vitalhealth

New Patient Information Form

Today's Date_____

Last Name_____ First Name_____ Middle Name _____

Nickname_____

Mailing Address_____City_____ State_____ Zip_____

Date of Birth_____ Gender_____Age _____ Employer_____

Physical address if different than above _____

Email address_____

Do you have health insurance? ◊Yes ◊No **If yes, who is your carrier?** _____

May we send appointment reminders, lab work, & other pertinent health information to the above address? ◊Yes ◊No

May we send appointment reminders & other pertinent health information to the above email address? ◊Yes ◊No

Would you like to receive Vital Health e-newsletter at the above email address? ◊Yes ◊No

Phone Numbers	May we call you at this number?	May we leave confidential, detailed voice messages at this number?
Home Phone ( )	◊Yes ◊No	◊Yes ◊No
Cell Phone ( )	◊Yes ◊No	◊Yes ◊No
Work Phone ( )	◊Yes ◊No	◊Yes ◊No

Mother's/Guardian's Name (minors only) _____Father's/Guardian's Name (minors only) _____

Emergency Contact_____ Relation_____ Contact's Phone _____

How did you hear about us? Referral *who?*_____ ◊Internet_____ ◊Ad *where?*_____ ◊Mailer

◊ Other_____

If you are currently under medical care, please list names of practitioners and conditions being treated:

	Name of Doctor	Phone Number	City, State	Condition(s) treated
Primary Care Doctor				
Other:				
Other:				

Guarantor Information: This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name_____ First Name_____ Middle Initial _____

Address_____City_____ State_____ Zip_____

Phone (_____)_____ Relationship to Patient _____

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 policies of Vital Health.

_____ _____

Guarantor's Signature Date

Chanté Wiegand, ND • Ph.208.201.7064 • Fax 1-888-464-0907 • www.vitalhealthnd.com

Policy Form

Payment Information
Full payment in the form of cash, check, or credit card is due at the time of service. Lab and dispensary fees are also due at the time of service. If payment is not made within 30 days of service, an interest rate of 15% per month will be applied to your account. Excessively overdue accounts will be forwarded to an outside collection agency and you will be responsible for any fees generated as a result of such efforts. There will be a $20 fee for returned checks.

Insurance Information
Vital Health does not bill to insurance, but we can provide you with an insurance ready bill which you can submit for reimbursement if you would like. *Please request at time of your appointment.*

Appointment Cancellations and Late Policy
A 24-hour cancellation policy is necessary so that I may have the opportunity to accommodate other patients. There will be a $30 fee for canceling with less than 24 hours notice, and a $40 fee for failure to show up for your appointment. If you are late for your appointment you will be seen for the remainder of the time, but will be charged the full rate of your scheduled service. If you are excessively late, at our discretion you may be asked to reschedule.

Phone Call and Email Policy
I am happy to answer any brief questions you may have via phone or email whenever I am available. However, if you are calling or emailing about a new or more detailed concern, I may ask you to schedule a phone consultation or office visit for more comprehensive care.

Dispensary Return/Exchange Policy
Opened dispensary items cannot be returned or exchanged. Unopened dispensary items may be returned for a refund or product exchange within 30 days of purchase date.

After Hours and Emergency Policy
Vital Health does not provide after-hours, emergency care, or hospital-based services. In the event of an emergency, please dial 911 or proceed to the nearest emergency room.

- *I have read and understand the above information regarding Vital Health's policies. I agree to all of the above policies, and understand that all services rendered are charged to me directly and I am personally responsible for payment.*
- *I understand that health and accident insurance policies are an arrangement between the insurance company and myself. I hereby authorize Vital Health to furnish medical information to my insurance carrier should it be necessary. I understand that no claims or guarantees have been made by Vital Health for future reimbursement.*
- *I understand that any guarantor listed on the patient information form 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 my guarantor for purposes of securing payment.*

X _____ _____ _____

Signature of Patient (or Guardian/Representative) Printed Name Date

Receipt of Privacy Policy *Please sign after downloading the policy online or upon receipt of policy at first visit.*

Vital Health respects your privacy. We understand that your personal health information is very sensitive. We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Dr. Chanté Wiegand is required to provide you with a copy of her Notice of Privacy Practices and to obtain written acknowledgement that you have been offered it or received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights, and explains how you may exercise those rights. This form is available for you to download online at www.vitalhealthnd.com or in hard copy form at your first office visit.

- *I acknowledge that I have received, been offered, or been directed to a copy of Vital Health's Notice of Privacy Practices.*

X _____ _____ _____

Signature of Patient (or Guardian/Representative) Printed Name Date

Informed Consent for Naturopathic Care

I, _____(print name), seek and consent to the services of Chanté Wiegand, N.D. to provide naturopathic care for myself or my minor child. Naturopathic medicine seeks to optimize health and wellbeing by addressing underlying causes of symptoms, removing obstacles to healing, and stimulating one's innate healing ability. Naturopathic services include the following: Assessment procedures (e.g. physical exam, laboratory tests); Naturopathic physical medicine: (e.g. muscle energy stretching, therapeutic massage techniques, heat and cold therapies, peat packs, therapeutic ultrasound, electromagnetic therapies, and other related treatments); Medical use of nutrition (therapeutic nutrition, nutritional supplementation, intramuscular vitamin injections); Botanical medicine (teas, alcoholic tinctures, capsules, tablets, creams, gels, or suppositories); Homeopathic medicine (the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses); Lifestyle counseling (promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work, spiritual awareness, and social activities).

Nature of Services: I understand that Dr. Wiegand is not an M.D. or D.O. and that naturopathic medicine is not a medical specialty but a separate and distinct healthcare tradition. Dr. Wiegand is a licensed, board-certified naturopathic doctor (N.D.) in the state of Washington, and she attended and graduated from a fully-accredited, four year doctorate program in naturopathic medicine at Bastyr University. Naturopathic physicians are licensed in 16 states, and in the District of Columbia, including Idaho. However the licensing law in this state is undergoing revisions and licenses are not currently being issued until appropriate delineations have been made between board-certified naturopathic physicians and traditional naturopaths. If I believe that I have a condition which requires traditional medical care, I will consult my primary care doctor or an appropriate specialist. When appropriate, Dr. Wiegand may communicate with members of my health team regarding my conditions, treatment options, and/or any health-related issues. Dr. Wiegand may refer me to other healthcare providers for medical care when necessary. I understand that if I am interested in discontinuing or modifying my prescription medications, I will work with my prescribing doctor to do so.

Potential Risks: As with any method of care, naturopathic medicine can involve some risk. I understand that I may experience aches, pains, or even new symptoms as the body responds by shifting its balance. This is generally a positive sign and shows the body is making positive movement. While herbs and botanical products are generally available over-the-counter and are considered safe based upon their long history of use in Europe, China, and the United States, many of them have not been widely tested and they are not regulated by the FDA. Negative reactions to natural remedies may include rare allergic reactions, including headaches, itching, hives, and difficulty breathing. I understand that the interactions between herbs, and between herbs and drugs are not yet well known, and that while unlikely, I could have an adverse reaction or experience a reduction or increase in the effect of other medications. I understand that I should let my other doctors know what herbs I am taking, particularly prior to surgery or other procedures. Potential risks of physical medicine therapies include pain, discomfort, blistering, discolorations, infection, and burns. I do not expect Dr. Wiegand, and/or any allied healthcare provider, to be able to anticipate and explain all potential risks and complications, and I wish to rely on the provider to exercise all judgment during the course of care based on the known facts. I understand that it is my responsibility to alert Dr. Wiegand of any adverse effects or reactions.

Notice to Pregnant Women: All female clients must alert Dr. Wiegand if they know or suspect that they are pregnant.

Potential Benefits: Potential benefits of naturopathic medicine include restoration and optimization of health, relief from pain and symptoms of illness, assistance in recovering from injury and disease, and prevention of disease or its progression. The focus of naturopathic care is to alleviate the underlying causes of illness rather than treat symptoms. While I may experience some immediate improvement from the use of natural remedies, I understand that the most effective results occur when I make a long-term commitment to rebuild my health. It is my responsibility as a patient to follow up with Dr. Wiegand within a recommended time period for evaluation of results or to change protocols as necessary.

No Guarantees: I am aware that there are wide individual differences in responses to naturopathic care, and no guarantees are made that I will gain any benefit or not suffer any adverse consequences. I understand that Dr. Wiegand will answer any questions that I have to the best of her ability, and that it is my responsibility to request that Dr. Wiegand explains services and therapies to my satisfaction. I am aware that Dr. Wiegand is not a psychologist or psychiatrist, and that counseling services are provided for support of improved lifestyle strategies. In the event that a dispute arises that we cannot resolve amicably and a legal case is brought forth, I agree that Dr. Wiegand shall be judged by the standards and principles of complementary, alternative, and/or naturopathic care and not the standards of consensus conventional medicine.

Consent Signature: By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent that I am seeking naturopathic assessment and consultation. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment. I sign this voluntarily and am aware that I may withdraw this consent and discontinue the recommendations at any time.

X _____ _____ _____

Signature of Patient | Name of Patient (printed) | Date