

# Initial Patient Intake Form

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Primary Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Please list your five major health concerns in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Blood Type: \_\_\_\_\_

Family History of disease: \_\_\_\_\_

Major Surgeries/Accidents: \_\_\_\_\_

## PART I Read the following questions and circle the number that applies:

**KEY:** 0 = Do not consume or use      2 = Consume or use weekly  
1 = Consume or use 2 to 3 times monthly      3 = Consume or use daily

### DIET

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- |  |   |  |
|--|---|--|
| <p><b>1.</b> 0 1 2 3 Alcohol</p> <p><b>2.</b> 0 1 2 3 Artificial sweeteners</p> <p><b>3.</b> 0 1 2 3 Candy, desserts, refined sugar</p> <p><b>4.</b> 0 1 2 3 Carbonated beverages</p> <p><b>5.</b> 0 1 2 3 Chewing tobacco</p> <p><b>6.</b> 0 1 2 3 Cigarettes</p> | <p><b>7.</b> 0 1 2 3 Cigars/pipes</p> <p><b>8.</b> 0 1 2 3 Caffeinated beverages</p> <p><b>9.</b> 0 1 2 3 Fast foods</p> <p><b>10.</b> 0 1 2 3 Fried foods</p> <p><b>11.</b> 0 1 2 3 Luncheon meats</p> <p><b>12.</b> 0 1 2 3 Margarine</p> <p><b>13.</b> 0 1 2 3 Milk products</p> | <p><b>14.</b> 0 1 Radiation exposure (0=no, 1=yes)</p> <p><b>15.</b> 0 1 2 3 Refined flour/baked goods</p> <p><b>16.</b> 0 1 2 3 Vitamins and minerals</p> <p><b>17.</b> 0 1 2 3 Water, distilled</p> <p><b>18.</b> 0 1 2 3 Water, tap</p> <p><b>19.</b> 0 1 2 3 Water, well</p> <p><b>20.</b> 0 1 2 3 Diet often for weight control</p> |
|--|---|--|

### LIFESTYLE

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- 21.** 0 1 2 3 Exercise per week (0 = 2 or more times a week, 1 = 1 time a week, 2 = 1 or 2 times a month, 3 = never, less than once a month)
- 22.** 0 1 2 3 Changed jobs (0 = over 12 months ago, 1 = within last 12 months, 2 = within last 6 months, 3 = within last 2 months)
- 23.** 0 1 2 3 Divorced (0 = never, over 2 years ago, 1 = within last 2 years, 2 = within last year, 3 = within last 6 months)
- 24.** 0 1 2 3 Work over 60 hours/week (0 = never, 1 = occasionally, 2 = usually, 3 = always)

### MEDICATIONS

Indicate any medications you're currently taking or have taken in the last month (0=no, 1=yes):

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- |   |  |
|---|--|
| <p><b>25.</b> 0 1 Antacids</p> <p><b>26.</b> 0 1 Antianxiety medications</p> <p><b>27.</b> 0 1 Antibiotics</p> <p><b>28.</b> 0 1 Anticonvulsants</p> <p><b>29.</b> 0 1 Antidepressants</p> <p><b>30.</b> 0 1 Antifungals</p> <p><b>31.</b> 0 1 Aspirin/Ibuprofen</p> <p><b>32.</b> 0 1 Asthma inhalers</p> <p><b>33.</b> 0 1 Beta blockers</p> <p><b>34.</b> 0 1 Birth control pills/implant contraceptives</p> <p><b>35.</b> 0 1 Chemotherapy</p> <p><b>36.</b> 0 1 Cholesterol lowering medications</p> <p><b>37.</b> 0 1 Cortisone/steroids</p> <p><b>38.</b> 0 1 Diabetic medications/insulin</p> | <p><b>39.</b> 0 1 Diuretics</p> <p><b>40.</b> 0 1 Estrogen or progesterone (pharmaceutical, prescription)</p> <p><b>41.</b> 0 1 Estrogen or progesterone (natural)</p> <p><b>42.</b> 0 1 Heart medications</p> <p><b>43.</b> 0 1 High blood pressure medications</p> <p><b>44.</b> 0 1 Laxatives</p> <p><b>45.</b> 0 1 Recreational drugs</p> <p><b>46.</b> 0 1 Relaxants/Sleeping pills</p> <p><b>47.</b> 0 1 Testosterone (natural or prescription)</p> <p><b>48.</b> 0 1 Thyroid medication</p> <p><b>49.</b> 0 1 Acetaminophen (Tylenol)</p> <p><b>50.</b> 0 1 Ulcer medications</p> <p><b>51.</b> 0 1 Sildenafil citrate (Viagra)</p> |
|---|--|

### SUPPLEMENTS

Indicate any supplements you're currently taking, the brand and dosage


KEY: 0=No, symptom does not occur      2=Moderate symptom, occurs occasionally (weekly)  
1=Yes, minor or mild symptom, rarely occurs (monthly)      3=Severe symptom, occurs frequently (daily)

**PART II (See key at bottom of page)****Section 1 – Upper Gastrointestinal System**

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- 52.0** 1 2 3 Belching or gas within one hour after eating
- 53.0** 1 2 3 Heartburn or acid reflux
- 54.0** 1 2 3 Bloating within one hour after eating
- 55.0** 1 Vegan diet (no dairy, meat, fish or eggs) (0=no, 1=yes)
- 56.0** 1 2 3 Bad breath (halitosis)
- 57.0** 1 2 3 Loss of taste for meat
- 58.0** 1 2 3 Sweat has a strong odor
- 59.0** 1 2 3 Stomach upset by taking vitamins
- 60.0** 1 2 3 Sense of excess fullness after meals
- 61.0** 1 2 3 Feel like skipping breakfast
- 62.0** 1 2 3 Feel better if you don't eat
- 63.0** 1 2 3 Sleepy after meals
- 64.0** 1 2 3 Fingernails chip, peel or break easily
- 65.0** 1 2 3 Anemia unresponsive to iron
- 66.0** 1 2 3 Stomach pains or cramps
- 67.0** 1 2 3 Diarrhea, chronic
- 68.0** 1 2 3 Diarrhea shortly after meals
- 69.0** 1 2 3 Black or tarry colored stools
- 70.0** 1 2 3 Undigested food in stool

**Section 2 – Liver and Gallbladder**

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- 71.0** 1 2 3 Pain between shoulder blades
- 72.0** 1 2 3 Stomach upset by greasy foods
- 73.0** 1 2 3 Greasy or shiny stools
- 74.0** 1 2 3 Nausea
- 75.0** 1 2 3 Sea, car, airplane or motion sickness
- 76.0** 1 History of morning sickness (0 = no, 1 = yes)
- 77.0** 1 2 3 Light or clay colored stools
- 78.0** 1 2 3 Dry skin, itchy feet or skin peels on feet
- 79.0** 1 2 3 Headache over eyes
- 80.0** 1 2 3 Gallbladder attacks (0=never, 1=years ago, 2=within last year, 3=within past 3 months)
- 81.0** 1 Gallbladder removed (0=no, 1=yes)
- 82.0** 1 2 3 Bitter taste in mouth, especially after meals
- 83.0** 1 Become sick if you were to drink wine (0=no, 1=yes)
- 84.0** 1 Easily intoxicated if you were to drink wine (0=no, 1=yes)
- 85.0** 1 Easily hung over if you were to drink wine (0=no, 1=yes)
- 86.0** 1 2 3 Alcohol per week (0=<3, 1=<7, 2 =<14, 3=>14)
- 87.0** 1 Recovering alcoholic (0=no, 1=yes)
- 88.0** 1 History of drug or alcohol abuse (0=no, 1=yes)
- 89.0** 1 History of hepatitis (0=no, 1=yes)
- 90.0** 1 Long term use of prescription/recreational drugs (0=no, 1=yes)
- 91.0** 1 2 3 Sensitive to chemicals (perfume, cleaning agents, etc.)
- 92.0** 1 2 3 Sensitive to tobacco smoke
- 93.0** 1 2 3 Exposure to diesel fumes
- 94.0** 1 2 3 Pain under right side of rib cage
- 95.0** 1 2 3 Hemorrhoids or varicose veins
- 96.0** 1 2 3 Nutrasweet (aspartame) consumption
- 97.0** 1 2 3 Sensitive to Nutrasweet (aspartame)
- 98.0** 1 2 3 Chronic fatigue or Fibromyalgia

**Section 3 – Small Intestine**

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- 99.0** 1 2 3 Food allergies
- 100.0** 1 2 3 Abdominal bloating 1 to 2 hours after eating
- 101.0** 1 Specific foods make you tired or bloated (0=no, 1=yes)
- 102.0** 1 2 3 Pulse speeds after eating
- 103.0** 1 2 3 Airborne allergies
- 104.0** 1 2 3 Experience hives
- 105.0** 1 2 3 Sinus congestion, "stuffy head"
- 106.0** 1 2 3 Crave bread or noodles
- 107.0** 1 2 3 Alternating constipation and diarrhea
- 108.0** 1 2 3 Crohn's disease (0 =no, 1=yes in the past, 2=current mild condition, 3=severe)
- 109.0** 1 2 3 Wheat or grain sensitivity
- 110.0** 1 2 3 Dairy sensitivity
- 111.0** 1 Are there foods you could not give up (0=no, 1=yes)
- 112.0** 1 2 3 Asthma, sinus infections, stuffy nose
- 113.0** 1 2 3 Bizarre vivid dreams, nightmares
- 114.0** 1 2 3 Use over-the-counter pain medications
- 115.0** 1 2 3 Feel spacey or unreal

**Section 4 – Large Intestine**

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- 116.0** 1 2 3 Anus itches
- 117.0** 1 2 3 Coated tongue
- 118.0** 1 2 3 Feel worse in moldy or musty place
- 119.0** 1 2 3 Taken antibiotic for a total accumulated time of (0=never, 1= <1 month, 2= <3 months, 3= >3 months)
- 120.0** 1 2 3 Fungus or yeast infections
- 121.0** 1 2 3 Ring worm, "jock itch", "athletes foot", nail fungus
- 122.0** 1 2 3 Yeast symptoms increase with sugar, starch or alcohol
- 123.0** 1 2 3 Stools hard or difficult to pass
- 124.0** 1 History of parasites (0=no, 1=yes)
- 125.0** 1 2 3 Less than one bowel movement per day
- 126.0** 1 2 3 Stools have corners or edges, are flat or ribbon shaped
- 127.0** 1 2 3 Stools are not well formed (loose)
- 128.0** 1 2 3 Irritable bowel or mucus colitis
- 129.0** 1 2 3 Blood in stool
- 130.0** 1 2 3 Mucus in stool
- 131.0** 1 2 3 Excessive foul smelling lower bowel gas
- 132.0** 1 2 3 Bad breath or strong body odors
- 133.0** 1 2 3 Painful to press along outer sides of thighs (Iliotibial Band)
- 134.0** 1 2 3 Cramping in lower abdominal region
- 135.0** 1 2 3 Dark circles under eyes

**Section 5 – Mineral Needs**

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KEY: 0=No, symptom does not occur	2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)

136.0	1	History of carpal tunnel syndrome (0=no, 1=yes)	150.0	1	History of bone spurs (0=no, 1=yes)
137.0	1	History of lower right abdominal pains or ileocecal valve problems (0=no, 1=yes)	151.0	1 2 3	Morning stiffness
138.0	1	History of stress fracture (0=no, 1=yes)	152.0	1 2 3	Nausea with vomiting
139.0	1 2 3	Bone loss (reduced density on bone scan)	153.0	1 2 3	Crave chocolate
140.0	1	Are you shorter than you used to be? (0=no, 1=yes)	154.0	1 2 3	Feet have a strong odor
141.0	1 2 3	Calf, foot or toe cramps at rest	155.0	1 2 3	History of anemia
142.0	1 2 3	Cold sores, fever blisters or herpes lesions	156.0	1 2 3	Whites of eyes (sclera) blue tinted
143.0	1 2 3	Frequent fevers	157.0	1 2 3	Hoarseness
144.0	1 2 3	Frequent skin rashes and/or hives	158.0	1 2 3	Difficulty swallowing
145.0	1	Herniated disc (0=no, 1=yes)	159.0	1 2 3	Lump in throat
146.0	1 2 3	Excessively flexible joints, "double jointed"	160.0	1 2 3	Dry mouth, eyes and/or nose
147.0	1 2 3	Joints pop or click	161.0	1 2 3	Gag easily
148.0	1 2 3	Pain or swelling in joints	162.0	1 2 3	White spots on fingernails
149.0	1 2 3	Bursitis or tendonitis	163.0	1 2 3	Cuts heal slowly and/or scar easily
			164.0	1 2 3	Decreased sense of taste or smell

## Section 6 – Essential Fatty Acids

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165.0	1	Experience pain relief with aspirin (0=no, 1=yes)	169.0	1 2 3	Headaches when out in the hot sun
166.0	1 2 3	Crave fatty or greasy foods	170.0	1 2 3	Sunburn easily or suffer sun poisoning
167.0	1 2 3	Low- or reduced-fat diet (0=never, 1=years ago, 2=within past year, 3=currently)	171.0	1 2 3	Muscles easily fatigued
168.0	1 2 3	Tension headaches at base of skull	172.0	1 2 3	Dry flaky skin or dandruff

## Section 7 – Sugar Handling

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173.0	1 2 3	Awaken a few hours after falling asleep, hard to get back to sleep	180.0	1 2 3	Headache if meals are skipped or delayed
174.0	1 2 3	Crave sweets	181.0	1 2 3	Irritable before meals
175.0	1 2 3	Binge or uncontrolled eating	182.0	1 2 3	Shaky if meals delayed
176.0	1 2 3	Excessive appetite	183.0	1 2 3	Family members with diabetes (0=none, 1=1 or 2, 2=3 or 4, 3=more than 4)
177.0	1 2 3	Crave coffee or sugar in the afternoon	184.0	1 2 3	Frequent thirst
178.0	1 2 3	Sleepy in afternoon	185.0	1 2 3	Frequent urination
179.0	1 2 3	Fatigue that is relieved by eating			

## Section 8 – Vitamin Need

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186.0	1 2 3	Muscles become easily fatigued	200.0	1 2 3	Can hear heart beat on pillow at night
187.0	1 2 3	Feel exhausted or sore after moderate exercise	201.0	1 2 3	Whole body or limb jerk as falling asleep
188.0	1 2 3	Vulnerable to insect bites	202.0	1 2 3	Night sweats
189.0	1 2 3	Loss of muscle tone, heaviness in arms/legs	203.0	1 2 3	Restless leg syndrome
190.0	1 2 3	Enlarged heart or congestive heart failure	204.0	1 2 3	Cracks at corner of mouth (Cheilosis)
191.0	1 2 3	Pulse below 65 per minute (0=no, 1=yes)	205.0	1 2 3	Fragile skin, easily chaffed, as in shaving
192.0	1 2 3	ringing in the ears (Tinnitus)	206.0	1 2 3	Polyps or warts
193.0	1 2 3	Numbness, tingling or itching in hands and feet	207.0	1 2 3	MSG sensitivity
194.0	1 2 3	Depressed	208.0	1 2 3	Wake up without remembering dreams
195.0	1 2 3	Fear of impending doom	209.0	1 2 3	Small bumps on back of arms
196.0	1 2 3	Worrier, apprehensive, anxious	210.0	1 2 3	Strong light at night irritates eyes
197.0	1 2 3	Nervous or agitated	211.0	1 2 3	Nose bleeds and/or tend to bruise easily
198.0	1 2 3	Feelings of insecurity	212.0	1 2 3	Bleeding gums especially when brushing teeth
199.0	1 2 3	Heart races			

## Section 9 – Adrenal

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213.0	1 2 3	Tend to be a "night person"	226.0	1 2 3	Arthritic tendencies
214.0	1 2 3	Difficulty falling asleep	227.0	1 2 3	Crave salty foods
215.0	1 2 3	Slow starter in the morning	228.0	1 2 3	Salt foods before tasting
216.0	1 2 3	Tend to be keyed up, trouble calming down	229.0	1 2 3	Perspire easily
217.0	1 2 3	Blood pressure above 120/80	230.0	1 2 3	Chronic fatigue, or get drowsy often
218.0	1 2 3	Headache after exercising	231.0	1 2 3	Afternoon yawning
219.0	1 2 3	Feeling wired or jittery after drinking coffee	232.0	1 2 3	Afternoon headache
220.0	1 2 3	Clench or grind teeth	233.0	1 2 3	Asthma, wheezing or difficulty breathing
221.0	1 2 3	Calm on the outside, troubled on the inside	234.0	1 2 3	Pain on the medial or inner side of the knee
222.0	1 2 3	Chronic low back pain, worse with fatigue	235.0	1 2 3	Tendency to sprain ankles or "shin splints"
223.0	1 2 3	Become dizzy when standing up suddenly	236.0	1 2 3	Tendency to need sunglasses
224.0	1 2 3	Difficulty maintaining manipulative correction	237.0	1 2 3	Allergies and/or hives
225.0	1 2 3	Pain after manipulative correction	238.0	1 2 3	Weakness, dizziness

## Section 10 – Pituitary

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KEY:	0=No, symptom does not occur	2=Moderate symptom, occurs occasionally (weekly)
	1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)

239.0	1	Height over 6' 6" (0=no, 1=yes)	245.0	1	Height under 4' 10" (0=no, 1=yes)
240.0	1	Early sexual development (before age 10) (0=no, 1=yes)	246.0	1 2 3	Decreased libido
241.0	1 2 3	Increased libido	247.0	1 2 3	Excessive thirst
242.0	1 2 3	Splitting type headache	248.0	1 2 3	Weight gain around hips or waist
243.0	1 2 3	Memory failing	249.0	1 2 3	Menstrual disorders
244.0	1	Tolerate sugar, feel fine when eating sugar (0=no, 1=yes)	250.0	1	Delayed sexual development (after age 13) (0=no, 1=yes)
			251.0	1 2 3	Tendency to ulcers or colitis

### Section 11 – Thyroid

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252.0	1 2 3	Sensitive/allergic to iodine	260.0	1 2 3	Mentally sluggish, reduced initiative
253.0	1 2 3	Difficulty gaining weight, even with large appetite	261.0	1 2 3	Easily fatigued, sleepy during the day
254.0	1 2 3	Nervous, emotional, can't work under pressure	262.0	1 2 3	Sensitive to cold, poor circulation (cold hands and feet)
255.0	1 2 3	Inward trembling	263.0	1 2 3	Constipation, chronic
256.0	1 2 3	Flush easily	264.0	1 2 3	Excessive hair loss and/or coarse hair
257.0	1 2 3	Fast pulse at rest	265.0	1 2 3	Morning headaches, wear off during the day
258.0	1 2 3	Intolerance to high temperatures	266.0	1 2 3	Loss of lateral 1/3 of eyebrow
259.0	1 2 3	Difficulty losing weight	267.0	1 2 3	Seasonal sadness

### Section 12 – Men Only

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268.0	1 2 3	Prostate problems	272.0	1 2 3	Waking to urinate at night
269.0	1 2 3	Difficulty with urination, dribbling	273.0	1 2 3	Interruption of stream during urination
270.0	1 2 3	Difficult to start and stop urine stream	274.0	1 2 3	Pain on inside of legs or heels
271.0	1 2 3	Pain or burning with urination	275.0	1 2 3	Feeling of incomplete bowel evacuation
			276.0	1 2 3	Decreased sexual function

### Section 13 – Women Only

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277.0	1 2 3	Depression during periods	287.0	1 2 3	Breast fibroids, benign masses
278.0	1 2 3	Mood swings associated with periods (PMS)	288.0	1 2 3	Painful intercourse (dysparenia)
279.0	1 2 3	Crave chocolate around periods	289.0	1 2 3	Vaginal discharge
280.0	1 2 3	Breast tenderness associated with cycle	290.0	1 2 3	Vaginal dryness
281.0	1 2 3	Excessive menstrual flow	291.0	1 2 3	Vaginal itchiness
282.0	1 2 3	Scanty blood flow during periods	292.0	1 2 3	Gain weight around hips, thighs and buttocks
283.0	1 2 3	Occasional skipped periods	293.0	1 2 3	Excess facial or body hair
284.0	1 2 3	Variations in menstrual cycles	294.0	1 2 3	Hot flashes
285.0	1 2 3	Endometriosis	295.0	1 2 3	Night sweats (in menopausal females)
286.0	1 2 3	Uterine fibroids	296.0	1 2 3	Thinning skin

### Section 14 – Cardiovascular

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297.0	1 2 3	Aware of heavy and/or irregular breathing	302.0	1 2 3	Ankles swell, especially at end of day
298.0	1 2 3	Discomfort at high altitudes	303.0	1 2 3	Cough at night
299.0	1 2 3	"Air hunger" or sigh frequently	304.0	1 2 3	Blush or face turns red for no reason
300.0	1 2 3	Compelled to open windows in a closed room	305.0	1 2 3	Dull pain or tightness in chest and/or radiate into right arm, worse with exertion
301.0	1 2 3	Shortness of breath with moderate exertion	306.0	1 2 3	Muscle cramps with exertion

### Section 15 – Kidney and Bladder

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307.0	1 2 3	Pain in mid-back region	310.0	1 2 3	Cloudy, bloody or darkened urine
308.0	1 2 3	Puffy around the eyes, dark circles under eyes	311.0	1 2 3	Urine has a strong odor
309.0	1	History of kidney stones (0=no, 1=yes)			

### Section 16 – Immune system

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312.0	1 2 3	Runny or drippy nose	317.0	1 2 3	Never get sick (0 = sick only 1 or 2 times in last 2 years, 1 = not sick in last 2 years, 2 = not sick in last 4 years, 3 = not sick in last 7 years)
313.0	1 2 3	Catch colds at the beginning of winter	318.0	1 2 3	Acne (adult)
314.0	1 2 3	Mucus producing cough	319.0	1 2 3	Itchy skin (Dermatitis)
315.0	1 2 3	Frequent colds or flu (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)	320.0	1 2 3	Cysts, boils, rashes
316.0	1 2 3	Other infections (sinus, ear, lung, skin, bladder, kidney, etc.) (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)	321.0	1 2 3	History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis or other chronic viral condition (0 = no, 1 = yes in the past, 2 = currently mild condition, 3 = severe)

KEY: 0=No, symptom does not occur	2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)

Thank you for your information! Please email a copy of this to [info@drtonivarela.com](mailto:info@drtonivarela.com) prior to your appointment along with any lab results or medical records within the last few years. Feel free to add more information below if you feel it is pertinent to your wellness.



## **INFORMED CONSENT and Request for Naturopathic Medicine**

I understand that naturopathic evaluation and treatment may include, but is not limited to:

- Physical exam (general and female)
- Common diagnostic procedures (pap smears, diagnostic imaging, laboratory evaluation of blood, urine, and stool and saliva)
- Dietary advice and therapeutic nutrition (use of foods, diet plans, nutritional supplements, and injections)
- Herbs/natural medicines (prescribing of various therapeutic substances including plant, mineral and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures, suppositories, which may contain alcohol, topical creams or other forms.
- Homeopathic remedies (often highly diluted quantities of natural occurring substances)
- Over the counter and prescription medications

I understand and I am informed that in the practice of Naturopathic Medicine there are some risks and benefits with evaluation and treatment including, but not limited to the following:

- Potential risks: allergic reaction to prescribed herbs, supplements, prescription medications; and aggravation of pre-existing symptoms.
- Potential benefits: restoration of the body's maximal functioning capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery and prevention of disease or its progression.
- Notice to pregnant women: all female patients must alert the provider if they know or suspect that they are pregnant, since some of the therapies could present a risk to the pregnancy.

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 also understand that it is my responsibility to request that the provider explains therapies and procedures to my satisfaction. I further acknowledge that no guarantees or services have been made to me concerning the results intended from the treatment. I intend that this consent form is to cover the entire course of treatments for my present condition and any future conditions for which I am seeking treatment.

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PATIENT'S NAME (signature)

DATE

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PATIENT'S NAME (print or type)



## **Financial Policy of Dr. Toni Varela, NMD**

### **PAYMENT POLICY**

Payment for services is due at the time services are rendered, including for products and labs not specifically covered by insurance.

### **INSURANCE REIMBURSEMENT POLICY**

Naturopathic Physicians may be covered by some PPO plans as out-of-network physicians. For your information Medicare does not cover Naturopathic Medicine.

Submission of a claim for reimbursement on your own, a superbill providing a summary of the services rendered, diagnoses and charges applied, can be provided for you to send to your insurance company at the time of your visit. A fee may be assessed for retroactive superbill requests.

### **RETURNED CHECKS**

For checks returned as unpaid by your bank, you will be charged a \$25 returned check fee.

### **MISSED APPOINTMENTS**

Please provide at least 24 hours notice of cancellation as a courtesy. A charge of the cost of your booked appointment will be applied for failure to notify Dr. Toni Varela, NMD of a cancellation prior to the scheduled appointment time.

By signing below I am stating that I have read and understand the Financial Policy of California Naturopathic Clinic.

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PATIENT'S NAME (signature)

DATE

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PATIENT'S NAME (print or type name)