berkeley naturopathic MEDICAL GROUP

## PATIENT INFORMATION

Name (last, first, MI) _____

Address _____

Preferred Phone # C/W/H OK to leave confidential messages here? Y N

Alternate Phone # C/W/H OK to leave confidential messages here? Y N

Email OK to leave confidential messages here? Y N

Gender M F T | Date of Birth

Occupation & Employer _____

Marital Status | Name of spouse/partner(s)

Names (& Ages) of Children _____

## PRIMARY INSURANCE

Primary Insurance Company Name

Type of Insurance (please check all that apply):

❑ HMO ❑ PPO ❑ HSA ❑ FSA ❑ Other_____

Berkeley Naturopathic Medical Group is a fee for service clinic. Patients are responsible for payment in full at the time of service. Patients will be provided with a super bill that can then be submitted to insurance for possible reimbursement. It is each patient's responsibility to inquire about insurance reimbursement and to know the limits of coverage in regards to Naturopathic medicine and Naturopathic Doctors.

## EMERGENCY CONTACT INFORMATION

Emergency Contact | Relationship to you

Preferred Phone # ❑ Home ❑ Work ❑ Cell

Alternate Phone # ❑ Home ❑ Work ❑ Cell

How did you find out about the clinic?

If a person, may we thank them for the referral? ❑ Yes ❑ No

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officemanager@berkeleynaturopathic.com | www.berkeleynaturopathic.com

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# CONTEXT OF CARE

Why did you choose to come to this clinic?

What do you know about our approach?

What three expectations do you have from this visit to our clinic?
1.

2.

3.

What long term expectations do you have from working with our clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle?
(Rate from 0 to 10 with 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

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What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive? (please list)

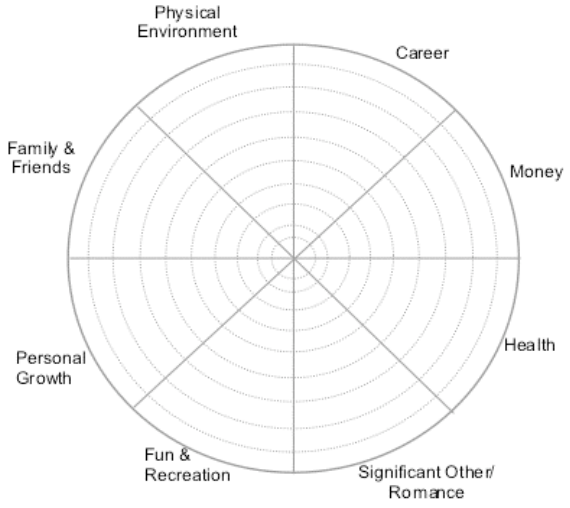
What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

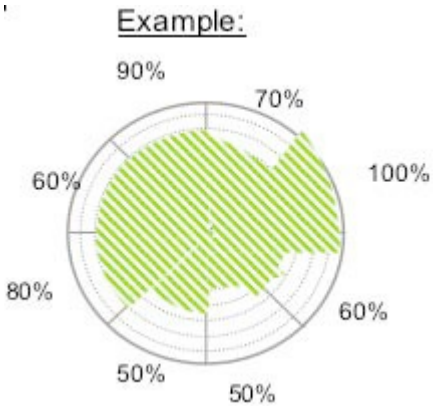
Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

What do you LOVE to do?

WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle below, shade your level of satisfaction in each area as it relates to you. For example, if you are extremely happy in your career, shade the entire pie shape for career. Do the same for each area, starting form the center point radiating outwards.

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# HEALTH HISTORY QUESTIONNAIRE *For Women*

**All questions contained in this questionnaire are strictly confidential and will become part of your medical record.**

| **Name:** *(Last, First, M.I.)* | **Date** | **DOB** |
|---|---|---|
| **PRIMARY CARE PHYSICIAN**: | **Physician Phone #**: | |
| **OTHER HEALTHCARE PRACTITIONERS**: Include acupuncturist, chiropractor, massage therapist, medical doctor, nutritionist, osteopath, other specialists etc.: | | |
| **Name:** | **Type of practice:** | **Phone number:** |
| | | |
| | | |
| | | |
| | | |

| **Date of last physical exam:** | **Date of last pap exam:** | **Date of last fasting blood labs:** |
|---|---|---|

**Please list your current health concerns in order of their importance to you**

| Concern: | Date of onset: |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

**Previous medical diagnoses**

| Diagnosis: | Diagnosed by: | Date of diagnosis: |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

**Traumas, Car Accidents, Injuries:**

**Surgeries and Hospitalizations:**

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |

**Have you ever had a blood transfusion?** ..... ☐ Yes ☐ No

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## CHILDHOOD MEDICAL HISTORY

**Prenatal history:**
Any complications during your mother's pregnancy with you? ☐ Yes ☐ No
If so, describe:

**Birth History:**
☐ Vaginal ☐ Cesarean Section ☐ Forceps ☐ Vacuum ☐ Trauma?
Any newborn problems? ☐ Jaundice ☐ Hospitalization ☐ Other, describe

**Nourishment**
As a baby, were you fed ☐ Breast milk ☐ Formula ☐ Mixed
Do you know at what age you first were given solid foods?
How would you describe your diet as a child?

**Childhood Illness:**
How often did you get sick as a child?
What kind of illnesses did you usually experience? i.e. ear infections, sore throat, cough, allergies, asthma…

How often did you take antibiotics?
Other medications taken regularly as a child?

Did you ever have:
☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken Pox ☐ Rheumatic Fever
☐ Polio ☐ Pertussis ☐ Other infectious diseases

**List Any Other Medical Problems You Had As A Child:**

**Vaccinations:**
☐ I am fully vaccinated
☐ I am selectively vaccinated
☐ I am not vaccinated
Last tetanus booster:
Do you get the flu vaccine?

Check those vaccinations you've had:

| | |
|---|---|
| ☐ Chicken Pox | ☐ MMR |
| ☐ DPT | ☐ Pneumonia |
| ☐ Hepatitis_____ | ☐ Polio |
| ☐ HIB | ☐ PPD |

Ever had an adverse reaction to vaccine? ☐ Yes ☐ No

**Home Environment:**

How many children in your family? Your birth order (3rd of 4 kids…)

What adults lived with you?

Was your home safe?

Did you have any traumas or losses as a child?

Did you grow up in the city, suburbs or in a rural area?

Did anyone in your home smoke or use drugs regularly?

## FAMILY HEALTH HISTORY

**Are you adopted? .....** ☐ Yes ☐ No

**Family History, note relationship below**

| | | | |
|---|---|---|---|
| ☐ High blood pressure | ☐ Diabetes | ☐ Allergy | ☐ Epilepsy |
| ☐ Tuberculosis | ☐ Stroke | ☐ Cancer | ☐ Substance abuse |
| ☐ Heart disease | ☐ Kidney disease | ☐ Obesity | ☐ Osteoporosis |
| ☐ Thyroid disorder | ☐ Arthritis | ☐ Autoimmune disease | ☐ Other |

| | Age | Age at Death | Significant Health Problems or Cause of Death |
|---|---|---|---|
| **Father** | | | |
| **Mother** | | | |
| **Brothers and Sisters** | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |

| | Age | Age at Death | Significant Health Problems or Cause of Death |
|---|---|---|---|
| **Children** | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| **Grandparents (Mother's Side)** | | | |
| ***Male*** | | | |
| ***Female*** | | | |
| **Grandparents (Father's Side)** | | | |
| ***Male*** | | | |
| ***Female*** | | | |

*Please leave this space blank for physician use*

## MEDICATIONS

| **PRESCRIPTION MEDICATIONS (include strength & frequency taken)** | |
|---|---|
| 1. | 7. |
| 2. | 8. |
| 3. | 9. |
| 4. | 10. |
| 5. | 11. |
| 6. | 12. |
| **OVER THE COUNTER DRUGS (include strength & frequency taken)** | |
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |
| **SUPPLEMENTS: please list homeopathics, herbs, vitamins & minerals (include strength, frequency taken & brand)** | |
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

## ALLERGIES

| **Name of Drug** | **Reaction** |
|---|---|
| | |
| | |
| | |
| **Allergies to Foods** | **Reaction** |
| | |
| | |
| | |
| **Environmental Allergies** | **Reaction** |
| | |
| | |
| | |

## ELIMINATION

**GUT:**

How often do you have a bowel movement?
Is your stool:
☐ Formed ☐ Loose ☐ Hard ☐ Dry ☐ Greasy
☐ Brown ☐ Tan ☐ Black ☐ Green ☐ Yellow
In your stool, do you ever notice: ☐ Undigested food ☐ Bright red blood ☐ Mucus
Do you strain to pass stool? ..... ☐ Yes ☐ No ☐ Occassionally
Do you have hemorrhoids? ..... ☐ Yes ☐ No
Do you experience gas, bloating or belching daily? ..... Yes ☐ No Do you ever unintentionally pass stool? ..... Yes ☐ No ☐

| | |
|---|---|
| ☐ Abdominal pain | ☐ Constipation |
| ☐ Heartburn/ indigestion | ☐ Diarrhea |
| ☐ Nausea/ vomiting | ☐ Difficulty swallowing |
| ☐ Recent change in bowel movements | ☐ Hernia |

**KIDNEYS:**

How often do you urinate?
Do you have any of the following:

| | |
|---|---|
| ☐ Pain with urination | ☐ Must get up at night to urinate |
| ☐ Urinate too frequently/ too much | ☐ Leaking urine |
| ☐ Urgency to urinate | ☐ when laughing or coughing |
| ☐ Urinary flow obstruction | ☐ at other times |
| ☐ Dribbling at end of urination | ☐ Kidney stones |
| ☐ Recurrent urinary tract infections | |

**SKIN**:

Do you sweat easily? What makes you sweat?
Do you regularly apply lotion or oils to your skin? If so, what type
Do you scrub or dry brush your skin regularly?

Note if you have or have had any of the following:

| | |
|---|---|
| ☐ Acne | ☐ Moles |
| ☐ Eczema | ☐ Hives |
| ☐ Rash | ☐ Pigment changes |
| ☐ Chronic itching | ☐ Skin cancer |
| ☐ Dry skin | ☐ Hair loss or unusual growth |
| ☐ Contact dermatitis | ☐ Jaundice- yellowing of the skin |

**LUNGS:**

Note if you have had any of the following:

| | |
|---|---|
| ☐ Asthma | ☐ Can't sleep flat |
| ☐ Chronic cough | ☐ Painful breathing |
| ☐ Difficulty breathing | ☐ Recurrent lung infections |

**LIVER:**

| Note if you have had any of the following: | Are you unable to tolerate: |
|---|---|
| ☐ Yellowing of the skin | ☐ Cigarette smoke |
| ☐ Chronic itching | ☐ Perfume |
| ☐ Nausea/ vomiting | ☐ Alcohol |
| ☐ Abdominal pain | ☐ Caffeine |
| ☐ PMS | |
| ☐ Menstrual irregularities | |

| OTHER LIFESTYLE FACTORS | |
|---|---|
| **Activity:** | ☐ Sedentary (No exercise)<br>☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)<br>☐ Occasional Vigorous Exercise (i.e., work or recreation less than 4x/week for 30 min.)<br>☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)<br>After moderate or vigorous exercise, do you feel ☐ great ☐ drained |
| **Weight:** | Current weight _____ ☐ don't know<br>Ideal body weight _____<br>What is the most _____ and least _____ you have weighed as an adult? (excluding pregnancies)<br>Do you have, or have you ever had, an eating disorder?<br>☐ Binging ☐ Purging ☐ Avoidance of food<br>Do you diet to lose weight? ..... ☐ Yes ☐ No<br>Do you take medications, herbs or supplements to lose weight?. Yes No<br>If so, list: |
| **HOME** | Is your home a sanctuary for you? ..... ☐ Yes ☐ No<br>Do you live in an ☐ apartment ☐ house ☐ other<br>Year building was built<br>Who lives with you?<br>Name Relationship<br><br>Do you live with animals? If so, describe<br><br>Does your home have lead paint?..... ☐Yes ☐No<br>Is your home moldy/damp? ..... ☐ Yes ☐ No<br>Is your home safe? ..... ☐ Yes ☐No<br>Does your home have an alarm system?..... ☐ Yes ☐No<br>Do you have smoke alarms?..... ☐ Yes ☐No<br>Does your home have bars on the windows/door?..... ☐ Yes ☐ No<br>Is there a gun in your home?..... ☐ Yes ☐ No |
| **OCCUPATION** | Do you work primarily inside or outside the home?..... ☐ Inside ☐ Outside<br>If so, what type of work?<br><br>How many hours a week do you work? How many days a wk?<br>Do you spend most of your day at ☐ a desk ☐ computer ☐ in car ☐ other<br>Do you take vacations? ..... ☐ Yes ☐ No<br>Are you happy in your work?..... ☐ Yes ☐ No ☐ Other_____ |

## HABITS

**Alcohol:**

Do you drink alcohol? ..... ☐ Yes ☐ No
If yes, what kind?

How many drinks per day? _____ per week? _____
Are you concerned about the amount you drink? ..... ☐ Yes ☐ No
Have you considered stopping? ..... ☐ Yes ☐ No
Have you ever experienced blackouts? ..... ☐ Yes ☐ No
Are you prone to "binge" drinking? ..... ☐ Yes ☐ No
Do you drive after drinking? ..... ☐ Yes ☐ No
Have you ever had a problem with drinking in the past?..... ☐ Yes ☐ No

**Tobacco:**

Do you use tobacco currently? ..... ☐ Yes ☐ No
Did you use tobacco in the past? ..... ☐ Yes ☐ No
If you answered yes to either question above, please provide details:
☐ Cigarettes - Pks/day ☐ Chew - #/day ☐ Pipe - #/day
☐ Cigars - #/day ☐ # of Years ☐ or Year Quit

**Drugs:**

Do you currently use recreational or street drugs? ..... ☐ Yes ☐ No
Have you ever given yourself street drugs with a needle? . ☐ Yes ☐ No

**Caffeine:**

Coffee…….…….. ☐ Yes ☐ No Amount:
Soda……..... ☐ Yes ☐ No Amount:
Caffeinated tea……☐ Yes ☐ No Amount:
Chocolate…….…….. ☐ Yes ☐ No Amount:
Other……Amount:

**TOXIC EXPOSURES**

| | | |
|---|---|---|
| ☐ Pottery | ☐ Nuclear power plant | ☐ Asbestos |
| ☐ Glass blowing | ☐ Frequent air travel | ☐ Second hand smoke |
| ☐ Painting | ☐ Electric power lines | ☐ Other solvents |
| ☐ Model building | ☐ Mercury fillings | ☐ Other heavy metals |
| ☐ Cleaning chemicals | ☐ Other mercury exposure | ☐ Pesticides |
| ☐ Anesthesia | ☐ Lead paint | ☐ Pthalates |

## SEXUAL AND REPRODUCTIVE HEALTH

***All questions contained in this questionnaire are optional and will be kept strictly confidential.***

**Menstrual History**

At what age did you first bleed? _____

What was the first day of your most recent period? _____

How long is your cycle, month to month? _____

Is your cycle length regular?..... ☐ Yes ☐ No

How many days do you bleed? _____

Is your flow … ☐ Light ☐ Moderate ☐ Heavy

Describe:

PMS? ……☐ Yes ☐ No

Describe:

Do you skip periods? …… ☐ Yes ☐ No

Any mid cycle spotting?..... ☐ Yes ☐ No

If yes, describe (flow, frequency, etc):

*Check if you experience any of the following*

**Menstrual Symptoms** (if premenopausal)

☐ Cramps
☐ Swelling
☐ Breast tenderness
☐ Mood swings
☐ Anxiety, Irritability
☐ Cravings Describe:
☐ Fatigue
☐ Confusion
☐ Acne
☐ None

**Menopausal Symptoms** (if peri/postmenopausal)

☐ Night sweats
☐ Hot flashes
☐ Vaginal dryness
☐ Fatigue
☐ Sleep disturbances
☐ Difficulty concentrating
☐ Mood swings
☐ Anxiety, Irritability
☐ Joint pain
☐ Weight gain
☐ None

**Gynecologic Conditions**

*check if you have had any of the following*

☐ Genital herpes
☐ Genital warts
☐ Gonorrhea
☐ Chlamydia
☐ Syphilis
☐ Hepatitis
☐ HIV
☐ PID
☐ Yeast infection
☐ Bacterial vaginosis
☐ Trichimonas
☐ PCOS
☐ Endometriosis
☐ Uterine fibroid
☐ Ovarian Cyst
☐ Breast lump
☐ Fibrocystic breasts
☐ Nipple discharge
☐ Pain with intercourse
☐ DES exposure
☐ Itching, odor, discharge
☐ None

**Sexual History**

Are you sexually active?

☐ Currently ☐ Past ☐ Never

Age you were first consensually sexually active:

Partners? ☐ Male ☐ Female ☐ Both

Are you in a monogamous relationship?

☐ Yes ☐ No

Do you have difficulty having an orgasm?

☐ Yes ☐ No

Is sex painful? ☐ Yes ☐ No ☐ Depends

Feel knowledgeable about safe sex?

☐ Yes ☐ No

Do you practice safe sex? ☐ Yes ☐ No

Any other concerns? ☐ Yes ☐ No

Have you ever had an STD screening? If so, when?

Have you ever had an abnormal pap?

☐ Yes ☐ No

Date of last annual gyn exam with pap

**Pregnancy History:**

| Date | Outcome (vaginal delivery, caesarean, miscarriage, abortion, etc) | Did you breastfeed? | How long? |
|---|---|---|---|
| | | ☐ Yes ☐ No | |
| | | ☐ Yes ☐ No | |
| | | ☐ Yes ☐ No | |
| | | ☐ Yes ☐ No | |
| | | ☐ Yes ☐ No | |
| | | ☐ Yes ☐ No | |
| | | ☐ Yes ☐ No | |

Are you currently trying to get pregnant?..... ☐ Yes ☐ No

Have you made any changes in your diet/lifestyle while trying to get pregnant?..... ☐ Yes ☐ No

If so, what?

Do you plan to become pregnant in the future?..... ☐ Yes ☐ No

If so, when?

Have you ever had difficulty getting or staying pregnant?..... ☐ Yes ☐ No

**Contraceptive/Safe-sex practice History:** *What birth control methods/safe-sex practices have you used? (Fertility awareness, condoms, sponge, cap, diaphragm, IUD, oral contraceptives, norplant, Depo-provera…)*

| Type: | How long? | Any problems? | Current use? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## REVIEW OF SYSTEMS

**Check if you have, or have had, concerns in the following areas to a significant degree. Also note any recent changes in the areas listed below.**

### CONSTITUTIONAL

- ☐ Weight
- ☐ Energy level
- ☐ Sleep
- ☐ Appetite
- ☐ Strength
- ☐ Night sweats
- ☐ Sense of wellbeing
- ☐ Libido
- ☐ Other

### EYES, EARS, NOSE, MOUTH, THROAT

- ☐ Vision loss
- ☐ Double vision
- ☐ Excessive tearing
- ☐ Dry eyes
- ☐ Blind spots
- ☐ Eye pain
- ☐ Eye discharge
- ☐ Hearing loss
- ☐ Ringing in the ears
- ☐ Vertigo/ dizziness
- ☐ Nose bleeds
- ☐ Chronic stuffy nose
- ☐ Post nasal drip
- ☐ Recurrent sinus infections
- ☐ Headaches
- ☐ Missing teeth
- ☐ Gingivitis
- ☐ Bad breath
- ☐ Neck stiffness or swelling
- ☐ Other

### HEART AND BLOOD VESSELS

- ☐ Chest wall pain
- ☐ Palpitations
- ☐ Short of breath w/mild exercise
- ☐ Short of breath lying flat
- ☐ Heart murmur
- ☐ Varicose veins
- ☐ Clotting disorder
- ☐ Vessel inflammation
- ☐ Fainting
- ☐ Swelling
- ☐ Leg pain when walking
- ☐ Anemia
- ☐ Other

### LUNGS

- ☐ Painful breathing
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Chronic bronchitis
- ☐ Coughing sputum
- ☐ Coughing blood

### MUSCULOSKELETAL

- ☐ Back pain
- ☐ Scoliosis
- ☐ Bone loss/ fractures
- ☐ Muscle weakness
- ☐ Muscle cramps
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Morning stiffness
- ☐ Hot/red muscles or joints
- ☐ Limited range of motion

### NEUROLOGIC AND PSYCHOLOGICAL

- ☐ Seizures, convulsions
- ☐ Paralysis
- ☐ Numbness/ tingling
- ☐ Tremor
- ☐ Lack of coordination
- ☐ Speech difficulties
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Suicidal history

### IMMUNE SYSTEM

How many times a year are you sick?
Where do you get sick first?
What are your typical 1st symptoms?

Do you recover easily?
☐ Lymph node swelling

### ENDOCRINE

- ☐ Breast enlargement-men
- ☐ Thyroid problems
- ☐ Heat or cold intolerance
- ☐ Excessive urination
- ☐ Excessive thirst
- ☐ Spacey feeling after food
- ☐ Waking at night
- ☐ Fainting
- ☐ Swelling
- ☐ Leg pain when walking

# Welcome to Berkeley Naturopathic Medical Group!

We are happy that you have chosen to pursue naturopathic medicine at Berkeley Naturopathic Medical Group. Our goal is to provide you with the highest quality naturopathic medical care possible. We are committed to a healthy and honest relationship from the start and for this reason we ask that you take the time to review our appointment and payment policies.

Please sign below to acknowledge that you have read and understand these policies.

## Fees:

First Office Call:

- General (90-120 min) ……. $360
- Pediatrics
  Newborn to 12 yrs (60 min)… $210
- 13-17 yrs (1.5 hr)…….$290
- Acute (30 -60min) ……. $115- $210

Return Office Call

- 90 min…….$290
- 60 min …….. $210
- 45 min ……..... $160
- 30 min …….. $115
- 15 min ……..… $60

## Cancellation Policy:

At Berkeley Naturopathic Medical Group, we respect your time, and we trust that you respect ours. We require a minimum of 2 business days* (not counting Saturdays and Sundays) notice for return patients and 3 business days* notice for new patients when canceling or rescheduling appointments. If we do not receive a minimum of 2-3 business days notice, you will incur a credit card charge of 100% of the scheduled office visit cost. *By 5pm on that business day.

Please understand that this policy is in place as a means of respecting the time and efforts of your physician and her office staff, as well as other patients who would have benefited from a medical visit during this time. Should we have to change appointments, we will do our best to give you 2 business days notice and will be sure to accommodate your needs and re-schedule your appointment in a timely fashion.

## Phone Consultations:

If you are unable to come to our office, follow-up visits via telephone are available after an initial in-person visit. These are billed at the regular in-office rate and payment is due via credit card at the end of each call.

## Email Consultations:

Naturopathic treatments are individualized, and often require multiple changes in diet and lifestyle. In between your office visits we are happy to answer short questions that clarify treatment plan instructions via email. However, email is not a substitute for an office visit. Your email questions should be no more that 3-5 lines long and pertain to your current treatment plan. If your doctor determines that your email is too complex, requires an in-depth explanation or professional advice, or will result in an alteration to your treatment plan, please know that your email will be forwarded to our staff. They will contact you to schedule a 15-30 minute phone consult with your doctor so your question may be adequately and appropriately addressed. These calls are billed at the regular in-office rate and payment is due via credit card at the end of each call.

*Please be aware that e-mail communication can be intercepted in transmission or misdirected. Please consider communicating any sensitive information by telephone, fax, or mail.*

## Supplements:

All sales on supplements and botanicals are final. Please note that the purpose of selling supplements to patients is to make available the most effective and highest quality products that are often only available for sale through licensed professionals.
It may happen that you need a refill prior to your next appointment. *Please call or email with your refill request 5 business days before you are scheduled to finish your supplements. Supplement orders requested less than 5 business days in advance will be accommodated as soon as possible but may not be immediate due to available time and stock*. All refills must be paid for at the time they are dispensed and can be picked up at the office or mailed to your home. If you need to pick up supplements after hours, supplements are left out at your own risk.

### Scent-Free Policy:

Our office is a fragrance-free zone. Please refrain from wearing perfume, cologne, and other scented products when visiting us, in order to support the health of our chemically sensitive clients.

## Insurance & Payment:

Your health insurance policy is a contract between you and your insurance company and you are responsible to know your coverage. Many private insurance companies have policies that do cover some or part of the care you receive from Berkeley Naturopathic Medical Group. Whether your particular policy is one that has such coverage is a detail you can learn from your insurance agent as our office does not have access to that information. All charges incurred at our office are your responsibility regardless of insurance coverage.
Payment in full is due at the time of service. This includes fees for medical office visits, labs and any herbal/nutritional supplements prescribed for you. For your convenience we accept cash, check, Visa, and MasterCard. At the end of each visit, you will be provided with a superbill that you can use to submit to your insurance for possible reimbursement. The Berkeley Naturopathic Medical Group does not bill insurance and currently, federal programs such as Medicare and Medicaid do not reimburse for naturopathic medical services.
Bounced checks incur a $25 processing fee. Refunds on labs are available with a $25 processing fee, provided the labs were not performed, the kits were not tampered with and are returned in a reusable state and that no more than 10 months have passed since their issue. There are no refunds on services.

*I understand and agree to the conditions listed above.*

Print Name_____

Signature_____ Date_____

berkeley naturopathic MEDICAL GROUP

# INFORMED CONSENT FOR TREATMENT

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

A number of different approaches are used, including but not limited to, botanical medicine, homeopathy, clinical nutrition, hydrotherapy, physical medicine and lifestyle counseling, all of which are included in the scope of practice for licensed naturopathic doctors in the State of California.

Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those with multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important therefore that you inform your naturopathic doctor immediately of any disease process that you are suffering from, if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding, please advise your naturopathic doctor immediately.

***I recognize the potential risk and benefits of these procedures as described below:***

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of medications or vaccinations, aggravation of pre-existing symptoms, discomfort, pain, infection, burns, nausea, light headedness, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures.

*Notify Berkeley Naturopathic Medical Group if you experience any symptoms which may be secondary to the above procedures.*

Potential benefits: restoration of health and the body's maximal functional capacity without the use of drugs or surgery, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or it's progression.

***Notice to Pregnant Women***: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the doctor, or any personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the day of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential.

I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

Signature of Patient _____Date_____

Signature of Patient Representative or Guardian_____

2615 Ashby Ave | Berkeley, CA 94705 | P: 510.845.8600 | F: 888.972.7331
officemanager@berkeleynaturopathic.com | www.berkeleynaturopathic.com