection agency and/or not be able to be scheduled for future appointments. __________(Initials)
-In the event that a credit card is not on file with the office, I understand that I need to put down a deposit for an initial visit of $162. The deposit via credit card on file, check/cash may be forfeited if the initial appointment is missed with less then 2 business days' notice. _ _ (Initials) We hope we do not need to charge you for this:-)

Insurance, Billing, & Labs: If I am billing insurance for services rendered and/or getting lab work done, I understand and agree to the following:
-I authorize Vermont Natural Family Medicine to release pertinent medical records related to billing/laboratory work directly to the laboratory/insurance carrier._________(Initials)
-I am solely responsible for any and all charges that my insurance company and/or laboratory will not cover, and will pay my share of the co-pay, deductible, and/or any other charges on the day of service, before, or after as requested by Vermont Natural Family Medicine PLC, insurance company, or any laboratory facilities in co-ordination with my care with Vermont Natural Family Medicine PLC.___________(Initials)
-I understand that although I may have the intention of corning to Vermont Natural Family Medicine PLC for a preventive visit, that sometimes laboratory work and/or office visits will not meet that criteria and so are not covered fully or at all by insurance due to procedural (CPT) and/or diagnostic coding (ICDlO) that although is medically appropriate might not meet criteria for a preventive visit/code ________ (Initials)
-I must pay for all services in full at the time of service or prior to pick-up at the office that are not normally covered by insurance, such as but not exclusive to supplements, remedies, visits or treatments, that are deemed by the insurance company to be not medically necessary or investigational or non-evidence based, regardless of whether I am reimbursed by my insurance company directly at a later date ________ (Initials)

Advanced Beneficiary Notice:I also realize that the insurance company or representatives of may at any time decide that a past, present, or future visit is not medically necessary, and/or they or representatives of the insurance company may give me incorrect information regarding coverage for visits, and that I agree to pay for all services not covered by my insurance company rendered by Vermont Natural Family Medicine PLC. ______(Initials)

Scheduling:
I understand that I need to return this intake form before I will be scheduled for my first appointment.

Signature of Acknowledgement of Terms and Conditions of Treatment including Advanced Beneficiary Notice
I have fully read and understand *ALL OF* the above agreements and authorizations, yay legalese!

X____ _______/_______/_______ _
Patient (18 years or older) Date
X____ ____ ____
Parent, Guardian, Responsible Party Date

Welcome! We are happy to help you.

If you have any questions or need anything, please ask :-)