

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, and treat the cause of the illness by taking into consideration physical, mental, and emotional aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

It is very important therefore, that you provide such information as any medications or over the counter drugs you are currently taking, disease processes you are currently suffering from or if you suspect that you are pregnant.

**This is to acknowledge that I have been informed and I understand that:**

1. I have read all the foregoing information and that I understand that the ultimate responsibility for my health is my own.
2. I am a Naturopathic Doctor, not a Medical Doctor.
3. All treatments offered are within the Naturopathic scope of practice.
4. Any treatment or advice given to me as a patient is not mutually exclusive from any treatment or advice that I may receive now, or in the future, from another licensed health care provider.
5. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider.
6. I accept full responsibility for any fees incurred during care and treatment. I agree to fully discharge this responsibility at the time of the visit unless prior arrangements have been made.
7. There are some slight health risks to treatment by Naturopathic medicine. These include but are not limited to:
  - Allergic reactions to supplements or herbs
  - Side effects of medications (eg. Hormone Therapy, Antibiotics)
  - Pain, bruising, infection or injury from injections

**PLEASE NOTE: There is a 24-hour cancellation policy at the clinic. If you are unable to make your appointment, please notify the clinic 24-hours in advance to ensure you are not charged the initial visit fee. \_\_\_\_\_ initial here please**

I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

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Patient Signature/ Signature of Guardian

**CONFIDENTIAL HEALTH RECORD**

Dr. Kelly M. Austin, B.H.Sc., N.D  
 Doctor of Naturopathic Medicine

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 858.705.1727

Last Name		First Name	
Home Address		City	Zip Code
Home Phone ( )		Work Phone ( )	E-mail
Date of Birth ( mm / dd / yy )		Gender <input type="radio"/> Male <input type="radio"/> Female	Marital Status: <input type="radio"/> S <input type="radio"/> M <input type="radio"/> W <input type="radio"/> D <input type="radio"/> Sep
Emergency Contact & Name		Permission to Leave Message: <input type="radio"/> YES <input type="radio"/> NO	
Occupation/Employer			
Medical Doctor's Name & Number			
How did you hear about our clinic?			
Height:		Current Weight:	Ideal Weight:

**Your usual health is:**  Excellent  Good  Fair  Poor

**Major health concerns in order of importance**

1.	4.
2.	5.
3.	6.

**Please list ALL of your Prescription medications taken on a regular basis (include birth control)**

Name	Dose	Duration	Side Effects
1.			
2.			
3.			
4.			
5.			
6.			

*Use the back of this sheet if additional paper is necessary*

**Non-Prescription medications you take (include vitamins / minerals / herbs)**

Name and brand	Dose	Duration	Side Effects
1.			
2.			
3.			
4.			
5.			
6.			

*Use the back of this sheet if additional paper is necessary*

**Have you had all standard vaccinations:**  YES  NO **Are you following any special diets?** \_\_\_\_\_

**Other treatments you are currently following (massage, rehab, diets etc.)** \_\_\_\_\_

**Family History (include siblings, parents, grandparents, uncles, aunts):**

Anemia  Arthritis  Eczema  Glaucoma  Seizure or epilepsy  Heart disease  Hypertension  Other \_\_\_\_\_  
 Thyroid  Diabetes  Asthma  Alcoholism  High cholesterol  Mental illness  Cancer \_\_\_\_\_

**Please list any past surgeries:** \_\_\_\_\_

**Please list any hospitalizations or injuries:** \_\_\_\_\_

**Number of times per week you exercise:** \_\_\_\_\_ **Type of exercise:** \_\_\_\_\_ **Do you lift weights?**  YES  NO

**Record the number of servings you consume daily of each of the following:**

Coffee	Decaf Coffee	Regular Tea	Herbal Tea	Soft Drinks	Milk	Juice	Water	Alcohol / Beer
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**Allergies**

Medications	Have you ever had an allergy test? <input type="radio"/> YES <input type="radio"/> NO
Food	
Environment (pollen, dust)	

**Smoking History**

Do you currently smoke tobacco?	<input type="radio"/> YES <input type="radio"/> NO	Start date:	If yes, how many/day
Did you previously smoke:	<input type="radio"/> YES <input type="radio"/> NO	Start date:	Quit date:

**Stresses**

*Do you currently face or have faced any of the following*

	Ü	Year	Ü	Year
Loss of someone close			Divorce	
Illness in someone close			Pregnancy	
Loss of job			Alcohol/Drug addiction (you or loved one)	
Change of workplace			Physical abuse	
A move			Emotional abuse	
Marriage			Other:	

## WHEN YOU NEED A REFILL

Two weeks before you need a refill, please book an appointment by calling the office 858-705-1727 or booking on-line at [www.nhealth.ca](http://www.nhealth.ca). Appointments are usually done every 2 – 3 months with Dr. Austin. Appointments are needed to review and properly document how well you are doing with your prescriptions, and lifestyle changes. At this time, we can go over blood work, symptoms, questions, concerns and update Dr. Austin on your progress.

Please allow two weeks, as it takes time to do a follow up and for the pharmacy to mail you your prescription medications on time. This will ensure continuation of your treatment protocol without interruption. If you are unable to come into the office for an appointment and your prescription is going to run out, please let us know two weeks prior and we will be happy to offer you a phone consult. If you are financially unable to do a visit, we will accept post-dated checks and arrange a payment plan for you so this does not stand in the way of your treatment protocol.

Please feel free to e-mail the office with any questions you have about your treatment protocol. Please avoid e-mailing the office with health updates as e-mail is not a secure way to transmit information and we want to be able to keep track of your progress in your file. Sometimes we will not have access to your file when answering e-mails. In the case where you just need a refill called in for a pharmaceutical you have been on for years and we deemed you stable, a refill may be called in for a \$10 admin fee.

I understand the above,

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Signature of patient

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Printed name of patient and date

## POLICIES

### Hours

Monday	9AM – 5PM
Tuesday	9AM – 5 PM
Wednesday	9AM – 5 PM
Thursday	9AM – 5PM
Friday	9AM – 5PM

Office visits are by appointment only  
B12 walk-ins are welcomed!

### Fees

- \$250 for a comprehensive, first office visit (60 minutes)
- \$90 follow-up (30 minutes)
- \$45 acute care

### Payment

- Payment is due at the time of service. Please discuss any fee questions with Dr. Austin before your appointment so you can know what to expect.
- We accept cash or check only
- Lab testing is not included in the fee. If you have a PPO, we will use labs that your insurance will cover. If you have a HMO, we can use your HMO MD to run the labs we need.
- All fees are required at time of service. If you do not have cash or check to pay for the visit, please feel free to use one of the six local banks located beside the clinic.
- Fee schedules can be arranged with the doctor prior to a visit if you are in financial need.

### Insurance

- Insurance does not directly cover naturopathic doctors.
- However, we can provide you with a "super-bill" after every visit which you can try to submit to your insurance company to request out-of-network reimbursement. Some services may not be covered by certain health insurance plans.
- It is your responsibility to know what your insurance plan covers. We are not responsible for unpaid claims by your insurance company for services we provide.

### Appointments

- *First appointment:* Please find on the website [www.nheath.ca](http://www.nheath.ca) the intake forms, consent forms and a welcome letter for you to view and fill out. Please complete these and bring them to the visit with you.
- Please arrive at the office 10 minutes before your scheduled appointment. Please do not wear any scented products, as many of our patients are chemically sensitive. These include lotions, cologne, perfume, hair spray.
- Follow-up consults may be scheduled in 15, 30, 45, or 60-minute blocks of time, depending on your needs.
- *All consultations are charged for the time used, not the time booked.*
- Research requested by the patient is a billable service, and will be charged at the hourly rate.
- Follow-up Visits: we generally recommend that all patients have an office consultation every 3 months at a minimum.

### Cancellations

- If you cannot keep a scheduled appointment, you must notify us at least 24 hours prior to your scheduled time, or you will be charged for the missed appointment.
- As a courtesy, our office will send you an email or call you to confirm your appointment 1 business days in advance.

### Phone Consultations

- We will call you for your scheduled appointment. Please allow 5-10 minutes window of buffered time.
- All appointments are scheduled for the Pacific Standard Time zone.

### Medical Letters

- We can provide medical letters (for schools, insurance companies, etc). The charge for generating these will be billed at the doctor's hourly rate.

### Follow-up Questions:

- You can contact the doctor with follow-up questions, but please keep these brief. If a question is more involved, a consult may be required to respond to your inquiry.

### Prescriptions

- We require 24-hour notice for refills.
- We do not mail prescriptions or lab test orders.
- Hormone prescriptions are done on a 3 month basis, and require a phone consult or office visit to renew them.
- Prescriptions need to be obtained at your appointment.
- Please come to all appointments prepared with a complete medication list and let us know which of these require refills.
- Prescriptions for controlled medications for sleep, diet, or pain must be picked up at the office on a 3 month basis. These prescriptions cannot be phoned in to pharmacies.
- No prescription dose changes will be made without an appointment.
- If you are sick or have side effects, please contact us immediately.

### Tests

- If you misplace an order for testing, we require 24-hour notice to rewrite the order. You can pick it up at the office or we can e-mail this to you.
- Test results will not be discussed via phone unless there is an appointment set up with the doctor to do a phone consult as your visit. Otherwise, test results will be discussed at appointments at the office. This will prevent unsafe e-mailing of this information or discussing of confidential health information outside the clinic.

### General

- Please keep all health concern discussions to office visits. Please note, the doctor cannot discuss your health concerns while at Henry's Marketplace.
- Please avoid discussing other people's health concerns at the visit. We have limited time together and we want to ensure we give you the attention and time you need to feel better. I cannot prescribe medication for others who are not my patients.

**The policies listed above have been established by me to sure quality care to my patients and improve staff efficiency. Should you have any question please contact our office.**