2 Broadway, North Haven, CT 06473 203-239-3400 / beallergyfree@gmail.com

Date

Dear

Recognizing and respecting our abilities as human beings to heal ourselves, we offer natural therapies that support the body's inherent healing abilities. We embrace the whole family: babies, children, adults, and seniors.

Your initial appointment has been scheduled on__________________,
________________________________ at _____ _____ _.

Please arrive 10 minutes before your scheduled time to complete your paperwork. If you must cancel or change this appointment, please notify us at least two business days in advance.

Please complete the following forms and bring them with you to your appointment. Copies of relevant medical records and lab results would be appreciated.

Dr. Mitchell is a provider with Connecticut Anthem Blue Cross. Don't forget your insurance card. If you need a referral, please arrange that with your referring physician. Many other insurance companies cover naturopathic medical services. Call your insurance company. It may take persistence.

Feel free to call if you have any additional questions. We look forward to meeting you.

Many of the people who come to our office have severe allergies.
Please don't wear perfume, cologne or strong scents when you come.
Thank you.

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PATIENT INFORMATION (Please Print)

Name_______________________________________Date of Birth______________ Age_________

Address____________________________________ City_______________ST____ Zip_________

Phone #______________________ Email____________________ Cell # _____________________

Name of Employer____ SS# ____________________

Work Address____ Work # ________________

Name of spouse/ partner_____________________________________ Work # ________________

If minor, name of parent/guardian(s)____

Home # _________________________________ Work # __________________________________

Emergency contact_______________________________________Relationship_________________

Address____

Home # ____________________________________Work # ________________________________

How did you find out about us? ____

INSURANCE INFORMATION for Anthem Blue Cross only

Please give us your insurance card to copy.

Name of Insurance Company____

ID # _____________________________Plan Name & #___________________________________

Name of Insured (if different from patient)____

Address of Insured____

Date of Birth_____________ SS# _________________ Employer____________________________

I authorize any holder of medical information about me to release to HCFA and its agents, or any other supplier of medical benefits, any information needed to determine those benefits, or the benefits payable for related services. I request that payment of authorized benefits be made on my behalf to Anne Mitchell, N.D. for any services furnished to me.

SIGNATURE____DATE_____________________________

Office Policy

Thank you for choosing naturopathic medicine and this office for your health care needs. We hope your time with us is all you wish it to be. We encourage comments, questions, and suggestions. Your health and well being are our prime considerations.

- **Office hours**
  Office hours are Tuesday, Wednesday, Thursday and Friday.

- **Cancellation Policy**
  Your appointment time is reserved for you so please notify us if you can't come.
  We try to remind you by phone before your appointment. If you do not want us to call or leave a message for you please let us know.
  We ask for a minimum of 48 hours notice for cancellations so we can give your time to someone else. You may be charged for a missed appointment.

- **Telephone calls**
  The staff is knowledgeable and available to answer most of your questions. If we are busy with patients, the telephone will be answered by an automated system. Leave a message and your call will be returned as soon as possible. If you're ill or in pain, please say so at the time of your call so we can determine if you need to be seen immediately.

- **HIPAA**
  This is a very small medical office. Your health care information is confidential and access is limited. We use your health care information about you for diagnosis and treatment, to consult with other health care practitioners when necessary and with your permission, to obtain payment for treatment, for administrative services, and to evaluate the quality of care you receive. We will not disclose health information for other reasons without your signed permission unless it is required by law. You have the right to examine your records and to have copies for a reasonable fee. You may request a change in your records if you believe they are incomplete or incorrect. If you are concerned we have violated your privacy rights you may complain to us or directly to the US Department of Health and Human Services. We are required by law to protect the privacy of your information and to provide you with this information. More complete rules and regulations are available on request.

I understand my rights under the Health Insurance Portability and Accountability Act of 1996.

Patient Signature ____________________________________Date ______________

Financial Policy

We make every effort to keep down the cost of your health care. Payment is expected at the time of your visit. Any laboratory tests and medications from our dispensary that you and your doctor decide are necessary are in addition to your visit charge. They must be paid for when you receive them. We accept VISA, Master Card, and of course, cash and checks. There is a fee for returned checks. If we have to bill you, we will charge you $5 each time we send you a bill. We reserve the right to seek outside counsel for any unpaid bills.

Many insurance companies cover naturopathic medical services. Read your policy. Submit your claims. Don't give up easily! If your policy covers out-of-plan providers, or is a point-of-service plan and allows you to choose your doctor, it's likely that you will be reimbursed by your insurance company when you send in your claims. Payment is required at the time of your visit. You may submit the receipt we give you for out-of-plan coverage as it provides all the information your insurance company needs. Dr. Mitchell's services are frequently covered in this way.

Dr. Mitchell is a provider for CONNECTICUT ANTHEM BLUE CROSS.
With Anthem policies, we will collect your co-payment. We will submit claims and accept the amount allowed by your insurance company for covered services. Some of the services may not be covered by your insurance company. These are procedures or treatments or testing that they do not recognize. If your insurance company does not cover these fees, you are responsible for them. As Anthem will pay for approximately 15 minutes of Dr. Mitchell's time with a new patient, you may be charged an additional fee at that visit. These charges will be discussed with you prior to treatment. You will need to contact your PCP for a referral if it is required by your health plan.

Unfortunately, MEDICARE does not cover naturopathic services. There is no coverage under Medicare through Anthem Blue Cross even with participating naturopathic physicians. Medicare is a federal program and the federal government does not recognize naturopathic physicians. We are required by law to submit claims to Medicare for denial, however, payment is due at the time of service. To our knowledge, Federal Blue Cross programs do not cover any naturopathic services. We do not accept Workers Compensation coverage, auto medical benefit coverage, Medicaid or Title 19.

I have read and understood the information provided above. I hereby authorize Dr. Anne Mitchell and her designated assistants to examine and treat me. I understand and agree that I am responsible for payment in full on my account.

Name of Patient_____________________________________Date___________________
Patient Signature____
Signature of Responsible Party____

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SYMPTOM SURVEY

NAME______________________________

DATE______________________

What is your major complaint? ______________________________

____

____

Are you coming for any specific therapy? (i.e. homeopathy, acupuncture, nutritional counseling, physical medicine, "anything that works")______________________________

____

This survey will help us to evaluate you more completely. Please place a check mark next to those symptoms which you NOW experience or have experienced in the PAST. Include all the complaints which are familiar to you. If there are one or more words in a line which describe your specific problem you may want to circle those words.

NOW	PAST	GENERAL SYMPTOMS
_____	_____	tired, weak, lack of energy
_____	_____	depression, melancholy, moodiness
_____	_____	worry, anxiety, nervousness, irritability
_____	_____	sleeplessness or sleep too much
_____	_____	frequent colds or other illness
_____	_____	headaches
_____	_____	don't sweat enough
_____	_____	sweat too much
_____	_____	night sweats
_____	_____	dizziness, fainting, convulsions
_____	_____	loss or gain of weight
_____	_____	other__________________________

NOW	PAST	SKIN AND HAIR
_____	_____	acne or pimples
_____	_____	skin rashes
_____	_____	hives
_____	_____	stretch marks
_____	_____	skin ulcers or sores
_____	_____	dryness, roughness or scaling skin, scalp, elbows, knees, feet, around nose, ears, eyebrows, etc.
_____	_____	hair loss or thinning
_____	_____	dry, coarse hair or split ends
_____	_____	bruise easily
_____	_____	nails weak, ridged or split easily
_____	_____	brown spots or bronzing on skin
_____	_____	moles, warts or skin tags
_____	_____	sunburn easily
_____	_____	cuts heal slowly or scar badly
_____	_____	flush easily
_____	_____	hands or feet numb or tingling
_____	_____	feet burn
_____	_____	athletes foot
_____	_____	other________________________

NOW	PAST	RESPIRATORY
_____	_____	cough frequently
_____	_____	spitting up mucus or blood
_____	_____	difficulty breathing
_____	_____	shortness of breath on exertion
_____	_____	chest pain
_____	_____	other________________________

NOW	PAST	EYES
_____	_____	nearsightedness or farsightedness
_____	_____	blurred or failing vision
_____	_____	dry, burning or itching eyes
_____	_____	eyes water excessively
_____	_____	eyes sensitive to light
_____	_____	night blindness
_____	_____	bloodshot or puffy eyes
_____	_____	other______________________

NOW	PAST	EARS
_____	_____	earaches
_____	_____	noises or ringing in ears
_____	_____	ear discharges
_____	_____	loss of hearing
_____	_____	lots of wax
_____	_____	other______________________

NOW	PAST	NOSE AND THROAT
_____	_____	hay fever, sinusitis, runny nose
_____	_____	dry mouth or nose
_____	_____	nosebleeds
_____	_____	cracks in corners of mouth
_____	_____	dry or chapped lips
_____	_____	sore throats or tonsillitis
_____	_____	clear throat often
_____	_____	sore, red or cracked tongue
_____	_____	cold sores or herpes
_____	_____	inability to smell or taste
_____	_____	lots of cavities
_____	_____	bleeding gums
_____	_____	hoarseness
_____	_____	other________________________

NOW	PAST	MUSCULO-SKELETAL
_____	_____	muscle pain or stiffness where?______________________
_____	_____	swollen, painful or stiff joints
_____	_____	bone pains
_____	_____	painful feet, ankles or calves
_____	_____	tremors or twitches
_____	_____	loss of strength
_____	_____	hernia

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_____ _____ muscle wasting
_____ _____ other_________________________

NOW	PAST	GASTROINTESTINAL
_____	_____	loss of appetite
_____	_____	gagging, difficulty swallowing
_____	_____	nausea or vomiting
_____	_____	bad breath
_____	_____	metallic or bitter taste in mouth
_____	_____	food cravings or strong desires
_____	_____	can't eat fats
_____	_____	heartburn
_____	_____	indigestion or distress
_____	_____	heaviness after eating
_____	_____	belching or gas
_____	_____	bloating
_____	_____	stomach or abdomen tender or painful
_____	_____	symptoms relieved by eating
_____	_____	symptoms worse after eating
_____	_____	avoid certain foods
_____	_____	headache, dizziness or irritability if skip meal
_____	_____	diarrhea or loose stools
_____	_____	constipation
_____	_____	change in bowel movements
_____	_____	light colored or greasy stools
_____	_____	dark stools or blood in stool
_____	_____	feeling of incomplete evacuation
_____	_____	undigested food in stool
_____	_____	foul odor of stool or gas
_____	_____	hemorrhoids
_____	_____	other__________________________

NOW	PAST	CARDIOVASCULAR
_____	_____	heart beats fast or irregularly
_____	_____	tightness in chest
_____	_____	discomfort at high altitude
_____	_____	dizzy or weak upon standing up
_____	_____	swollen feet, ankles or legs
_____	_____	cold hands or feet
_____	_____	hands or feet turn blue
_____	_____	blue fingernails
_____	_____	leg pains when walking
_____	_____	varicose veins
_____	_____	tendency to anemia
_____	_____	high blood pressure
_____	_____	low blood pressure
_____	_____	other________________________

NOW	PAST	URINARY
_____	_____	difficulty urinating
_____	_____	urinate frequently at night
_____	_____	bedwetting
_____	_____	incomplete urination or dribbling
_____	_____	pain when urinating
_____	_____	bladder infections
_____	_____	kidney infections
_____	_____	kidney stones
_____	_____	lower back pain
_____	_____	other________________________

NOW	PAST	MALE
_____	_____	prostate problems
_____	_____	difficult or unusual urination
_____	_____	discomfort or pain in genital area
_____	_____	diminished sexual desire
_____	_____	excessive sexual desire
_____	_____	difficulty maintaining an erection
_____	_____	other____

NOW	PAST	FEMALE
_____	_____	irregular menstruation
_____	_____	pain prior to or with periods
_____	_____	depressed, tense or irritable around periods
_____	_____	painful or swollen breasts
_____	_____	lumps in breasts
_____	_____	discharge from breasts
_____	_____	symptoms occur in monthly pattern
_____	_____	pain, discomfort or itching in genital area
_____	_____	vaginal discharge
_____	_____	hot flashes
_____	_____	diminished sexual desire
_____	_____	excessive sexual desire
_____	_____	difficulty having orgasm
_____	_____	inability to conceive

other symptoms ______________________________
____

Date of last period___________________ # of days_____________ length of cycle__________________________
Date of last PAP smear_______________ Have you ever had an abnormal PAP? ____________________________
Present type of birth control_____________________Have you ever used birth control pills or an IUD? _________
What type and for how long?____
Pregnancies? ________ Number of children? ___________ Miscarriages or abortions ?______________________

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Is your diet?
____typical American ____Kosher
____vegetarian ____fast food
____vegan ____low fat
____macrobiotic ____other

Do you get regular exercise?
what? how often?
____
____
____

Do you use any of the following?
____cigarettes or tobacco ____packs per day
____coffee or black tea ____cups per day
____marijuana or other drugs ____times per week

Are you allergic to anything? Include food, plants medications, pollens, insects, MSG, chemicals, etc.
____
____

Please list any vitamins or medication which you are taking. Use the back of the page if necessary

VITAMINS OR MINERALS
____
____
____
____

PRESCRIPTION MEDICINES
____
____
____
____

HERBS OR FOOD SUPPLEMENTS
____
____
____

OVER-THE-COUNTER MEDICATIONS
____
____
____

Have you ever been hospitalized or had surgery, a serious illness or accident?
what when where
____
____

Have you or any of your family members had any of the problems in this chart? Please indicate who has had which problems by checking the appropriate space.

	Thyroid problems	Diabetes	Tuberculosis	Hypoglycemia	Stroke	Heart Attack	Epilepsy	Cancer	Asthma	Allergies	Anemia	Migraines	Hepatitis	Heart disease	Birth Defects	High Blood Pressure	Gall Bladder Disease	Arthritis	Alcoholism/addictio
Self																			
Children																			
Mother																			
Father																			
Sister(s)																			
Brother(s)																			
Grandparents																			
Others																			

Thank you for taking the time to fill out this questionnaire. For additional comments use the other side.

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CONSENT TO TREATMENT OF MINOR CHILD

I authorize Dr. Anne Mitchell and her assistants to evaluate and treat my child. My child's care will be discussed with me so that therapeutic decisions are made with my full knowledge and consent.

____

(Child's Name)

Signed: _________________________________Date: ___________________

Relationship: ____

Witnessed by: ____________________________ Date: ___________________