Maureen S. Wilson, N.D.

CONFIDENTIAL PATIENT INFORMATION

Name ____ Date of Birth _____/_____/_____ Age ____

Email____ free health updates provided

Address ____

City ___________________ State _________ Zip _________ Home Phone ______________________

Occupation __________________________________ Cell Phone ______________________

If Married, Name of Spouse ____

Whom to Contact in Case of an Emergency ____

Phone ___________________________

How Did You Hear About Us? ____

Please select one of the following:

- ☐ I give my authorization and consent for lab results and other private health information relating to my treatment at Alternatives in Health to be left on an answering machine or voice mail. A message may be left at the following number:______________________

- ☐ I do not want any private health information to be left on an answering machine or voice mail. I understand that I will only receive a message that I am to call Alternatives in Health. It will be my responsibility to do so to receive my results.

What is your primary health problem or concern? ____

How long has this been troubling you? ____

What additional health problems or concerns would you like to address?
____

Please list your goals for improving your health ____

Allergies to Medications____

Family History

Please list ages, health problems and if deceased, cause of death:

	Age	Health Problems	Died (age?)	Cause
Your Mother	_____	_______________________	_____	____________
Your Father	_____	_______________________	_____	____________
Your Brothers	_____	_______________________	_____	____________
	_____	_______________________	_____	____________
Your Sisters	_____	_______________________	_____	____________
	_____	_______________________	_____	____________
Your children	_____	_______________________	_____	____________

415-786-3931
phone/fax 1-800-609-4036

Have you had any previous hospitalizations or surgeries?

Date (aprox) Procedure

_____________ ____

_____________ ____

_____________ ____

Current Medications:

Name Strength and Dosage For how long?

1. ____
2. ____
3. ____
4. ____
5. ____

Vitamins, Herbs or Nutritional Supplements:

Name Strength and Dosage For how long?

1. ____
2. ____
3. ____
4. ____
5. ____

Do you use any of the following?:

- ☐ Cigarettes _____ packs per day for _____ years
- ☐ Alcohol_____ drinks per ___ day ___ month of ________________
- ☐ Marijuana or other drugs _____ times per month
- ☐ Coffee or black tea _____ cups per day
- ☐ Sodas _____ drinks per day

Subjective Stress Assessment

Directions: Place an "X" on the position of the line that corresponds most closely to how you rate yourself on the scale below.

For example:
Relaxed
/------------X-------------/---------------------------/
Tense

Relaxed -- Tense

Calm -- Anxious

Worry Free -- Worry Excessively

Happy-- Depressed

High Energy -- Low Energy

Sleep Well -- Sleep Poorly

Women

Menses:
Started at age ___________ Stopped at age ______________

Regular / Irregular Short cycle _____________ days / Long cycle ____________ days

Clotting _____________ Color ________________ Amount ________________

PMS________________ Symptoms ____

Date of last PAP ______________________ Abnormal PAP's ___________________________________

Birth control ____ Pregnancies ______________________

Men

Date PSA was last checked___________ any difficulty urinating _________
Other ____

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Financial Policy

Thank you for choosing Dr. Maureen S. Wilson for your healthcare, we are committed to providing the best care possible. Please understand that the payment of your bill is considered a part of your treatment. The following statement explains our financial policy which we ask you to read, sign and return to us prior to your treatment. Your payment is due at the time services are provided. We gladly accept cash, check or credit cards (Visa or Mastercard).

Naturopathic medicine may be covered by some PPO plans. Check with your insurance company to determine if this is a covered benefit for you. We do not submit billing claims for you. A superbill will be provided for you to send in to your insurance company for reimbursement.

We reserve the right to report any balances due to any and all credit reporting agencies. Your signature on this form is your consent to agreement that in event of any default of payment you will pay collection fees and /or attorney fees as well as any other costs incurred by Summer's House of Health and Healing, in addition to your outstanding balance. I understand that I am financially responsible for the charges that I incur during my treatment under the care of Maureen S. Wilson, N.D. I have read and agree to the financial policy.

Cancellations: Please provide a 24-hour notice of cancellation. For unforeseen emergencies, which require cancellation, please notify as soon as possible. Our policy is to charge for missed appointments without appropriate notice. Please help us to serve you better by keeping scheduled appointments.

Average cost You may expect your average visit to cost between 100-500 dollars depending on complexity of case, services provided, laboratory fees and supplements purchased.

Calls to Doctor: There will be charges for phone consultations equal to in office consultations. Please have all questions ready to take the most advantage of your time.

Payment: ***PAYMENT IS EXPECTED AT THE TIME OF SERVICE.*** Overdue accounts will be referred to a collection agency.
Insurance: You are encouraged to submit any physician visits or lab work directly to your insurance company. Medicare does not cover naturopathic care, however, you may wish to submit visits and lab work.

Informed Consent: I consent to the use and/or disclosure of my protected health information by Maureen S. Wilson, N.D. for purposes of diagnosing or providing treatment to me or obtaining payment for my health care bills. I consent to treatment and understand that Dr. Wilson is a licensed Naturopathic Doctor in the states of California and Arizona. I understand and agree that diagnosis or treatment of me by Dr. Wilson may be conditioned upon my consent as evidence by my signature on this document.

I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE, I AM RESPONSIBLE FOR THE BALANCE ON THIS ACCOUNT FOR ANY SERVICES, SUPPLEMENTS, MEDICINES, AND LABORATORY WORK.

SIGNATURE ____ DATE _______________________

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