YELLOWSTONE NATUROPATHIC CLINIC
720 N 30th St Billings, MT 59101 406-259-5096 Fax: 406-545-0044

PRP/STEM/Regenerative Injection Therapy Initial Visit

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained herein will not be released without your written authorization. Please take the time to fill out this questionnaire carefully. If you have a question, please ask for help. The completed form will greatly help in a complete evaluation of your health.

Personal History

Print Name: _____ Occupation: _____ DOB: _____

Medication Allergies _____

This visit is solely for the purpose of screening for the above procedures only.

It is limited in scope and not a replacement for a personal physician.

If you would like a report sent to your physician, please ask the front desk for a specific form to complete.

Please Answer the Following Questions:

Have you tried prolotherapy before? ☐ Yes ☐ No
Are you nervous about needles? ☐ Yes ☐ No
Do you have a tendency to faint? ☐ Yes ☐ No
Do you bleed for a long time or bruise easily? ☐ Yes ☐ No
Have you eaten in the last 3 hours? ☐ Yes ☐ No
Are you very tired now? ☐ Yes ☐ No
Do you have a communicable disease? ☐ Yes ☐ No

Have you ever had Hepatitis? ☐ Yes ☐ No
Do you have a pacemaker? ☐ Yes ☐ No
Women: Are you pregnant? ☐ Yes ☐ No
Allergies to procaine, novacaine or lidocaine? ☐ Yes ☐ No
Do you have joint replacement? ☐ Yes ☐ No
Do you have diabetes? ☐ Yes ☐ No
Do you have any type of heart disease? ☐ Yes ☐ No

Present Health

Major Complaint: _____

When did you first notice your problem? _____

Is there pain? ☐ Yes ☐ No Minimal ++++++++++++++++++++++++++++++++++++ Unbearable

Is your condition: Getting worse _____ Constant _____ Comes and Goes _____

Have you ever been given a diagnosis for your condition? ☐ Yes ☐ No If yes, then what was the diagnosis, when and by whom? _____

What kinds of treatment have you tried? _____

Current medical doctor: _____

Other healthcare professionals: _____

Other current health problems: _____

Medical History

Significant Past Illnesses: _____

Surgeries (type & date): _____

Social History

Do you:

Use tobacco? ☐ Yes ☐ No How much? _____

Consume alcohol ☐ Yes ☐ No How much? _____

Use recreational drugs? ☐ Yes ☐ No

Use caffeine? ☐ Yes ☐ No

CONTINUED ON BACK

Review of Systems

Please check any symptoms that you are experiencing now or have experienced in the last 3 months.

Head, Ears, Eyes, Nose, Throat
- Dizziness/Vertigo
- Headaches/Migraines
- Ringing in Ears
- Poor Hearing
- Jaw Click/Teeth Grinding
- Teeth/Gum Problems
- Poor Vision/Eye Pain
- Nose Bleeds
- Sinus Problems
- Loss of Smell
- Sores on Lips or Tongue
- Recurrent Colds/Sore Throat
- Allergies

Cardiovascular
- High/Low Blood Pressure
- Irregular Heartbeat
- Chest Pain/Pressure
- Blood Clots
- Cold Hands/Feet
- Swelling in Hands/Feet
- Fainting/Dizziness
- Varicose Veins
- Pain or Cramping in Legs
- Other _____

Respiratory
- Recurring Cough
- Asthma/Bronchitis
- Shortness of Breath
- Tightness in Chest
- Pneumonia
- Production of Phlegm
- What color? _____

Gastrointestinal
- Nausea/Vomiting
- Poor Appetite
- Belching/Indigestion
- Abdominal Pain/Cramps
- Flatulence/Gas
- Diarrhea/Constipation
- Hemorrhoids
- Blood in Stool
- Rectal Pain
- Other _____

Musculoskeletal
- Joint Pain/Stiffness
- Muscle Pain
- Numbness/Tingling
- Neck Pain
- Back Pain
- Shoulder Pain
- Hip Pain
- Knee Pain
- Other _____

Neuro-Psychological
- Frequent Headaches
- Poor Memory
- Seizures
- Depression
- Fear/Anxiety
- Irritability/Anger
- Concussion
- Easily Stressed
- Poor Coordination
- Other _____

Genito-Urinary
- Problems with Urination
- Urgency to Urinate
- Frequent Urination
- Incontinence
- Kidney Stones
- Scanty/Dark Urine
- Wake at Night to Urinate?
- How Often? _____

Skin and Hair
- Dry/Oily/Itchy
- Moles/Lumps
- Rashes/Hives
- Sores/Ulcers

Men

Date of Last Prostate Exam

_____

Women

Pregnancies _____
Births _____
Premature/Miscarry _____
First Menses _____
Last Pap _____
Last Menses _____
Duration of menses _____
Days between menses _____
- Birth Control
- What kind? _____
- Vaginal discharge
- PMS
- Breast Soreness/Lumps
- Other _____

You may discuss the above with the doctor instead of indicating your concern(s) on this form.

Signature _____ Date _____

Physician Signature _____

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Name _____ Doctor _____ Date _____

Please list any current Medications and Supplements below.

(Include all prescribed and over-the-counter items.)

Medication/Supplement	Dosage	Directions

_____ <-- MARK HERE if you used the back to list more medications/supplements.

Any Drug or Other Allergies? No _____ Yes (please list) _____, _____

_____, _____, _____, _____

Do you smoke? ____ Yes ____ No ____ Never - **If Yes:** How many packs per day?_____ How many years did you smoke?_____

If No: Have you ever smoked?_____Yes _____ No

If Yes: How many packs per day: _____ How many years:_____ How many years ago did you quit:_____

If No/Never: Have you been exposed to second-hand smoke?____ Yes ____ No ____ Never

Are you having difficulty in your ability to perform routine daily living activities, or has there been a change since your last visit? No _____ Yes (please explain) _____

_____

Have you had any recent x-rays, imaging or scans? No ____ Yes (please list) _____

Do you have concerns about safety in your home/falls? No _____ Yes _____

Do you have concerns about physical or emotional abuse? No _____ Yes _____ (optional)

(You may discuss the above with the doctor instead of indicating your concern(s) on this form.)

Surgical History:_____

Last Mammogram:_____ **Last Pap**_____ **Last GYN exam**_____

Last Colonoscopy:_____ **Last DRE/PSA**_____

FAMILY MEDICAL HISTORY

Please list ages, health problems and, if deceased, cause of death (only include blood relatives)

Relative	Age	(L)iving or (D)eceased	Cause of Death	Health Concerns: Cancer, Diabetes, Depression, Heart Disease, High Blood Pressure, Stroke, Epilepsy, Mental Illness, Asthma, Kidney Disease, Glaucoma, Tuberculosis, Endocrine Disease (ie. Thyroid, Adrenal), Multiple Sclerosis, Neurological Disease, Auto Immune Disease, etc.
Mother				
Father				
Brothers				
Sisters				
Children				
Grandparents:				
Mother's mom				
Mother's dad				
Father's mom				
Father's dad				

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Patient's **LEGAL** Name _____ aka/Nickname _____ Date _____

Date of Birth _____ Soc. Sec. #_____ Male ___ Female ___ Marital Status _____

Cell Phone:_____ Home Phone:_____

→Can we leave messages with detailed medical information at the contact phone numbers listed above?

(mark one) Yes _____ *No _____ **If "No", to remain HIPAA Compliant, we will be required to leave a vague message asking you to return our call to receive any medical information.*

Email Address:_____ *(used for appointment reminders and Patient Passport System)*

Residence Address (physical address) _____

City _____ State _____ Zip Code _____

Mailing Address (if different) _____

City _____ State _____ Zip Code _____

How long at present address? _____

If patient is a minor, parent/guardian's name _____

Employer _____ Work Phone Number _____

City _____ State _____ Zip Code _____

Responsible Party for Account _____

Address (if different from above) _____

City _____ State _____ Zip Code _____

In Case of Emergency, Whom Should We Notify? _____

Address _____ Relationship _____

Primary Contact Number _____ Alternate Phone Number _____

How did you learn of our Clinic?

Doctor Referral (which physician?) _____

(*circle one*) Personal Referral /Gazette / Simply Family / T.V. / Rimrock Neighbors / Social Media (*circle one*)

Other (please describe) _____

Payment is due at the time of service as we do **NOT** bill insurance.
We accept cash, check and all major credit cards.

Yellowstone Naturopathic Clinic will verify this contact information whenever you come in for an appointment. However, if your circumstances change, it is your responsibility to give us your new contact information.

Signature _____ Date _____

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Clinic Policy

Print Patient Name:_____ **DOB:**_____

Appointments:
Your appointment time has been reserved for you. If you cannot make this appointment, please inform us as soon as possible so that we may give this time to another patient. FAILURE TO PROVIDE US WITH 24 HOURS NOTICE OF APPOINTMENT CANCELLATION WILL RESULT IN A CHARGE TO YOUR ACCOUNT.

Your first visit will be scheduled for 90 minutes. The charge is $310.00**. During this time your doctor will talk with you in depth about your health concerns, pertinent past medical history, etc. Medical records of previous care by other physicians may be requested at this time. Your doctor may also discuss and arrange for laboratory testing to be done before your next visit. Not all lab tests require fasting. Please remember, there is no need to fast unless specifically told to do so.

The second appointment will also cost $310.00**. This appointment is typically 2 - 3 weeks later and includes a comprehensive physical examination, review of laboratory results and an individual treatment plan designed to start you on the road to better health. If you have a health problem of an acute nature, we will address that problem while keeping our primary focus on uncovering and resolving the underlying cause. The charges for the two initial visits do not include any dispensary items that may be prescribed for you.

****Fees, Insurance and Accounts Receivable:**
Subsequent visits are scheduled as brief, routine or extended and are billed at $125, $170 and $230. **We expect payment at the time of visit unless prior arrangements have been made.** Please note that Yellowstone Naturopathic Clinic accepts VISA, Discover, MasterCard and American Express. If you have insurance coverage, we will provide you with a form that includes all the appropriate procedure and diagnostic codes your insurance company will need to process your claim. Unfortunately, Medicare and Medicaid do **not** cover naturopathic care. **We are NOT in-network providers with any insurance company, so there is no guarantee that your insurance plan will cover these charges.** Numerous health insurance companies do cover naturopathic doctors as primary care physicians so we encourage you to check with your insurance company to verify if these services will be covered under your plan.

Phone Consultations and Questions:
Please feel free to discuss with us any questions you may have. During all phases of your care, it is important that you fully understand your treatment program. If you have any questions please address them to the Yellowstone Naturopathic Clinic staff. The staff will relay your questions promptly to the appropriate doctor. The doctors maintain full schedules and may not be able to answer your questions directly or immediately. Either the doctor or a staff member will get back to you as soon as possible. Should you have a number of questions regarding your treatment or progress, we suggest that you make an appointment so that we may properly meet your needs. **Doctor's telephone consultations that extend beyond 5 minutes will be billed to your account.** PLEASE NOTE THAT TELEPHONE CONSULTATIONS ARE NOT USUALLY COVERED BY MOST INSURANCE COMPANIES.

Emergencies:
One of our doctors is on-call 24 hours a day. Calls to the Clinic at 259-5096, outside regular business hours, are automatically transferred to our answering service. The service will then contact the doctor to return your call. For medical emergencies, please call 911.

Acknowledgements:
We hope that you will find your visit with us pleasant as well as beneficial. Our goal is to help you in building better health.

Signing this form acknowledges that you understand and accept the policies of the Yellowstone Naturopathic Clinic.
****All fees subject to change****

Signed _____ Date: _____

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The term 'health care provider(s)' in this form means Yellowstone Naturopathic Clinic, Oasis Health Spa, their physicians, employees and members of the medical staff who provide care to patients.

CONSENT TO TREAT

I give permission to all health care providers involved in my care to administer such examination, treatment, testing and procedures as they deem necessary in the course of my care.

RELEASE OF INFORMATION

I understand that as part of my health care, health care providers create and maintain health records that may include my health history, symptoms, examination and test results, diagnoses, treatment and any plan for care including future treatment. I understand that this information serves as a basis for planning my treatment and care and is a tool for routine health care operations including assessing quality and reviewing competency of our staff and/or other health care providers.

FINANCIAL RESPONSIBILITY

I agree to pay all charges for my health care treatment. If charges to my account are not paid after reasonable notice, the account shall be deemed delinquent. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amounts in default.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for use and disclosure of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

Turn over for more information and signature lines →

Print Patient Name:_____ **DOB:**_____

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request or refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliant Officer. You have the right to review our privacy notice, to request restrictions and to revoke consent in writing after you have reviewed our privacy notice.

Patient's Representative(s): (the following must be filled out, even if the answer is none)
This person is a family member or friend who may call our office on your behalf. Unless their name is listed below, we will not be able to speak with them about your medical concerns.

*** I hereby authorize the following individuals to have access to my healthcare information:**

_____, Relationship to Patient _____
_____, Relationship to Patient _____
_____, Relationship to Patient _____

PHOTOGRAPH

I authorize YNC to take a photograph of me for my file. ☐ **Yes** ☐ **No**

A photo helps us improve medical care. Photos prevent identification errors and (in conjunction with written records) prompt our physicians in recalling your needs, concerns and medical issues. This image will not be shared outside of Yellowstone Naturopathic Clinic. The confidentiality of this image will be maintained in accordance with HIPPA regulations.

TERM

This consent will be in effect for one year from the date signed.

Printed Name of Patient _____ **Date** _____

Signature of Patient or Responsible Party _____

Responsible Party's Relationship to Patient _____

Witness _____ **Date** _____

** *If you would like a copy of this form, once signed, please ask the receptionist* **

Patient Compliance Assurance Notification

To our valued families and patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to insure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also know that we are not perfect! Because of this fact our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. Thank you, for being one of our highly valued patients!

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