Sage Naturopathic Health, LLC

WELCOME LETTER

Welcome to our practice! We look forward to meeting you and working with you on your journey to greater health. Please fill out the enclosed forms prior to your first visit, as this will allow us to use our time together in the office more efficiently. Along with these forms, please bring to your first visit any supplements or medication that you are currently taking and any recent laboratory work that you may have. Also, please bring your insurance card so we can get a copy for your chart.

INSURANCE

Insurance is an agreement between you and your insurance company. We bill BCBS, Cigna, Aetna, MVP, and Medicaid from this office. We highly encourage patients to call their insurance company before having an appointment to ensure coverage.

PAYMENT

As a patient of this office, you are directly responsible for payment of all charges incurred while under treatment, including laboratory fees and the cost of any supplements you choose to obtain through the clinic. Office fees are discounted for those who pay on the day of service. Our office works with Quest Diagnostics and CVH laboratories, with Quest prices tending to be cheaper. Please be aware that not all labs are covered by insurance. Dr. Stephanie does her best to ensure that the codes she uses will get coverage, but it is ultimately up to the patient to know what one's insurance will and will not cover. We accept cash, checks, and all US cards with a Visa, Mastercard, Discover, American Express, JCB, or UnionPay logo.

CANCELLATIONS

Appointments are not double booked - your appointment time is reserved specifically for you. If you need to cancel or reschedule an appointment, kindly give 24 hours notice to allow us to utilize your time slot. Our no-show fee is $25.00.

CONTACT

Our office phone number is (802) 461-7238, and we can be reached during our regular business hours. The office is open Monday, Tuesday, and Thursday 9:00 AM - 5:00 PM, and Friday 9:00 AM -1:00 PM. The on-call number for after hours is (802) 552-0512. Our email is sagend@protonmail.com. We kindly ask that you only use our email to clarify treatment plans. In the event of an emergency, if you are unable to contact Dr. Stephanie, please call your primary care physician (if it is not Dr. Stephanie), an emergency facility, or 911.

Stephanie Wawrzyniak, ND
Sage Naturopathic Health, LLC
301 River Street, Suite 201 ~ Montpelier, VT 05602

Phone (802) 461-7238 Fax (802) 448-5904

Date: _____
Patient Name: _____ Age: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
For Pediatric Patients - Parent/Legal Guardian Names _____
_____

After writing in your phone number, please circle which number (if any) is okay to leave a confidential message on
Telephone (Home): _____ (Work): _____ (Cell): _____
e-mail: _____

Gender Assigned at Birth: Male Female
Gender Identified As: Male Female Non-Binary Other _____
Preferred Pronoun: He She They Other _____ Transgender Y/N
Single Married Partnership Separated Divorced Widowed
Occupation: _____
Employer: _____

Insurance: _____ SS#: _____

Emergency Contact: _____ Relationship: _____
Telephone (Home): _____ (Work): _____ (Cell): _____

Are we your Primary Care Provider? Y/N If No, Who is? _____

How did you hear about this clinic? _____
Please list any family members also treated at this clinic _____
_____

What are your most important health concerns? Please list in order of importance

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Medications and/or Supplements currently taking (please include strength and frequency):

_____
_____
_____
_____
_____

Allergies/Sensitivities (food, medication, environmental): _____

_____
_____

Please list any Hospitalizations or Surgeries and when they occurred: _____

_____
_____
_____

Please circle any past history of Illness

Measles Mumps Rubella Chickenpox Whooping Cough Pneumonia Polio Scarlet Fever Rheumatic Fever Mononucleosis Frequent Colds Frequent Ear Infections Tuberculosis Tonsillitis
Other: _____

Please circle all immunizations received

Hep B Polio DTaP Hib PCV MMR Tetanus Influenza Chicken Pox HPV Small Pox Varicella
Other: _____

Birth History (if known - Most Applicable for Pediatric Patients)

Gestation age at birth _____ Weight at birth _____
Mother's age at birth _____ Father's age at birth _____
Length of labor _____ Any Complications with Pregnancy or Birth _____
_____

Height: _____ Weight: _____ Weight one year ago: _____ Maximum Weight: _____
Any history of disordered eating? _____
Do you exercise? Y/N How often and how much? _____
Do you spend time outside Y/N How often? _____
How much screen time do you have in a day? _____ a week? _____
Do you drink alcohol Y/N How often and how much? _____
Do you drink caffeine Y/N How often and how much? _____
Do you smoke tobacco Y/N How often and how much? _____
Do you use recreational drugs Y/N What kind, how often and how much? _____
_____
Are you sexually active Y/N With men, women, or both? _____
Do you use birth control Y/N What type? _____

Please circle C (current) or P (past) next to the following conditions. If never had leave blank.

Headaches C/P	Migraines C/P	Head Injury C/P
Cataracts C/P	Glaucoma C/P	Double Vision C/P
Corrective Lenses C/P	Impaired Hearing C/P	Ringing in Ears C/P
Dizziness C/P	Nose Bleeds C/P	Nasal Congestion C/P
Loss of Smell C/P	Gum Disease C/P	Teeth Grinding C/P
Jaw Clicks (TMJ) C/P	Shortness of Breath C/P	Asthma C/P
Chronic Cough C/P	Wheezing C/P	Sleep Apnea C/P
High Blood Pressure C/P	Chest Pain C/P	Palpitations C/P
Heart Murmurs C/P	Difficulty Swallowing C/P	Nausea C/P
Vomiting C/P	Heartburn C/P	Blood in Stool C/P
Abdominal Pain C/P	Gas or Bloating C/P	Undigested Food in Stool C/P
Pain with Urination C/P	Urinary Urgency C/P	Urinary Frequency C/P
Joint Pain/Stiffness C/P	Muscle Pain C/P	Muscle Weakness C/P
Easy Bruising C/P	Anemia C/P	Anxiety C/P
Depression C/P	Trauma C/P	

Patients With Male Genitalia Only:

Testicular Mass C/P Testicular Pain C/P Hernia C/P Prostate Disease C/P
Impotence C/P

Patients With Female Genitalia Only:

Painful Cycles C/P PMS C/P Endometriosis C/P Ovarian Cyst C/P
Breast Lump C/P Breast Tenderness C/P Nipple Discharge C/P Mastitis C/P
Age of first menses _____ Date of last menstrual cycle _____Age of Menopause _____
Length of Cycle _____ Length of blood flow _____ Are cycles regular Y/N
Date of last PAP _____ Any irregular PAP Y/N If yes, how treated _____
Self Breast Exam Y/N
Number of Pregnancies _____ Number of Births _____ Number of Miscarriages _____
Number of Abortions _____

Any other conditions past or present that have not been asked about? _____
_____
_____
_____

Family History - Please list any immediate family members who have these conditions

Diabetes _____ High Blood Pressure _____
Heart Disease _____ Stroke _____
Kidney Disease _____ Thyroid Disease _____
AutoImmune Conditions _____
Cancer _____ Mental Illness _____

Terms and Conditions of Treatment

Consent for Treatment:

I understand that my care as a patient at Sage Naturopathic Health is directed by a licensed Naturopathic Physician. I consent to services rendered and provided to me under the instructions of these professionals assisting in my care. I may be contacted by Sage Naturopathic Health physicians for voluntary participation in clinical research projects. I do, however, have the right to refuse these programs without jeopardizing my future care at Sage Naturopathic Health in any way.

HIPAA Notice of Privacy Practices and Consent:

I hereby consent to the use and disclosure of my protected health information by Sage Naturopathic Health for the purposes of treatment, payment and healthcare operations, or as otherwise required by law.

Statement of Financial Responsibility: I understand and agree to the following:

- Payment for services rendered is my responsibility as the patient or patient's responsible party.
- I am responsible for paying for all services, including lab tests, rendered at the time of service.
- If I am receiving a discount of any sort, I am responsible for providing accurate and thorough documentation supporting it and I am responsible for paying in full at the time of service.

Insurance Billing: If I am billing insurance for services rendered, I understand and agree to the following:

- I authorize Sage Naturopathic Health to release pertinent medical records related to billing directly to my insurance carrier. This release applies to support of the insurance billing process only.
- I am responsible for any and all charges that my insurance company will not cover.

Welcome Letter: I have received a copy of Sage Naturopathic Health's welcome letter, and agree to everything set forth within said letter.

I have fully read and understand the above agreements and authorizations.

_____ _____

Patient (18 years or older) Date

_____ _____

Parent, Guardian, Responsible Party Date

TELEMEDICINE INFORMED CONSENT

We ask that all new patients also complete our Telemedicine Informed Consent form, even if you are not currently using Telemedicine. This helps make the process more efficient if we do use Telemedicine in the future.

PATIENT NAME: _____

DATE OF BIRTH:_____

LOCATION OF PATIENT : Vermont

Stephanie Wawrzyniak ND, Vermont State License Number 099-010-7503

Physical office location: 301 River Street, Suite 201, Montpelier, VT 05602

I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to the provider of Sage Naturopathic Health providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments or co-insurances that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Sage Naturopathic Health at 802-461-7238.

As long as this consent is in force (has not been revoked) the provider of Sage Naturopathic Health may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient (or person authorized to sign for patient):

_____

Date: _____

If authorized signer, relationship to patient:

_____

I have been offered a copy of this consent form (patient's initials):

_____ Initials: _____