

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.**

**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 \_\_\_\_\_

Child's name \_\_\_\_\_ Nickname \_\_\_\_\_  
 Date of birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
 Parent's name(s) \_\_\_\_\_  
 Reason for this visit \_\_\_\_\_

**SYMPTOMS**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Hives           | <input type="checkbox"/> Cough              | <input type="checkbox"/> Flat feet          |
| <input type="checkbox"/> Eczema          | <input type="checkbox"/> Hearing loss       | <input type="checkbox"/> Muscle/bone pain   |
| <input type="checkbox"/> Acne            | <input type="checkbox"/> Stomach aches      | <input type="checkbox"/> Dizzy spells       |
| <input type="checkbox"/> Chronic Rash    | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Diarrhea           |
| <input type="checkbox"/> Jaundice        | <input type="checkbox"/> Excessive fatigue  | <input type="checkbox"/> Hair loss          |
| <input type="checkbox"/> Bleeding gums   | <input type="checkbox"/> Gas, colic         | <input type="checkbox"/> Body/breath odor   |
| <input type="checkbox"/> Canker sores    | <input type="checkbox"/> Lack of appetite   | <input type="checkbox"/> Cries easily       |
| <input type="checkbox"/> Teeth problems  | <input type="checkbox"/> Vomiting spells    | <input type="checkbox"/> Unusual fears      |
| <input type="checkbox"/> Nose bleeds     | <input type="checkbox"/> Burning urination  | <input type="checkbox"/> Nervousness        |
| <input type="checkbox"/> Frequent colds  | <input type="checkbox"/> Bloody urine       | <input type="checkbox"/> Sleep problems     |
| <input type="checkbox"/> Sore throats    | <input type="checkbox"/> Heart murmur       | <input type="checkbox"/> Anemia             |
| <input type="checkbox"/> Hay fever       | <input type="checkbox"/> Runny nose         | <input type="checkbox"/> Nightmares         |
| <input type="checkbox"/> Night sweats    | <input type="checkbox"/> Bleeding tendency  | <input type="checkbox"/> Wheezing           |
| <input type="checkbox"/> Easy bruising   | <input type="checkbox"/> Sensitive to light | <input type="checkbox"/> Frequent headaches |
| <input type="checkbox"/> Motion sickness | <input type="checkbox"/> Joint pains        |   |

**BIRTH HISTORY**

Term: Full \_\_\_\_\_ Late \_\_\_\_\_ Weight at birth \_\_\_\_\_  
 Length of labor \_\_\_\_\_ Complications? \_\_\_\_\_  
 Mother's age at child birth? \_\_\_\_\_  
 Mother's health during pregnancy:  
 Bleeding  Physical or emotional trauma  
 Nausea  Cigarettes, alcohol, drug consumption  
 Illness  Thyroid problems  
 Hypertension  Diabetes  
 Medications (please list) \_\_\_\_\_  
 \_\_\_\_\_  
 Previous pregnancies by Mother, miscarriages, or complications? \_\_\_\_\_

Has your child had any of the following problems:

- |                                   |                                   |  |                                   |
|-----------------------------------|-----------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Birth defects | <input type="checkbox"/> Rashes   |
| <input type="checkbox"/> Colic    | <input type="checkbox"/> Fever    | <input type="checkbox"/> Allergies     | <input type="checkbox"/> Seizures |

Child's sleep patterns (first year) \_\_\_\_\_  
 Feeding: breast fed \_\_\_\_\_ how long \_\_\_\_\_ Formula \_\_\_\_\_ milk / soy / other  
 Age began solid foods \_\_\_\_\_  
 Age began: Sitting \_\_\_\_\_ Crawling \_\_\_\_\_ Walking \_\_\_\_\_ First words \_\_\_\_\_

Childhood Illnesses:

- |                                      |  |   |
|--------------------------------------|--|---|
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Scarlet fever   | <input type="checkbox"/> Tonsillitis    |
| <input type="checkbox"/> Measles     | <input type="checkbox"/> Pneumonia       | # of times _____                        |
| <input type="checkbox"/> Mumps       | <input type="checkbox"/> Frequent colds  | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Rubella     | <input type="checkbox"/> Rheumatic fever | # of times _____                        |

Other \_\_\_\_\_

Has your child had any of the following tests?

	When	Where	Results
Electroencephalogram	_____	_____	_____
Psychological evaluation	_____	_____	_____
Hearing	_____	_____	_____
Speech / Language	_____	_____	_____
Vision	_____	_____	_____

Any known allergies:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Injuries / Surgeries / Hospitalizations:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**IMMUNIZATIONS**

_____ Polio	_____ MMR	_____ HIB	_____ Hepatitis B
___ DPT	_____ Tetanus	_____ Chickenpox	Other _____

**MEDICATIONS**

	Now	Past	Other _____
Aspirin	_____	_____	_____
Tylenol	_____	_____	_____
Decongestant	_____	_____	_____
Ibuprofen	_____	_____	Allergies to medicines
Antibiotics	_____	_____	_____
Antihistamine	_____	_____	_____

**FAMILY HISTORY**

___ Heart disease	_____ Diabetes	_____ Birth defects
___ Hypoglycemia	_____ Hypertension	_____ Arthritis
___ Tuberculosis	_____ Hepatitis	_____ Cancer
___ Allergies	_____ Mental illness	

**DIET**

Please describe your child's typical daily diet:

Breakfast: \_\_\_\_\_  
 Lunch: \_\_\_\_\_  
 Dinner: \_\_\_\_\_  
 \_\_\_\_\_  
 Snacks: \_\_\_\_\_  
 Beverages: \_\_\_\_\_

**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: \_\_\_\_\_