

## A WELLSPRING OF NATURAL HEALTH, PC

Person-Centered Health Care • Natural Medicine for the Whole Family

### Adult New Patient

\_\_\_ Mitchell Bebel Stargrove, ND, LAc

\_\_\_ Lori Beth Stargrove, ND

Name (Patient) \_\_\_\_\_ Date of first visit \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Telephone # (home) \_\_\_\_\_ (work/cell) \_\_\_\_\_

Email address \_\_\_\_\_

Age \_\_\_\_\_ Gender identity \_\_\_\_\_ Ethnic/Ancestral origins \_\_\_\_\_

Birthdate \_\_\_\_\_ Birth time \_\_\_\_\_ a.m./p.m. Birth place \_\_\_\_\_

Relationship status: Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Partnership \_\_\_

Live with: Spouse \_\_\_ Partner \_\_\_ Parents \_\_\_ Children \_\_\_ Friends \_\_\_ Alone \_\_\_ Community \_\_\_

Occupation \_\_\_\_\_ Hours per week \_\_\_\_\_ Retired \_\_\_\_\_

Employer \_\_\_\_\_

Work address \_\_\_\_\_

Who referred you to WellSpring? \_\_\_\_\_

Next of kin or other to reach in an emergency \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Primary medical insurance \_\_\_\_\_ Policy/Group # \_\_\_\_\_

Telephone # \_\_\_\_\_ Address \_\_\_\_\_

Policy holder's name \_\_\_\_\_ Birthdate \_\_\_\_\_

Secondary medical insurance \_\_\_\_\_ Policy/Group # \_\_\_\_\_

Telephone # \_\_\_\_\_ Address \_\_\_\_\_

Policy holder's name \_\_\_\_\_ Birthdate \_\_\_\_\_

Eligible for Medicare coverage/benefits? Yes \_\_\_ No \_\_\_ Health/Medical savings account? Yes \_\_\_ No \_\_\_



## Health History Questionnaire

Safe, effective and individualized medical treatment and health care requires your clinician to understand you as a whole person in your real life context. Please complete this questionnaire as thoroughly as possible. Print all information, and mark anything you **don't** understand with a question mark.

Are you currently being treated by any health care or medical provider(s)? Yes \_\_\_\_ No \_\_\_\_

If yes, where and from whom? \_\_\_\_\_

\_\_\_\_\_

If no, when and where did you last receive medical treatment or health care? \_\_\_\_\_

\_\_\_\_\_

What was the reason? Did your condition resolve or is it ongoing? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are your most important health and medical concerns? List in order of importance.

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

5) \_\_\_\_\_

6) \_\_\_\_\_

7) \_\_\_\_\_

8) \_\_\_\_\_

Is your health: Excellent \_\_\_\_ Good \_\_\_\_ Average \_\_\_\_ Poor \_\_\_\_?

Is your walking pace: Brisk \_\_\_\_ Average \_\_\_\_ Slow \_\_\_\_?

Do you have any contagious diseases at this time? No \_\_\_\_ Yes \_\_\_\_

If yes, what? \_\_\_\_\_



What do you do to enhance your health? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are your family, work and social supports and stressors? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How has your dysfunction and disease affected your life? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did you experience any significant stresses, traumas, and/or accidents in the two years before your condition appeared? Please describe. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Who in your life deeply inspires you? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What relationships are challenging for you? How? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Why are you choosing to focus on improving your health now? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## Family History

☐ Check if adopted

	MOTHER			FATHER			Siblings
	Mother	Grandmother	Grandfather	Father	Grandmother	Grandfather	
Age (if living)	_____	_____	_____	_____	_____	_____	_____
Health (Robust, Compromised, Mixed)	_____	_____	_____	_____	_____	_____	_____
Age at death (if deceased)	_____	_____	_____	_____	_____	_____	_____

### Check (✓) those applicable

*Please highlight any significant recent changes.*

Cancer	_____	_____	_____	_____	_____	_____	_____
Diabetes /hypoglycemia	_____	_____	_____	_____	_____	_____	_____
Heart disease	_____	_____	_____	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____	_____
Depression/anxiety	_____	_____	_____	_____	_____	_____	_____
Asthma/hayfever/hives	_____	_____	_____	_____	_____	_____	_____
Obesity	_____	_____	_____	_____	_____	_____	_____
Kidney disease	_____	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____	_____
Chemical/pesticide exposure	_____	_____	_____	_____	_____	_____	_____
Dysfunctional family	_____	_____	_____	_____	_____	_____	_____
Sexual abuse/rape	_____	_____	_____	_____	_____	_____	_____
Addiction/alcoholism	_____	_____	_____	_____	_____	_____	_____
Violence	_____	_____	_____	_____	_____	_____	_____
Food deprivation	_____	_____	_____	_____	_____	_____	_____
Poverty	_____	_____	_____	_____	_____	_____	_____
Immigration	_____	_____	_____	_____	_____	_____	_____
War	_____	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____	_____



***For the Following, Please Circle:***

**Y = Yes      N = No**

**Childhood Illnesses**

Scarlet fever	Y N	Chicken pox	Y N	Rheumatic fever	Y N
Mumps	Y N	Measles	Y N	German measles	Y N

**Hospitalization and Surgery**

What hospitalizations or surgeries have you had? When?

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**X-Rays, Imaging and Special Studies**

X-ray	Y N	Thermography	Y N
MRI	Y N	Electrocardiogram/EKG	Y N
CT/CAT scan	Y N	Electroencephalogram/EEG	Y N
Mammography	Y N	Food sensitivity/intolerance testing	Y N

**Immunizations**

Diphtheria/Tetanus/Pertussis (DTaP)	Y N	Hepatitis A	Y N
Measles/Mumps/Rubella (MMR)	Y N	Hepatitis B	Y N
Chicken Pox/Varicella	Y N	Human Papillomavirus (HPV)	Y N
Polio	Y N	Meningococcal	Y N
Flu/Influenza	Y N	Pneumococcal/Pneumonia	Y N
Tetanus (alone)	Y N	Shingles/Herpes zoster	Y N
Other _____		Other _____	

**Sensitivities/Reactions**

Are you hypersensitive or reactive to...

Any medications/drugs? \_\_\_\_\_

Any foods? \_\_\_\_\_

Environmental and Climate stressors? \_\_\_\_\_



## Drugs, Medications, Nutrients, Herbs, Remedies

Which of these substances have you used or been prescribed?

Pain relievers	Y N	Anxiety medication	Y N	Laxative	Y N
Steroid	Y N	Antidepressant	Y N	Antacid	Y N
Anti-inflammatories	Y N	Thyroid medication	Y N	Statin drug	Y N
Sleeping aid	Y N	Hormone replacement	Y N	Antibiotics	Y N

Please list *any and all* prescription drugs, over-the-counter medications, nutrients, herbs or other remedies you are *currently* taking.

Medicines (Drug, vitamin, nutrient, herb, etc.)	How much? How often?	Prescribed by?	Since when?	Take regularly? Y/N



## Medical Treatment Coordination and Health Care Collaboration

Do you fully inform your conventional and natural medicine practitioners of all the herbs, nutrients, remedies and drugs that you take? What do you share and with whom? Why? If not, what information do you withhold?

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With which healthcare provider(s) do you have the most honest communication and respectful relationship?

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Do your medical providers share information and collaborate with each other and you in shaping your medical treatment and health care? If so, how? \_\_\_\_\_

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Do you have the resources and support to fully implement the health care and medical treatment recommended/ prescribed by the clinicians you see? If not, what are the limiting factors? \_\_\_\_\_

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## Typical Food and Drink Intake

Breakfast: \_\_\_\_\_

\_\_\_\_\_

Lunch: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Dinner: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Between Meals: \_\_\_\_\_

\_\_\_\_\_

Liquids: \_\_\_\_\_

\_\_\_\_\_

Cravings: \_\_\_\_\_

\_\_\_\_\_

## Household and Environmental Supports and Stressors

Where do you buy most of your groceries? \_\_\_\_\_

What household cleaners do you use? \_\_\_\_\_

What fertilizers, pesticides, weed killers do you use? \_\_\_\_\_

What shampoo do you use? \_\_\_\_\_

Do you use hair dye or coloring? \_\_\_\_\_

What toothpaste do you use? \_\_\_\_\_

Do you have mercury amalgam dental fillings? Removed? \_\_\_\_\_

Do you have mold in your home? Previously? \_\_\_\_\_

Are you sensitive to electromagnetic stressors? \_\_\_\_\_





## General History

Weight \_\_\_\_\_ lb.. Height \_\_\_\_\_ Vitality \_\_\_\_\_

ABO Blood Type? \_\_\_\_\_ FUT2 Secretor status? \_\_\_\_\_

What time of the day is your energy the highest? \_\_\_\_\_ Lowest? \_\_\_\_\_

In broad terms, what are your health strengths and challenges? \_\_\_\_\_

## Review of Systems

*For the Following, Please Circle:*

**Y** = Condition you have now      **N** = Never      **P** = Previous condition

### Relationships

Adoption	Y N	Divorce (parental)	Y N
Birth trauma	Y N	Sexual abuse	Y N
Familial alcoholism/addiction	Y N	Violence in family of origin	Y N

### Emotional

Treated for emotional problems	Y P N	Depression	Y P N
Mood swings	Y P N	Anxiety or nervousness	Y P N
Considered/attempted suicide	Y P N	Tension	Y P N

### Hormones/Endocrine

Hypothyroid	Y P N	Heat or cold intolerance	Y P N
Hypoglycemia	Y P N	Diabetes	Y P N
Excessive thirst	Y P N	Excessive hunger	Y P N
Fatigue	Y P N	Seasonal depression	Y P N
Adrenal stress	Y P N	Night sweats	Y P N

### Immune/Lymphatic

Vaccinations	Y P N	Chronically swollen glands	Y P N
Chronic Fatigue Syndrome	Y P N	Chronic infections	Y P N
Reactions to vaccinations	Y P N	Slow wound healing	Y P N



### **Brain/Nervous System**

Seizures	Y P N	Paralysis	Y P N
Muscle weakness	Y P N	Numbness or tingling	Y P N
Loss of memory	Y P N	Easily stressed	Y P N
Vertigo or dizziness	Y P N	Loss of balance	Y P N
Hypersensitivity	Y P N	Concussion	Y P N

### **Skin/Hair**

Rashes	Y P N	Eczema, hives	Y P N
Acne, Boils	Y P N	Itching	Y P N
Color Change	Y P N	Perpetual hair loss or thinning	Y P N
Lumps	Y P N	MRSA	Y P N

### **Head**

Headaches	Y P N	Head injury	Y P N
Migraines	Y P N	Jaw/TMJ problems	Y P N

### **Eyes/Vision**

Spots in vision	Y P N	Eye pain/strain	Y P N
Impaired or blurry vision	Y P N	Glasses or contacts	Y P N
Tearing or dryness	Y P N	Glaucoma	Y P N
Color blindness	Y P N	Macular degeneration	Y P N
Double vision	Y P N	Cataracts	Y P N

### **Ears/Hearing**

Impaired hearing	Y P N	Ringings/Tinnitus	Y P N
Earaches	Y P N	Dizziness	Y P N

### **Nose and Sinuses**

Hayfever	Y P N	Nose Bleeds	Y P N
Stiffness	Y P N	Frequent colds	Y P N
Sinus problems	Y P N	Loss of smell	Y P N



### Mouth and Throat

Frequent sore throat	Y P N	Copious saliva	Y P N
Teeth grinding	Y P N	Sore tongue/lips	Y P N
Gum problems	Y P N	Hoarseness	Y P N
Dental cavities	Y P N	Jaw clicking	Y P N

### Neck

Lumps	Y P N	Swollen glands	Y P N
Goiter	Y P N	Pain or stiffness	Y P N

### Respiratory

Cough	Y P N	Chronic phlegm	Y P N
Croup	Y P N	Wheezing	Y P N
Asthma	Y P N	Bronchitis	Y P N
Pneumonia	Y P N	Pleurisy	Y P N
Emphysema	Y P N	Difficulty breathing	Y P N
Pain on breathing	Y P N	Shortness of breath	Y P N
Spitting up blood	Y P N	Shortness of breath on exertion	Y P N
Tuberculosis	Y P N	Shortness of breath at night	Y P N

### Cardiovascular/Heart

Heart disease	Y P N	Angina	Y P N
High or low blood pressure	Y P N	Murmurs	Y P N
Blood clots	Y P N	Fainting	Y P N
Phlebitis	Y P N	Palpations/Fluttering	Y P N
Rheumatic Fever	Y P N	Chest pain	Y P N
Swelling in ankles	Y P N	Cold hands and/or feet	Y P N

### Blood/Peripheral Vascular

Easy bleeding or bruising?	Y P N	Anemia	Y P N
Deep leg pain?	Y P N	Cold hands/feet	Y P N
Varicose veins?	Y P N	Thrombophlebitis	Y P N



### **Gastrointestinal/Digestive**

Trouble swallowing	Y P N	Heartburn/Reflux/GERD	Y P N
Change in thirst	Y P N	Hiatal hernia	Y P N
Nausea	Y P N	Vomiting	Y P N
Ulcer	Y P N	Bowel movements	How often? _____
Blood in stool	Y P N		Is this a change? Y N
Black stools	Y P N		Urgency? Y P N
Belching or passing gas	Y P N	Constipation	Y P N
Abdominal pain or cramps	Y P N	Diarrhea/Loose stools	Y P N
Jaundice	Y P N	Gall bladder problems	Y P N
Liver disease	Y P N	Hemorrhoids	Y P N
Gluten intolerance	Y P N		

### **Musculoskeletal**

Neck pain or stiffness	Y P N	Muscle spasms or cramps	Y P N
Mid-back pain or stiffness	Y P N	Arthritis	Y P N
Low back/hip pain or stiffness	Y P N	Fibromyalgia	Y P N
Sciatica	Y P N	Broken bones	Y P N
Foot/ankle pain or stiffness	Y P N	Bursitis	Y P N
Knee pain or stiffness	Y P N	Tendinitis	Y P N

### **Urinary**

Pain on urination	Y P N	Increased frequency	Y P N
Frequency at night	Y P N	Incontinence	Y P N
Frequent infections	Y P N	Kidney stones	Y P N

### **Male Sexual/Reproduction**

Hernias	Y P N	Prostate disease	Y P N
Testicular pain	Y P N	Masturbation	Y P N
Testicular masses	Y P N	Reduced libido	Y P N
Are you sexually active?	Y P N	Discharge or sores	Y P N
Are you sexually satisfied?	Y P N	Chlamydia	Y P N
Sexual orientation:		Herpes	Y P N
Impotence	Y P N	HPV/Venereal warts	Y P N
Premature ejaculation	Y P N	Gonorrhea	Y P N
Birth control	Y P N	Syphilis	Y P N
If so, what type?			



### Female Sexual/Reproduction/Breasts

Age of first menses: _____		Masturbation	Y P N
Date of last menses: _____		Pain during intercourse?	Y P N
Length of menstrual cycle: _____ days		Are cycles regular?	Y P N
Duration of menses: _____ days		Bleeding between periods?	Y P N
Painful menses	Y P N	Clotting	Y P N
Heavy or excessive flow	Y P N	Discharge	Y P N
PMS	Y P N	Birth control	Y P N
If yes, what are your symptoms? _____		What type? _____	
_____		Age of first use: _____	
Endometriosis	Y P N	Number of pregnancies: _____	
Ovarian cysts	Y P N	Number of live births: _____	
Difficulty conceiving	Y P N	Number of miscarriages: _____	
Cervical dysplasia	Y P N	Number of abortions: _____	
Breast pain/tenderness	Y P N	Menopausal symptoms	Y P N
Breast lumps	Y P N	Abnormal PAP	Y P N
Nipple discharge	Y P N	Chlamydia	Y P N
Do you do breast self-exams?	Y P N	HPV/Venereal warts	Y P N
Sexual orientation: _____		Syphilis	Y P N
Are you sexually satisfied?	Y P N	Herpes	Y P N

Any other health patterns or medical concerns? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Life Situation, Habits and Values



How does your current condition affect you? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What do you think is happening? Why? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What do you feel needs to happen for you heal? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you experienced major trauma? If so, please describe? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Main creative activities, interests and hobbies? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How do you exercise? How often? \_\_\_\_\_

\_\_\_\_\_

What is your relationship to family, friends and community? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have a religious faith or spiritual practice? Yes \_\_\_\_ No \_\_\_\_ If yes, what? \_\_\_\_\_

\_\_\_\_\_

How do you nourish and cultivate yourself? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What is your relationship to the place where you live? \_\_\_\_\_

\_\_\_\_\_



What do you know about your birth? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you made any plans for your dying? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What do you enjoy most in your life? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Eat three meals a day?	Y N	Read?	Y P N
Eat out often?	Y N	How many hours per day? _____	
Go on diets often?	Y N	Watch television?	Y P N
Cook meals at home?	Y N	How many hours per day? _____	
Drink coffee?	Y N	Use computer?	Y P N
Drink black tea?	Y N	How many hours per day? _____	
Drink cola or other soft drinks?	Y N	Gaming or internet overuse or addiction?	Y P N
Eat sugar or sweets?	Y N	Substance overuse or abuse?	Y P N
Add salt to food?	Y N	Recreational or entheogenic substance use?	Y P N
Have a supportive relationship?	Y N	Alcohol use or abuse?	Y P N
Enjoy your work?	Y N	How often? _____	
Take vacations?	Y N	Smoke or chew tobacco?	Y P N
Sleep well?	Y N	How much? _____	
Average 7-9 hrs. sleep?	Y N	Tobacco use or abuse?	Y P N
Awaken rested?	Y N	How many years? _____	
Spend much time outside?	Y N	How much? _____	

How much are you willing and able to make changes to improve your daily life?

MINIMAL      SOME      COMPLETE



***Welcome to WellSpring! We are here to serve you.***



## Patient-Clinician Relationship Acknowledgement

The undersigned patient (“Patient”) understands and agrees that Patient is retaining the services of a **clinician** (“Clinician”) at A WellSpring of Natural Health, P.C. (“WellSpring”) **as an independent health care and medical practitioner.**

Patient recognizes, understands and agrees that the **Clinician they are working with is a sole practitioner** and is not a partner or otherwise affiliated with any other Clinician who may be providing similar services at WellSpring.

Patient further recognizes, understands and agrees that the clinician they are seeing is solely responsible for and shall provide all professional services to Patient and that Patient is relying solely on the skill of the Clinician they have engaged for the professional services rendered at WellSpring. The Patient is free to receive medical treatment and health care services from any other clinicians(s) of their choice. This agreement is not intended to restrict the Patient from receiving medical treatment or healthcare services from other clinicians at this clinic or anywhere else.

Patient further recognizes that their Clinician may prescribe medication(s), which may be purchased from a seller of the patient’s choice.



**READ, UNDERSTOOD AND AGREED**

PATIENT

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (or Signature of Parent/Legal Guardian)

\_\_\_\_\_  
Print Your Clinician’s name (here at WellSpring)





## Informed Consent for Treatment

I, \_\_\_\_\_, hereby request and consent to receive naturopathic, acupuncture and/or Chinese medical treatment and health care by the licensed acupuncturist and/or licensed naturopathic physician (“Clinician”) at A WellSpring of Natural Health, P.C. (“WellSpring”) who now or in the future may treat me while working at or associated with WellSpring. Further, such consent and request applies equally to any other licensed acupuncturist and/or licensed naturopathic physician serving as for medical care back-up or in *locum tenens* for my Clinician at WellSpring, whether signatories to this form or not. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I have also read and understand the attached “Notice of Patient Privacy”, which discusses my rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Examples of Diagnostic Procedures, Health Care and Medical Treatment:

- Customary diagnostic procedures: including but not limited to general physical exams, venipuncture, PAP smears, blood and urine lab work.
- Traditional naturopathic, Chinese and other natural medicine systems of diagnosis and pattern evaluation, such as pulse and abdominal palpation, tongue and facial appearance, muscular armoring and tension dynamics, gait and postural observation.
- Lab tests and procedures: including referral for x-ray, MRI, or other diagnostic imaging.
- Minor office procedures: e.g., dressing a wound, ear cleaning, incision repair, laceration repair, wart removal, skin biopsy, etc.
- Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, injections of nutrients.
- Botanical therapies: substances may be prescribed as teas, infusions, alcoholic tinctures, capsules, tablets, crèmes, plasters, or suppositories.
- Homeopathic medicine: the use of diluted quantities of naturally-occurring substances to gently stimulate the body’s self-healing responses, given orally, topically, or by injection.
- Prescription of pharmaceuticals or bio-identical hormones.
- Counseling: life choices, psychological processes, self-actualization, creative expression, health promotion including recommendations for exercise, sleep, contraception, and stress reduction.
- Naturopathic manipulative therapies: specific manipulation of muscles, joints (including cranial bones), or soft tissue.
- Tui na massage, cupping, moxibustion, heating or bleeding of acupuncture points.
- Acupuncture and trigger point needling, including injections such as bee venom therapy, prolotherapy, homeopathic injections.

I have had the opportunity to discuss with my Clinician at WellSpring the nature and purpose of health practices, acupuncture, naturopathic therapies and procedures. I am aware that all existing methods of diagnosis and treatment, including naturopathic medicine and acupuncture and other practices of Chinese medicine, pose some level of risk. Within the general clinical setting, the possible adverse outcomes of these practices by a naturopathic physician and/or acupuncturist range from minor to potentially fatal.

The health care and medical treatment we provide may or may not be directed at a specific disease or disorder. It may be preventive in nature, designed to improve overall health and well-being, restore your body’s innate self-healing processes, and support you in living consciously and creatively. We will always strive to provide full disclosure of all information relevant to your clinical care. I understand that in providing treatment my Clinician is relying on the information that I am providing to them about the Patient, the Patient’s health, and the Patient’s response to therapies and my own behavior. I agree that the information I provide will be true and accurate and that I will disclose to the physician everything needed for treatment.



The herbs, homeopathic medicines and nutrients (which are from plant, animal, mineral and other sources) that have been recommended, are considered safe when taken as instructed in the practice of naturopathic and/or Chinese medicines. It is extremely important that the prescribed recommendations be followed when taking herbs, homeopathic medicines and nutritional agents because they may induce adverse effects when taken in excessive amounts or inappropriate situations. I understand that herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I understand that some herbs and nutrients may be inappropriate during pregnancy, and I will immediately notify those providing my clinical care at WellSpring if I become aware that I may be or am pregnant.

I will immediately inform the Clinician at WellSpring if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), bruising or burns (associated with acupuncture, injections, cupping or moxibustion), or any unanticipated or unpleasant effects associated with treatment or the herbs or other therapies prescribed by the Clinician at WellSpring. I understand that while this document describes the most common risks of treatment, other adverse effects and risks may occur. In order to properly treat my medical condition and support my health and medical progress, the Clinician at WellSpring must be contacted promptly if an adverse reaction or condition occurs. In any event, if an emergency medical condition arises, it is important to seek treatment immediately from an emergency care facility or call 911.

With this knowledge, I voluntarily consent to the above procedures and that I acknowledge that no guarantees have been given to me by my Clinician or the staff of A WellSpring of Natural Health, P.C. regarding cure or improvement of my health and medical condition(s).

**I have read, or have had read to me, and understand the above information and consent. I have also had an opportunity to ask questions about its content, and by voluntarily signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.**



**READ, UNDERSTOOD AND AGREED**

PATIENT

Printed Name

Date

Signature (or Signature of Legal Guardian)

Print Your Clinician's name (here at WellSpring)



## Economics and Billing

Dear New Patient:

Welcome to WellSpring. We, the clinicians and staff at A WellSpring of Natural Health, P.C. ("WellSpring"), look forward to providing for your medical needs and health goals. We encourage your questions and participation in all aspects of your medical treatment and health care.

You understand that you are retaining the services of only the clinician named below. You recognize, understand and agree that your clinician is a sole practitioner and is not a partner or otherwise affiliated with any other healthcare practitioner who may be providing similar services at WellSpring or elsewhere. You further recognize, understand and agree that your clinician is solely responsible for and shall provide all professional services to you and that you are relying solely on your clinician's skill for the professional services rendered at WellSpring.

You are important to us. We wish to keep you informed of our policies regarding your payment responsibilities. We feel that it is essential that we share a clear understanding of our economic relationship so as to enhance and not interfere with our therapeutic relationship. We recognize and appreciate that health care can involve a significant financial commitment. That is exactly why we want you to know that our primary goal of the healthcare providers at WellSpring is to provide you with safe, effective and affordable healthcare.

As the patient of your healthcare provider, you are responsible for the total charges incurred from each clinic visit. **Charges are to be paid at the time of the visit unless specific arrangements have been made prior to the office visit.** We accept VISA, MasterCard, checks and cash. There will be a charge of \$30.00 each for any returned check(s). **If we are billing your insurance, we require that your deductible has been met and that payment of your co-portion of each bill is paid at the time of each visit.** If your insurance company does not pay the outstanding balance within 60 days of the treatment date, you will be required to pay the full amount along with any new charges incurred. If immediate full payment will present major difficulties for you, please ask about our procedures to assess your financial abilities and formulate a payment plan with you.

**You are encouraged to bill your insurance company directly for services we provide. The terms of your insurance policy and its riders may or may not cover the care you receive at WellSpring.** We are willing to assist you in billing your insurance company when naturopathic and/or acupuncture care is covered. We provide initial billing to your insurance company, for each visit as a courtesy at no additional charge. If it becomes necessary to re-bill your insurance company for any outstanding balance, a \$10.00 per re-billing fee may be charged. We will only bill your insurance twice. Be aware that any account over 60 days past due will accrue interest at 1.5% monthly (18% per annum). Please remember, that **you have the primary relationship with your insurance company and are responsible for the total amount owing if your insurance carrier determines that it will not pay for services that have been provided.**

**The terms of the Affordable Care Act requires that acupuncture or naturopathic medical services be covered in accordance with licensing of providers and their respective scope of practice as defined by the State of Oregon.** Specifically, Section 2706 – the provider non-discrimination provision of the Public Health Service Act as amended by the Affordable Care Act mandates that insurance coverage prohibits insurance companies from discriminating against naturopathic physicians or licensed acupuncturists (or any other provider for that matter) when the clinician is treating the same conditions or performing the same services that the insurer would otherwise cover.

**Patients will be billed a \$75 fee for any missed appointment or cancellation of an appointment with less than one full business day (i.e., 24 hours) advance notice.** This charge will not be submitted to your insurance company. Any emergencies warranting special consideration will be respected as a reasonable exceptions.



**Furthermore, arriving for an appointment late by 15 minutes or more may qualify as a missed appointment and a \$75 fee may apply.**

Your clinician may prescribe nutrients, herbal preparations and/or other medications, which may be purchased either at this location or elsewhere. Such products are available at this site from a separate business; payment for all medicinal items is not related to your clinical or economic relationship with WellSpring. Most insurance policies do not cover or reimburse for the nutrient and herbal products that your Clinician prescribes, but certain medical savings accounts or employee benefit plans may reimburse for prescribed medicines. In such cases, WellSpring will provide you with an appropriate Letter of Medical Necessity for submission.

If you have any questions concerning any of these policies, or need to formulate a payment plan, please feel free to contact our staff *before* your office visit. If you accept these terms of relationship, please sign the bottom of this form and hand it in at the front desk.

**I have read and understand the above-stated policies of A WellSpring of Natural Health, P.C. and will comply with them in all respects. If my insurance company requires a release of my medical records, I hereby give my permission by signing this form.**



**READ, UNDERSTOOD AND AGREED**

PATIENT

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Relationship to Patient



## Missed Appointment Policy

Scheduling an appointment with a clinician at WellSpring represents a bond of trust and good faith between you as a parent or legal guardian, the patient, your clinician and the clinic as a whole. It implies that we will be here to serve you and that you will be present and on time for your appointment. We schedule appointments in increments of time that balance your individual needs and the typical time requirements for effective health care and medical treatment. We do our best to stay on schedule in a comfortable and caring environment. While always respectful of your time, we do encounter situations where patients require more than the scheduled time. We ask for your understanding and patience on these occasions. You will appreciate our efforts at balancing timeliness and attentiveness some day when you need extra time and attention.

Contact the clinic as soon as possible to reschedule if you will be unable to be at your appointment in a timely manner. For rescheduling or canceling appointments, we require a 24-hour notice, or one full business day in the case of weekends and holidays. If you are not able to reach us during clinic hours you may leave a message in the front desk mailbox of our voicemail system; a message left outside of normal business hours will be considered as received at the opening time of the next business day. A cancellation without adequate notice will be considered a missed appointment. Likewise, if you are more than 15 minutes late for your scheduled time, the appointment will be considered as “missed” and will have to be rescheduled.

**Both missed appointments and late cancellations are subject to a \$75 fee.**

We appreciate your understanding of this policy. Our goal is to nourish a professional relationship based upon trust, confidence and mutual respect, which will enhance the quality of your health care and medical treatment. Please talk to the office staff if you need clarification of this policy.



**READ, UNDERSTOOD AND AGREED**

PATIENT

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Relationship to Patient



## Notice of Patient Privacy (Short Form)

### Health Insurance Portability and Accountability Act (HIPPA)

Effective Date: April 14, 2003

Updated: June 21, 2015

A WellSpring of Natural Health, P.C. ("WellSpring") is dedicated to preserving your "Protected Health Information" (PHI). We are required by law to protect your health information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information. This Notice of Privacy Practices describes your rights and WellSpring's responsibilities with respect to your Protected Health Information.

WellSpring may use or disclose your PHI for the purpose of diagnosing or providing medical treatment, obtaining payment for health care bills or to conduct health care operations.

We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

Your PHI means health information, including your demographic information, collected by us, other health care providers, a health care clearinghouse, or an employer. This protected medical and health care information relates to your past, present or future physical or mental health or condition and identifies you, or there is a reasonable basis to believe the information may identify you.

You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, request that we restrict certain uses and disclosures of your health information, and file a complaint if you think your rights have been violated. All requests and complaints must be made in writing.

We have available a detailed NOTICE OF PRIVACY PRACTICES (long form) which fully explains your rights and our obligations under the law. You have the right to receive a copy of our most current NOTICE in effect, please ask at the front desk and we will provide you with a copy. This document is also available in the Forms section of the [wellspringofhealth.com](http://wellspringofhealth.com) website.

We may revise our NOTICE from time to time. The Effective Date at the top right hand side of this page indicates the date of the most current NOTICE in effect.

You may contact our Privacy Officer, Clinic Director Dr. Lori Stargrove at 503.526.0397 if you have any questions, concerns or complaints or seek further information about the complaint process.

By signing this form you are acknowledging that you have been provided information regarding our privacy practices pertaining to your "Protected Health Information."



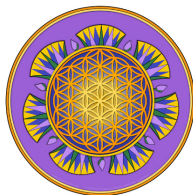
**READ, UNDERSTOOD AND AGREED**

PATIENT

Printed Name

Date

Signature (or Signature of Legal Guardian)



## A WELLSPRING OF NATURAL HEALTH, PC

*Person-Centered Health Care • Natural Medicine for the Whole Family*

### Directions to WellSpring ~ 4720 SW Watson Avenue, Beaverton

#### From South I- 5 or Tigard:

Take Interstate-5 to Hwy 217. Follow Hwy 217 North heading toward Beaverton. Take the **Allen Street Exit**. Turn left at the first stoplight, which is Allen Street. Go forward to the **third stoplight**, which is **Hall Boulevard**. Turn right onto Hall going North. After the stoplight at 5th Avenue, turn **left onto Third Avenue**. Go forward just short of **two blocks**. Our parking lot and building are located on the **right-hand side**. The clinic is on the Northeast corner of 3rd and Watson at 4720 SW Watson Avenue.

#### From Downtown Portland:

Take **Highway 26 West** to Highway 217 South. Follow Hwy 217 and take the **Beaverton-Canyon Road Exit** (Highways 8 and 10). Turn right at the **second stoplight**, which is **Beaverton-Hillsdale Highway**, and then becomes **Farmington Road** as you cross the railroad tracks. Go forward to the **fourth stoplight**, which is **Watson Avenue** (two blocks past Hall Blvd.). Turn left onto Watson. The clinic is located **three blocks down** on the left-hand side. We are on the left-hand (NE) corner, nearest you, of 3rd and Watson at 4720 SW Watson Avenue.

#### From SW Portland:

Take **Beaverton-Hillsdale Highway** west. After you pass underneath **Hwy 217**, go straight up to the **fifth stoplight**, which is **Watson Avenue**. Turn left onto Watson. The clinic is located **three blocks down** on the left-hand side. We are on the left-hand (NE) corner of **3rd and Watson** at 4720 SW Watson Avenue.

#### From Hillsboro or Aloha:

Take **Farmington Road** to downtown Beaverton. Turn right onto **Watson Avenue**. (If you have come to Hall Boulevard, you have gone two blocks too far.) The clinic is located **three blocks down on the left-hand corner**. We are on the left-hand (NE) corner of **3rd and Watson** at 4720 SW Watson Avenue.







## Communication Guidelines

These are some guidelines that can make our communication more effective:

1. When you call, give the receptionist a message including a detailed description of your concerns and/or questions and a few times during which you will be available to talk on the phone. This initial information will enable your clinician to make a preliminary determination about whether your needs can be adequately addressed on the phone or whether you need to come into the office.
2. If the doctor has not returned your call in what you feel is a reasonable amount of time, you may call again. Our ability to respond will be delayed in the event that you do not answer the phone when an attempt is made to call you. Our working together will best facilitate your needs being addressed in a timely manner.
3. Timing is important. If you or your child is sick, call early in the workday. Likewise, avoid waiting until late in the week to contact us with an acute need.
4. Accurately prescribing medication over the phone is inherently difficult and compromised. If your medical condition has changed significantly since a recent visit or a new condition has emerged we can only provide responsible, effective and ethical medical care by understanding the unique presentation of your symptoms and your experience of your condition. The person-centered health care offered at WellSpring is best delivered in person and we will work to accommodate your needs in a timely manner. Telephone, electronic or other indirect communication can not provide us with the opportunity to serve you as well as seeing you in person.
5. Children and illnesses do not always follow the rhythms of the clinic schedule. Your clinician is available in the beyond clinic hours if you feel that you have a medical condition requiring urgent decision-making and/or treatment; the WellSpring voicemail system (press #2) will contact your clinician and transmit the detailed message you leave. You will be called as soon as possible. In the event of a medical emergency, call 911 or go to the nearest urgent care facility or emergency room.
6. The WellSpring website provides a contact form for communicating with our staff and practitioners. These submissions will be reviewed and responded to but are not a timely or reliable means of communications with your clinician regarding your health care and medical treatment. In general, we at WellSpring prefer to communicate directly on the phone or in person and do not use electronic communications such as email or the WellSpring website for discussing your health care or medical treatment. Such forms of electronic messages are useful and appropriate for matters involving clinic hours and policies, insurance verification, and other matters of general business. The staff email ([care@wellspringofhealth.com](mailto:care@wellspringofhealth.com)) and WellSpring website contact forms are available to more appropriately serve these functions. The clinicians at WellSpring do not use email for discussing your case or receiving documents. Email and online form submissions do not meet the confidentiality and security standards required by HIPAA and other relevant regulations and thus are not appropriate for transmitting personal information such your birthdate, social security number, passwords, etc.

**Thank you!**

**The Clinicians and Staff of A WellSpring of Natural Health, P.C.**

