Natural Health Improvement Center

PATIENT REGISTRATION

Patient's Legal Name: _____ Date of Birth: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Primary Phone Number (Home or Cell): _____ Other: _____

May we leave detailed messages regarding your health information at your primary contact number? Yes/No _____(initial)

Social Security Number: _____ Male: _____ Female: _____

Primary Care Physician**:** _____

Are You on Medicare? Yes or No Marital Status: Single _____ Married _____ Widow(er) _____ Divorced _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Number (Home or Cell): _____ Other: _____

How did you hear about us? Website____ Facebook____ Existing Patient/Other (specify):_____

Email address: _____Would you like to receive info from NHIC? _____

----------NOTICE OF PRIVACY PRACTICES----------

By law we are required to provide you with our Notice of Privacy Practices (NPP & HIPAA). Our NPP book that fully describes our regulations given by HIPAA is available for you at the front desk and is also provided to you at your initial appointment at the Natural Health Improvement Center.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: "I hereby acknowledge that I understand NHIC's Notice of Privacy Practices and was provided access to my rights. I fully understand that if I have questions or complaints regarding my privacy rights that I may contact the designated HIPAA contact at NHIC. I further understand that the practice will offer me updates to this NPP in the provided NPP materials located at the front reception area should it be amended, modified, or changed in any way. I have the right to this information and fully understand my rights in the Notice of Privacy Practices."

_____

Print: Patient's Name

_____ _____

Signature: Patient's Date

☐ Patient Refused to Sign ☐ Patient was unable to sign because:_____

----------CONSENT TO DISCLOSE INFORMATION----------

I hereby give consent to Dr. Auburn & staff to disclose/discuss my medical information with the following parties (ie. Family):

Name: Relationship:

_____ _____

_____ _____

Specific Information NOT to be disclosed to any party:

_____

_____

I understand by giving my consent to disclose/discuss my information with the above parties, the doctor and the staff at NHIC will not be held liable by HIPAA protocol of doctor patient confidentiality with specified persons. I further understand that if I wish to remove any person(s) from the list that it is my responsibility to change the information on this form.

_____ _____

Signature: Patient's Date

Natural Health Improvement Center

GENERAL INFORMED CONSENT

Patient Name: _____ Date: _____
(Please Print) (M/D/YR)

I have sought the health care services of Ann Auburn, DO of the *Natural Health Improvement Center* for my personal care (or that of my family). I understand that this health care practice uses diagnostic and treatment methods that are known as complementary, alternative, or holistic as an integrated part of the family practice services which are also available here.

The terms *complementary, alternative,* and *holistic* refer to therapies that may include, but are not limited to, dietary and nutritional supplement advice, homeopathy and various diagnostic/testing procedures in conjunction with outside laboratories. Furthermore, the information gained from laboratory and evaluation tests may be interpreted differently from mainstream medical doctors. Approaches for improving general health and nutrition may be based upon the tests/evaluations and philosophies of complementary medicine and may or may not be consistent with mainstream medical tests/evaluations and philosophies.

Although prescriptions and over-the-counter medications are used when the health care provider deems necessary, foods, vitamins, minerals, enzymes, herbs, and other nutritional approaches may also be chosen as therapy or as adjunctive to medical therapies.

Many of the services, products, and outside laboratory tests that this office uses or recommends, are not covered by traditional medical or health insurance and/or benefits. Although we employ only those treatments, therapies, and diagnostic approaches we feel represent the most efficient and effective way to restore and maintain health, many of these would be considered as "experimental" or "unproven" or not of the consensus of medical opinion.

The doctor(s) here are not affiliated with any hospital. If you need to be hospitalized, the doctors at the hospital can reach Dr. Auburn if needed. Patients needing hospital care are instructed to go to the Emergency Room if their condition needs hospital attention.

By choosing to be a patient at our office, you are financially responsible for all services and products rendered at the office. If you have any financial concerns about the costs of your care, please discuss them with the Front Desk Receptionist or ask to speak to the Office Manager.

Dr. Auburn and Associates believe in a holistic approach. Therefore, she and her other practitioners will not recommend or condone the use of the following categories of medications at this practice: anti-psychotics, antidepressants, anti-anxiety meds, and some of the more harmful sedatives. There are many studies and reports that confirm addiction and harm to the human body with short and prolonged use of the above meds. If you are currently on any of these categories of drugs, then ensure that you maintain a relationship with the doctor who is currently prescribing these. Prescriptions for these meds will NOT be written nor managed through this office. This type of treatment is out of the scope of this office. IF however, you wish to use natural means to manage pain, anxiety or other difficulties, then discuss this with your practitioner here. There are many natural remedies that one can use as an option which not only work, but are not addictive, nor harmful in the long run to your brain or your body. Dr. Auburn understands the benefits of cannabinoids from hemp and marijuana and agrees with the use of topical CBD, however, she does not condone the use of THC. The physicians of the Natural Health Improvement Center will not write for a medical marijuana card. If you are questioning the use of medical marijuana, your physician may have other recommendations.

We are pleased you have decided to partner with us in the goal of improving your health. We feel that offering the best of conventional and complementary medicine in an integrated approach, is in the best interest of our patients.

Signed: _____ Date: _____
(Patient Signature)

Witness: _____ Date: _____

Natural Health Improvement Center

FINANCIAL POLICY

We wish to ensure that a visit to Natural Health Improvement Center is a pleasant experience. We fully believe that every patient has a right to know, and have the clinic provide, complete information about fee policies and payment requirements. We appreciate total payment at the time services are rendered. Payment may be made by cash, check, Master Card, Discover, Visa and American Express. A Superbill will be provided to you that you may send to your personal insurance provider, if services are covered under your plan ***(Medicare beneficiaries, please see the Physician-Patient Private Agreement).*** Contact your insurance provider to learn how to file your claim properly.

Please note that we do require a copy of your insurance card on file in order to bill some lab work, to set up any needed referrals and to complete prior authorizations.

NHIC does not file insurance claims in order to keep patient fees at a minimum. We will however assist in providing you with accurate information so that you may bill your insurance company. The patient remains in full financial responsibility of their account and payment at the time of services. The patient also understands that insurance fraud is a crime and is punishable by law. If you have any questions regarding our financial policy, please speak to our receptionist.

Medicaid Patients: Providers of the Natural Health Improvement Center are not enrolled in Medicaid. Claims for laboratory services or prescriptions ordered by providers who are not actively enrolled in Medicaid are no longer paid by Medicaid, resulting in full payment by the patient.

CANCELLATION AND NO-SHOW POLICY

Appointments must be cancelled at least 24 hours prior to the scheduled appointment time. Patients cancelling with less than 24-hour notice will incur a $50 missed appointment fee or 50% of the cost of I.V.s or injections that have been prepared for you. In the event a patient arrives greater than 15 minutes late to their appointment and cannot be seen by the provider on the same day, they will be rescheduled. In the event of a no-show, the patient will be billed a $100 missed appointment fee. A subsequent, consecutive no-show/late cancellation will result in a fee for the entirety of the office visit charge. This is $155 for a P.A. or $165 for Dr. Ann Auburn. A third occurrence may result in dismissal from the NHIC.

X_____ _____

Patient or Authorized Person's Signature Date

INSURANCE INFORMATION

Name of Primary Insurance: _____ Policy Number: _____

Subscriber Name: _____ Group Number: _____

Employer: _____Subscriber DOB: _____ Effective Date: _____

Name of Secondary Insurance: _____ Policy Number: _____

Subscriber Name: _____ Group Number: _____

Employer: _____Subscriber DOB: _____ Effective Date: _____

Natural Health Improvement Center

Health Maintenance and Preventive Health Care Recommendations

Patient Name: _____ Date: _____

Name of Primary Care Physician: _____

Date of Last Physical: _____

The physicians of the Natural Health Improvement Center are always striving to bring you the best in maintenance healthcare and preventive care. Therefore, we would like to remind you that certain health examinations and screenings are recommended on a regular basis. Please review the recommendations below, and then speak to your physician about which ones are right for you. In addition, please sign this form stating that you have read and understand these recommendations.

AGE	**RECOMMENDED SCREENING**	**FREQUENCY**
Men and Women		
18 years and older	Blood Pressure, Height, Weight, Physical	Every 1-3 years or as recommended by your physician.
35 years and older (earlier if at risk)	Lipid Profile Blood Chemistry Profile Complete Blood Count	Yearly or more if at higher risk/ by provider discretion
40 years and older (only recommended for higher risk patients)	ECG	Provider discretion depending on level of risk *Research shows little benefit of routine EKGs for low risk, asymptomatic patients. Research is inconclusive for higher risk patients and NHIC providers may still recommend EKGs for those patients they feel would benefit.
45 years and older until age 85	Stool sample for microscopic blood OR visual screening (for colorectal cancer)	Yearly fecal occult blood test **OR** Cologuard test every 3 years (sooner depending on risk or provider recommendation) **OR** colonoscopy every 10 years. *Any abnormal fecal occult or Cologuard test should be followed up with a colonoscopy.
Women		
25 years and older until age 65 if PAPs have been normal in the past. *As of 2020, the National Cancer Institute does not recommend cervical cancer screening for women under 25 years of age.	Pap, pelvic exams https://www.cancer.gov/news-events/cancer-currents-blog/2020/cervical-cancer-screening-hpv-test-guideline Breast Exams	Every 3 years for PAP, pelvic exams. Every 5 years for HPV. The NHIC recommends self-breast exams at least monthly.
40 years and older (or age 30 years if strong family history of breast cancer)	Mammography and/or Thermography	The NHIC recommends Mammogram **OR** Thermogram yearly.
65 years (or age 50 if menopausal, have a family history of osteoporosis, or are considered at greater risk for reasons such as petite frame, Caucasian ethnicity, or steroid medications).	Bone density measurement	Every 2 years (or yearly if severe osteoporosis)

Natural Health Improvement Center

Men		
50 years and older (or 45 years if at higher risk)	PSA blood test Prostate exam *The research shows that PSA level is the most effective method to detect prostate cancer, however there are some exceptions. Therefore, physicians may still recommend the traditional prostate exam.	1-2 years for PSA level. Can go to every 2 years if previous PSA was less than 2.5ng/mL. 1-2 years for prostate exam depending on physician recommendation.
65 years and older	Bone density measurement	The NHIC recommends every 2-5 years depending on the baseline measurement.

I have read and fully understand the Health Maintenance and Preventive Health Care Recommendation forms. I understand that it is my responsibility to take the appropriate action to make arrangements for the necessary exams, as well as any follow-up testing or treatments that may be recommended by my primary care or specialty physicians.

Signature: _____ Date: _____

Witness: _____ Date: _____

Sources:

American Academy of Family Physicians

American Cancer Society

American College of Cardiology

The Journal of the American Medical Association (JAMA)

National Cancer Institute (NIH)

Priority Health/ gvsu.edu

U.S Preventative Task Force Services

Natural Health Improvement Center
ONLY SIGN IF YOU HAVE MEDICARE INSURANCE
Physician-Patient Private Contract (Medicare Opt-Out Agreement)

This agreement is between the physicians of the Natural Health Improvement Center (Physician) and _____ (Medicare beneficiary, referred to in this contract as "Patient").

Dr. Ann Auburn, DO and the practitioners of the Natural Health Improvement Center have elected to opt-out of Medicare. A physician who opts out of Medicare is not required to submit claims on behalf of beneficiaries and is not subject to Medicare limits on charges for covered services.

The undersigned patient/Medicare beneficiary (or legal representative) is signing this private contract to evidence his or her understanding and agreement regarding payment for any services to be provided by The Natural Health Improvement Center.

Physician hereby certifies that Physician is not and has not been excluded from participation in the Medicare program under section 1128 or other applicable sections of the Social Security Act. Physician certifies that the effective date of Physician's opt-out is January 1st, 2017, and the estimated date of expiration of the opt-out period is December 31st, 2024, provided that Physician may extend the opt-out period further.

By executing this private contract, Patient acknowledges and agrees as follows with respect to all items or services provided by Physician to Patient:

1. That Patient will not submit a claim, or request Physician to submit a claim, for payment under Medicare, even if such items or services would otherwise be covered under Medicare.
2. That Patient agrees to accept full responsibility for payment in full at the time of service, in accordance with Physician's current fee schedule.
3. Patient understands that NO reimbursement can or will be provided by Medicare for such items of services provided by Physician.
4. That Physician is not limited by Medicare in the amount that he or she may charge Patient for the items or services provided, and that Patient will pay Physician's charges in full at time of service or use CareCredit financing option.
5. That Medigap plans do not make payment, and other Medicare supplemental insurance plans do not make payment, for items or services furnished by Physician.
6. That Patient has the right to have the items or services sought from Physician to be provided by other physicians or practitioners whose items or services would be covered by Medicare.
7. That Patient is not in an emergency or urgent health care situation.
8. That Patient agrees to reimburse Physician for any costs, collection fees, and reasonable attorney's fees that result from violation of this Agreement by Patient.
9. That Patient acknowledges a copy of this Agreement has been provided to Patient.
10. That Patient signs this Private Contract voluntarily and upon full understanding of its terms.

Patient/Medicare Beneficiary Signature: _____ Dated _____
Patient's Name: _____
If Representative, print name and relationship:_____

Physician:

Ann M. Auburn, DO Kristen L. Taylor, PA-C Linda Huizenga, PA-C Mary VanderWal, FNP, PhD

Natural Health Improvement Center

NHIC Patient History Intake Form

Name:

Date:

Date of Birth:

Primary Care Phys.

Please attach any additional information that is not covered in the form below or any information that you'd like your health care provider to have for your initial clinic office visit.

Sex: Male ____ Female_____

Race: Caucasian, African American, Hispanic, Other_____(please write in)

Chief complaint- Why are you here to see the doctor? _____

_____

What are your health care goals for your treatment at the Natural Health Improvement Center?

_____

_____

History of present illness:

When did your illness or problem start? _____

What are your symptoms? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

What have you done for this problem? _____

Past Medical History

Please check √ any of the following that apply to you:

- o Diabetes
- o Heart Attack
- o Stroke/TIA
- o Hypertension
- o Cancer, Type:_____
- o Tuberculosis
- o Lung disease (asthma, emphysema, other)
- o Ulcers, IBS, gastro disease
- o Renal failure/kidney disease
- o History of blood clots
- o Depression
- o Anxiety
- o Migraines/headaches
- o Arthritis/other joint or muscle diseases, if yes, where? _____ _____
- o Fibromyalgia
- o Other disease/condition not listed above: _____ _____

Family History (mother, father, siblings)

o Unknown Family History

Please check all that apply to your family medical history and please specify which relative.

- o Diabetes _____
- o Hypertension_____
- o Heart Attack_____
- o Stroke or TIA_____
- o Lung disease (asthma, emphysema, other) _____
- o Cancer_____
- o Tuberculosis_____
- o Ulcers, IBS, gastro disease_____
- o Kidney disease/failure_____
- o Neurological disease (Alzheimer's/Multiple Sclerosis/other) ___ _____
- o High cholesterol _____
- o Arthritis _____

Natural Health Improvement Center

Other diseases/conditions not listed above: _____

_____

Allergies: List name of medicine/animal/food/environmental items:

Item: _____ reaction: _____

Item: _____ reaction: _____

Item: _____ reaction: _____

Surgeries, procedures and hospitalizations (attach additional page if necessary):

Date of surgeries: Type of surgery:

_____ _____

_____ _____

Procedures:

Colonoscopy date done:_____ outcome:_____

Bone Density date done:_____ outcome:_____

Other (write in procedure):

_____ date done:_____ outcome:_____

_____ date done:_____ outcome:_____

Hospitalizations (write in where and reason for admission to hospital):

_____ date:_____ outcome:_____

_____ date:_____ outcome:_____

Social history:

Exercise Regularly ☐ Yes ☐ No If yes, what?_____ How often?_____

Alcohol? ☐ Yes ☐ No If yes, how much?_____How often?_____

Over-the-counter meds ☐ Yes ☐ No Type:_____How often?_____For what?_____

Recreational drugs ☐ Yes ☐ No Type: _____How often? _____ # of years: _____

Married ☐ Yes ☐ No # of children:____ Ages: _____

Employment: _____ Hobbies: _____

Exposure to carcinogens/ environmental toxins? What:_____ When:_____

Diet, list what you eat in a typical day: Specific food restrictions: dairy/wheat/gluten/eggs/soy/corn/other

Breakfast: _____

Lunch: _____

Dinner: _____ Snacks: _____

Natural Health Improvement Center

Review of systems (Rate each 0-none, 1-mild, 2-moderate, 3-severe)

General:
- — weight gain
- — weight loss
- — appetite loss
- — appetite excess
- — fever
- — chills
- — fatigue
- — night sweats

Skin:
- — Rashes
- — Bruises
- — easy bruising or bleeding tendencies
- — skin discolorations or lesions

Head:
- — Headaches
- — Dizziness
- — Seizures
- — Head trauma

Eyes:
- — Visual changes
- — Near/farsighted
- — Double vision
- — Dryness
- — Watering

Ears:
- — Ringing
- — Dizziness
- — Pain
- — Drainage
- — Wax
- — Hearing loss

Lymphatics:
- — Swollen lymph nodes in armpits or groin, other

Nose:
- — Drainage
- — Sinus pressure or pain
- — Nosebleeds
- — Seasonal allergy symptoms

Mouth/Throat
- — Dental disease
- — Hoarseness
- — Sore throat
- — Pain
- — Difficulty swallowing
- — Masses sores

Respiratory
- — Cough
- — Shortness of breath
- — Phlegm
- — Chest pain
- — History of TB
- — History of pneumonia

Cardiovascular:
- — Chest pain
- — Shortness of breath with activity of laying down
- — Swelling of extremities
- — Heart palpitations
- — Irregularity or racing
- — Pain in legs with walking

Gastrointestinal:
- — Difficulty swallowing
- — Abdominal pain
- — Nausea
- — Vomiting
- — Diarrhea
- — Bloody stools
- — Constipation
- — Gas/Bloating
- — Change in bowel habits

Genitourinary:
- — Painful urination
- — Urinary frequency/hesitancy/urgency
- — Urination at night

Males:
- — Penile discharge
- — Impotence
- — Testicular masses
- — Difficulty urinating

Endocrine:
- — Frequent urination
- — Excessive thirst
- — Skin or hair changes
- — Cold/heat intolerance
- — Fatigue
- — Hormonal therapy

Musculoskeletal:
- — Joint pain
- — Joint swelling
- — Arthritis
- — Muscle pain
- — Numbness/tingling of extremities
- — Spinal scoliosis
- — Injuries

Neuropsychiatric:
- — Seizures
- — Numbness
- — Tingling
- — Weakness
- — Memory difficulties
- — Emotional disturbances

Gynecological **(the rest of this page is for WOMEN only)**:

Breasts:
- o Sore
- o Masses
- o Discharge Right/Left
- o Do you do regular self-breast exams?
- o Told you have fibrous tissue?

First day of last menstrual period: _____ Duration: _____days How often?_____
- o Irregular periods, if yes, describe_____
- o Spotting between periods
- o Painful periods/cramps/clots

Any vaginal symptoms: itching/burning/discharge/painful intercourse/other (circle positives)
Last mammo- or thermogram: _____ Family history breast cancer? Yes____ no ____ who?_____
Number of pregnancies_____ Number of live births _____C-sections_____Stillbirths/abortions, spontaneous or other ____

Hysterectomy? Yes ___ No ___ If yes, total or partial (circle) Other procedures done? Yes ____ No ____ If yes, tubal ligation/D&C/ablation/other (circle positives).