Desert Naturopathic Health

Dear Patient,

Thank you for your interest in naturopathic care and the opportunity to work with you. Naturopathic medicine is an approach to care that provides an array of treatment options. More importantly, I believe naturopathic medicine offers a distinctly different way to thinking about health.

The following pages are the start of our comprehensive discussion to learn about you. This form is somewhat long, but I appreciate your time to thoughtfully answer these questions.

The first office visit is where we gather the largest amount of information. Accordingly, this visit can last 1 - 1 ½ hours. In order for me to prepare for this visit, I kindly request that this form be mailed or faxed to Desert Naturopathic Health at least 2 days prior to your first appointment. Additionally, if you have recent laboratory work or pertinent medical records, please bring these to the visit.

Thank you again for your interest in working with me. I look forward to meeting you.

Sincerely,

Jason W. Jensen, NMD

Naturopathic Physician

Desert Naturopathic Health, LLC 20045 N 19th Ave Suite 166 Glendale, AZ 85027
Phone: (602) 888-1201 Fax: (602) 288-0124
www.DesertNaturalHealth.com

Name: _____ (Last, First, MI) DOB: _____

NEW PATIENT INTAKE FORM

Today's Date: _____

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

Name: _____ (Last, First, MI) Sex: _____ Age: _____ DOB: _____

Address: _____ City: _____ State:_____ Zip:_____

Main Contact Phone (list type): _____ Other Phone: _____

Email Address: _____ May we contact you via email? Yes No

Emergency contact: _____ Relationship: _____ Phone: _____

Employer: _____ Occupation: _____

Marital Status: _____ # Children: _____

Primary care physician (PCP): _____ Phone #: _____

Address: City: State: Zip: _____

Date of last PCP visit: _____ Reason: _____

Insurance: _____ Ins ID#: _____ Group Number: _____

Ins. Number: _____(Please provide a copy of your insurance card)

Referred by: _____

Reason for today's visit: (in order of importance)

1. _____
2. _____
3. _____
4. _____

Please list any medical problems that other physicians have diagnosed:

_____

_____

Medication allergies (including reaction when taken):

_____

_____

Name: _____ (Last, First, MI) DOB: _____

Please list ALL **medicines**, prescribed and over the counter (OTC), **including vitamins, herbs, homeopathics, etc**

Medicine	Strength	Times/Day	Reason	Prescriber

Surgeries/Hospitalizations

Year	Reason	Hospital

Childhood Illness (Please circle)

Year	Reason	Hospital
Chicken Pox	Measles	Mumps
Rheumatic Fever	Diphtheria	Pertussis
Other:		

Immunizations (Please circle)

Polio	Pertussis	Tetanus
Diphtheria	Measles/Mumps/Rubella (MMR)	Varicella zoster (Chicken Pox)
Hepatitis B	Flu	Shingles
Other:		

Family Health History

Family Member	Age	Significant Health Problems
Father		
Mother		
Sibling 1 – Male/Female (circle)		
Sibling 2 – Male/Female (circle)		
Grandmother – Maternal		
Grandfather – Maternal		
Grandmother – Paternal		
Grandfather – Paternal		

Name: _____ (Last, First, MI) DOB: _____

Health Habits

Exercise (check one)

_____ Sedentary (no exercise)

_____ Mild Exercise (eg. Climb stairs, walk three blocks, golf)

_____ Occasional vigorous exercise (eg. Work or recreation, less than 4x/week for 30 min each time)

_____ Regular vigorous exercise (eg. Work or recreation, at least 4x/week for 30 min each time)

After exercise, how do you feel? (Energized, Fatigued, Same)? _____

Diet

Number of meals eaten in a typical day: _____

Please provide examples of:

Typical Breakfast & Time of Meal:_____

Typical Lunch & Time of Meal:_____

Typical Dinner & Time of Meal:_____

Typical Snacks: _____

Caffeine (check all that apply)

_____ None

_____ Coffee Number of cups per day _____

_____ Tea Number of cups per day _____ Usual type of tea: _____

_____ Soda Number of cans per day _____

Drug Use:

Do you drink alcohol? Yes No If yes, how many drinks per week? _____

Are you concerned about the amount of alcohol you drink? Yes No

Have you considered stopping? Yes No Do you drive after drinking? Yes No

Are you prone to binge drinking? Yes No

Do you use tobacco? Yes No

Cigarettes/packs per day? _____ Chew per day? _____ Cigars/day? _____

Do you currently use recreational or street drugs? Yes No

If yes, which kinds and how often? _____

Name: _____ (Last, First, MI) DOB: _____

Sexual History

Are you sexually active? Yes No Preference? Heterosexual Homosexual Bisexual

Are you trying for a pregnancy? Yes No If no, type of contraception method used? _____

Any discomfort with intercourse? Yes No

Mental Health

Is stress a major issue for you? Yes No Do you cry frequently? Yes No

Do you feel depressed? Yes No Have you ever attempted suicide? Yes No

Do you panic (anxiety) when stressed? Yes No Have you ever been to a counselor? Yes No

Have you ever thought about hurting yourself or others? Yes No

Exposures History

Have you worked in manufacturing or processing of: _____ Metals _____ Plastics _____Petroleum ____ Glass _____Ceramics _____Paper _____Electronics _____Batteries _____Fiberglass _____Textiles

For how long? _____

Have you had recent exposure to: _____ Chemical Fertilizers _____Pesticides _____Herbicides _____Mold _____Paints _____ Wood Preservatives _____Chemical Dyes _____Cigarette Smoke _____Gasoline _____Nail Salons
Have you lived or worked near: _____ Coal burning plant _____Metal Mine _____Nickel Refinery _____Golf course _____Major Freeway _____Nuclear Plant _____Orchard or Farm

What is your source of drinking water at home (circle one)? Direct from tap Filtered from Tap Well Reverse Osmosis Bottled Water Other: _____

Are you overly sensitive to perfumes, cigarette smoke, gasoline etc.? Y N P

Approximately how many rounds of Antiobiotics have you taken TOTAL in the past? (circle one)

0 1-5 6-10 11-15 16-20 20 or more

Do you take hormones or oral contraceptive pills? Y N P

Do you or did you have water pipes in your home from before 1978? Y N P

Have you used pressure treated lumber before 2003 for building projects, such as decks or playsets? Y N P

Do you have metal fillings in your teeth? Y N P Do you work in a dental office? Y N P

Do you eat seafood more than 3 times per month? Y N P Wild Alaskan/Atlantic/Farmed

Do your symptoms diminish or disappear if you are AWAY from your home or work? Y N P

Which symptoms? _____

Name: _____ (Last, First, MI) DOB: _____

Review of Systems

Weight

Current Weight _____ Weight one month ago: _____ Weight one year ago: _____

Maximum Weight and when: _____ Minimum weight as adult and when: _____

Height

Your current height: _____

REGARDING THE NEXT SECTION: Please circle (Y) if you have the problem CURRENTLY, (N) if you NEVER have had the problem, and (P) if you had the problem in the PAST.

Energy

Good Energy:	Y	N	P				
Fatigue:	Y	N	P				

If you have fatigue, when does it affect you most? What time of day? _____

Skin

Rash:	Y	N	P	Color change:	Y	N	P
Hives:	Y	N	P	Lump:	Y	N	P
Psoriasis:	Y	N	P	Itchy:	Y	N	P
Eczema:	Y	N	P	Warts/Moles:	Y	N	P
Dry:	Y	N	P	Perspiration:	Y	N	P
Cancer:	Y	N	P				

Head

Headache:	Y	N	P	Migraine:	Y	N	P
Dandruff:	Y	N	P	Head injury:	Y	N	P
Oily hair:	Y	N	P	Hair loss:	Y	N	P
Dry hair:	Y	N	P				

Nose

Colds:	Y	N	P	Nosebleeds:	Y	N	P
Congestion:	Y	N	P	Post nasal drip:	Y	N	P
Polyps:	Y	N	P	Seasonal allergies:	Y	N	P

Name: _____ (Last, First, MI) DOB: _____

Eyes

Dry eyes:	Y	N	P	Itchy eyes:	Y	N	P
Watery eyes:	Y	N	P	Blurry vision:	Y	N	P
Double vision:	Y	N	P	Cataracts:	Y	N	P
Glaucoma:	Y	N	P	Discharge:	Y	N	P
Eye strain:	Y	N	P	Dark under eyelids:	Y	N	P

Mouth/Throat

Canker sores:	Y	N	P	Cold sores:	Y	N	P
Sore throat:	Y	N	P	Gum disease:	Y	N	P
Dentures:	Y	N	P	Cavities:	Y	N	P
Loss of taste:	Y	N	P	Hoarseness:	Y	N	P
Difficult swallowing:	Y	N	P	Sore throat:	Y	N	P

Neck

Stiffness:	Y	N	P	Tension:	Y	N	P
Swollen glands:	Y	N	P				

Respiratory

Cough:	Y	N	P	Wheezing:	Y	N	P
Shortness of breath				TB:	Y	N	P
w/exertion:	Y	N	P	Bronchitis:	Y	N	P
Shortness of breath				Asthma:	Y	N	P
w/sitting:	Y	N	P	Painful Breathing:	Y	N	P
Shortness of breath							
w/lying down:	Y	N	P				

Cardiovascular

High blood pressure:	Y	N	P	Rheumatic fever:	Y	N	P
Low blood pressure:	Y	N	P	Murmurs:	Y	N	P
Arrhythmias:	Y	N	P	Palpitations:	Y	N	P
Edema:	Y	N	P	Chest pain:	Y	N	P

Name: _____ (Last, First, MI) DOB: _____

Gastrointestinal

Heartburn:	Y	N	P	Freq of Bowel movements: _____/day			
Indigestion:	Y	N	P	Recent BM change:	Y	N	P
Bloating:	Y	N	P	Diarrhea:	Y	N	P
Nausea:	Y	N	P	Constipation:	Y	N	P
Vomiting:	Y	N	P	Hemorrhoids:	Y	N	P
Change in Appetite:	Y	N	P	Liver/Gall Bladder Dz:	Y	N	P
Pancreatitis:	Y	N	P	Ulcer:	Y	N	P

Musculoskeletal

Weakness:	Y	N	P	Arthritis:	Y	N	P
Stiffness:	Y	N	P	Leg cramps:	Y	N	P
Tremors:	Y	N	P	Pain:	Y	N	P

Nervous

Paralysis:	Y	N	P	Sciatica:	Y	N	P
Tingling/numbness:	Y	N	P	Carpal tunnel:	Y	N	P
Seizures:	Y	N	P	Fainting:	Y	N	P

Mental/Emotional

Depression:	Y	N	P	Anger/Irritable:	Y	N	P
Suicidal:	Y	N	P	Tense:	Y	N	P
Anxiety:	Y	N	P	Fear/panic:	Y	N	P
Eating disorder:	Y	N	P	Psych hospitalization:	Y	N	P

Urinary Tract

Incontinence:	Y	N	P	Pain w/urination:	Y	N	P
Freq. infections:	Y	N	P	Kidney stones:	Y	N	P
Urgency:	Y	N	P	Discharge/blood:	Y	N	P

Name: _____ (Last, First, MI) DOB: _____

Male

Testicular Pain:	Y	N	P	Testicular Swelling:	Y	N	P
Discharge:	Y	N	P	STD:	Y	N	P
Hernia:	Y	N	P	Prostate Disease:	Y	N	P

Last Prostate Exam (DRE): _____ Abnormal DRE? Y N P

1. Do you have a decrease in libido (sex drive)? Y N
2. Do you have a lack of energy? Y N
3. Do you have a decrease in strength and/or endurance? Y N
4. Have you lost height? Y N
5. Have you noticed a decreased "enjoyment of life"? Y N
6. Are you sad and/or grumpy? Y N
7. Are your erections less strong? Y N
8. Have you noticed a recent deterioration in your ability to play sports? Y N
9. Are you falling asleep after dinner? Y N
10. Has there been a recent deterioration in your work performance? Y N

Female

Age of first menses: _____				How often menses occurs: _____ days			
How long menses lasts: _____				Heavy bleeding:	Y	N	P
Menstrual cramps:	Y	N	P	Menstrual pain:	Y	N	P
PMS:	Y	N	P	Food cravings:	Y	N	P
Number pregnancies: _____				Healthy libido:	Y	N	P
Number of births: _____				Vaginitis:	Y	N	P
Number of miscarriages: _____				Mammography:	Y	N	P
Last pap smear: _____				Vaginal dryness:	Y	N	P
Abnormal pap:	Y	N	P	Pain w/intercourse:	Y	N	P
Menopause since what age: _____				STD:	Y	N	P
Hormone replacement:	Y	N	P				

Hysterectomy (Date): _____ Ovaries intact? Y N Reason for Hysterectomy: _____

Ovarian Cyst: _____ Cancer _____ Uterine Fibroids: _____

Please list any birth control usage including what ages used:

_____

Name: _____ (Last, First, MI) DOB: _____

Sleep

What time do you typically go to bed? _____ What time do you wake up? _____

How long per night? _____ If you wake, for what reason? _____

What time(s) do you frequently wake? _____

Nightmares:	Y	N	P	Wake refreshed:	Y	N	P
Sleep walk:	Y	N	P	Grind teeth:	Y	N	P
Must nap during day:	Y	N	P	Snore:	Y	N	P

Please include any other concerns that you have that have not been addressed in this questionnaire:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to fill out this questionnaire thoughtfully and carefully.

Desert Naturopathic Health

Rescheduled / Cancelled Appointments
After-Hour / Emergency Appointments
NSF Check Fees / Insurance Reimbursement

Appointments:

The patient is ALWAYS responsible to call **24 hours prior to the scheduled appointment time** to reschedule or cancel. Failure to do so will result in a $ 45.00 charge to the patient for the missed appointment.

If you need to reach a doctor after regular business hours, there will be a $75 fee for the urgent phone call**.** If you have an emergency, please call 911.

Prescription Refills:

Please allow 7 days for normal prescription refills. Supplements may be purchased online, picked up at our office, or both. Please call us for more information and visit our medicinary online.

NSF Checks:

NSF checks that are returned to us will automatically mean a charge to the patient account of $25. The patient will be responsible to replace the amount of the check in addition to the $25 Non Sufficient Funds amount.

Payment for services:

An insurance policy is a contract between you and your insurance company. The patient is ALWAYS responsible for payment of all charges incurred regardless of any insurance or other third party payment arrangements.

- Payment will be collected at the time of service.
- Any lab kits purchased are non-refundable after 30 days.
- Most insurance companies do not cover Alternative Medical procedures. This includes but is not limited to Acupuncture, Colonics, Vitamin injections, Microscopy, Intravenous Nutrition and Metabolic Therapy.

The natural medicines that are prescribed by the center's physicians may be purchased here or at the pharmacy of your choice.

I certify that I have read and understand the above policies. I guarantee payment of all charges incurred as a patient of Desert Naturopathic Health, LLC.

Signed: ____

Parent or Guardian (if minor): ________________________________

Date: ____

Desert Naturopathic Health

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices (subsequent pages) for the office of Dr. Jason Jensen and Desert Naturopathic Health, LLC.

________________________________	__________________________
Patient or legally authorized individual signature	Date
________________________________	__________________________
Printed Name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative, etc.)

Revisions (if any):

____

____

____

- -

For Office Use Only

- -

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because (please specify):

____

____

____

Desert Naturopathic Health

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement officials.
4. When necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation or similar programs.
9. In cases of suspected child abuse or dependent adult or elder abuse, for which we are required by law to report.
10. If a patient is threatening serious bodily harm to another person(s), we must inform the intended victim.
11. If a patient intends to harm oneself, we must act to protect the life of the patient.

Your rights regarding your health information:

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Dr. Jason Jensen at Desert Naturopathic Health, 20045 N 19th Ave, Suite 166, Phoenix, AZ 85027. *Note: We must respond to this request within 30 days.*

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Dr. Jason Jensen, at Desert Naturopathic Health, 20045 N 19th Ave, Suite 166, Phoenix, AZ 85027. You must provide us with a reason that supports your request for amendment. *Note: We must respond within 60 days. The Privacy Officer or the patient's physician will usually do this. If the physician believes the information is complete and accurate, the physician can refuse to make any changes.*

5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the Office Manager.

6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager at Holistic Health Solutions, 20045 N 19th Ave, Suite 166, Phoenix, AZ 85027. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the Office Manager.

Desert Naturopathic Health

Consent to Treatment

Patient Name: _____
Date of Birth: _____
Social Security No.: _____
Today's Date: _____ Time: _____ am / pm

I, _____ (dated _____), hereby voluntarily consent to outpatient care at Desert Naturopathic Health, LLC, encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), and administration of medications prescribed by the physician.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including their designees as is necessary in the medical staff's judgment.

I understand that the treatment suggestions provided are not all accepted by the United States FDA and therefore should not be taken as such.

I understand that this consent form will be valid and remain in effect as long as I receive medical care at Desert Naturopathic Health, LLC.

This form has been explained to me and I fully understand this *Consent to Treatment* and agree to its contents.

Comments:
_____
_____

Signature of Patient or Person Authorized to consent for patient:

_____

Signature of Witness who explained the contents of this "Consent to Treatment" form:

_____

Desert Naturopathic Health, LLC 20045 N 19th Ave, Suite 166 Phoenix, AZ 85027
Phone: (602) 888-1201 Fax: (602) 926-0180
www.DesertNaturalHealth.com

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

Desert Naturopathic Health

Fee Schedule and Contract

Dr. Jensen does not provide any primary, urgent, or emergent medical care. All patients must retain their own primary care provider except in authorized circumstances. For any significant after-hours medical problems, patients must contact their primary care doctor or go to an emergency room. Dr. Jensen is available during business hours on M-T-W-Th, and schedules most appointments via Telehealth. He will answer e-mails within 24hrs unless otherwise noted. Please check your spam or junk email folder for lost correspondence. Supplement recommendations are sent via FullScript.

An in-office consultation is required at least once per year to renew prescription hormone therapy, except in unusual circumstances. A phone or office consult is required to renew prescriptions. Patients should have labs drawn soon after the date specified so that an appointment can be arranged before refills run out. If no labs are needed, call our office for an appointment after obtaining your last refill. There is a minimum $10 charge for refills needed due to failure to do labs or arrange a consult on time.

Basic Fee: $7 per minute for consultation and documentation time

Office Consultations	
New Patient Visit	**$225**
Follow up Visits	
30 minutes or less, minimum charge	**$90**
45 minutes	**$125**
60 minutes	**$170**
15min Increments	**$45**
Phone Consultations including post-call documentation time, minimum charge	**$90**
30 minutes or less, >30 min 15min increments at $45/15min, Same as Office Consultations	
E-mail Correspondence (for established patients)	**Free**
Including a new prescription or laboratory test request	**$20**
Including two or more prescriptions and/or lab request, in lieu of a consultation	**$30-$70**
Late Refills and Replacement Laboratory Requests	**$15**
(All interim charges are added to the patient's account, to be paid at next phone or office consultation.)	
Formal Letters and Reports	**$50-$100**

Fees are subject to change without notice. The above fee schedule does not include costs for lab tests, hormones, or supplements, which the patient will purchase directly from the supplier. Dr. Jensen does not bill insurance for consultations and does not participate in Medicare, Medicaid, or any insurance plans. Patients may submit paid invoices to their medical insurance, but not all will reimburse for services provided by a non-participating physician. Lab tests and hormones are generally covered by Medicare or PPO private insurance plans if the insurer agrees that the test or prescription is necessary. HMO's will not cover tests or prescriptions ordered by doctors who are not in the HMO. Cash pay lab services are available, and will be paid directly to Desert Naturopathic Health, LLC to receive patient discount, or can be paid directly to laboratory at a higher rate.

I understand that I am responsible for Dr. Jensen's fees for determining whether labwork will be covered by my insurance before undergoing testing ordered by Dr. Jensen.

Signed **Date**

Desert Naturopathic Health, LLC 20045 N 19th Ave Suite 166 Phoenix, AZ 85027
Phone: (602) 888-1201 Fax: (602) 288-0124
www.DesertNatural.com

HIPAA email consent

VERY IMPORTANT! PLEASE READ!

- HIPAA stands for the *Health Insurance Portability and Accountability Act*
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored on our computers is encrypted
- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email
- **When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.**
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA
- The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website - http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email

OPTION 1 – **ALLOW** UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to Desert Naturopathic Health to send me personal health information via unencrypted email.

Signature (parent or guardian if patient is a minor)	**Date**	**Printed name**	**Please print email address**

OPTION 2 – **DO NOT ALLOW** UNENCRYPTED EMAIL

I do not wish to receive personal health information via email

Signature (parent or guardian if patient is a minor)	**Date**	**Printed name**

Please bring completed form to your visit