Mission Healing Arts
420 1st Street East
Polson, MT 59860

Dr. Katie Carter N.D.
Naturopathic Physician
(406) 883-4325 / Fax (406) 883-4340

Financial Policy: Experience has shown it is wise to have a clear understanding with patients regarding financial policies. This form has been prepared for your information and convenience. Please read it carefully. We make every effort to keep our costs down, while providing high quality naturopathic service. Our primary concern is to be available to assist in your wellbeing. We will do our best to help you.

Payment for Dr. Carter's Physician Services:

All fees are paid at the time of service. We accept VISA, MasterCard, Discover and American Express for long distance consultation. **If you cannot keep your scheduled appointment you must give us 24 hours advanced notice to avoid being charged for a schedule visit.** The payment must be made for a missed appointment (in the event you fail to notify us) before you can be rescheduled.

Telephone calls with Dr. Carter that involve questions or clarifications of information exchanged during a previous appointment, or which are for the purpose of reporting the progress of an illness or a treatment plan established with your physician, are free of charge. A phone call with Dr. Carter that provides service usually received during a scheduled appointment and/or which lasts longer than 10 minutes will be charged accordingly.

Insurance: If you have insurance we will process the visit if you have met your deductible. There are some services that we cannot bill to insurance and are under our Non Covered Service Policy and are to be paid at the time of service.

I have read and understand the above financial policy. I agree to pay for services and materials at the time of service:

_____ _____ _____
Patient Signature Date e-mail address

_____ _____ _____
Name of Patient Birth Date SS#

_____
Address

_____ _____ _____
City/ State / Zip Code Phone Cell Phone

_____
Parent Signature (minors)

420 1[illegible]4068834325

Dr. Katie Carter N.D. Naturopathic Physician

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Signature of Patient or Legal Representative Witness

Date Notice Effective Date or Version

____Accepted _____ Denied

Signature_____

Date: _____

Email:_____@_____.

Patient Medical History

Name _____ Age ____ Sex _____ Height _____ Weight _____
Date of Birth_____. Marital Status: Single Married Divorced Widow

Present Complaint_____
_____
First Noticed_____
Occupation_____
No. of Children_____
Religion_____
Have you been exposed to toxic chemicals____
If yes, which ones_____
_____

Other health care providers you are seeing and their specialties:
_____
_____
_____

What diagnosis(s) were you given?
_____
_____

***Women only** *(next two lines)*:
Age at onset of menstruation:_____ No. of children:_____
No. of miscarriages/c-sections:_____ Age at onset of menopause:_____

How was your health as a child? *(circle one): Excellent Good Fair Poor*
Were there any complications with your delivery? (*Please explain)*_____
_____
Were you breast fed?_____ How Long? _____
Did you have any serious emotional or mental traumas as a child? Please explain: _____
_____

Check diseases for which you have been immunized:
___Measles ___Mumps ___Rubella ___Small Pox ___Influenza ___Tetanus ___Diphtheria
___Other_____

What is your blood type? *(circle one):* A B AB O I don't know

Serious Illnesses/Injuries/Surgeries	Date	Outcome

	Allergies/Sensitivities (Please Specify)	Typical Reaction
	Animal Hair/Dander:	
	Chemicals:	
	Drugs, Medications	
	Dust, Molds:	
	Food:	
	Grasses, Weeds, Pollen:	
	Others:	

Tests History

Please list the date of your most recent procedures. Circle any tests that were abnormal:

Test	Year	Test	Year	Test	Year	Test	Year
Chest x-ray		**TB Test**		**Pap Smear**		**Others:**	
Kidney x-ray		**EKG**		**Mammogram**			
GI Series		**MRI**		**Sigmoldoscopy**			
Colon x-ray		**CAT Scan**		**Rectal Exam**			
Spine X-ray		**Cardiac Stress**		**PSA**			
Blood Tests		**Cholesterol**		**Complete Physical Exam**			

Health Habits *(please print clearly)*

Please List all supplements/herbs/homeopathic you are currently taking (attach a separate sheet if necessary):

Type *(include brand name)*	Dosage

Please circle any of the following medications you are currently taking or have taken within the last 3 months:

Allergy medication	Chemotherapy	Oral Contraceptives	Ulcer Medication
Antacids	Cortisone	Pain Medication	Other _____
Anti-Inflammatory	Heart Medication	Radiation	_____
Antibiotic/Anti-Fungal	High Blood Pressure	"Recreational" Drugs	_____
Antidepressants	Hormones	Relaxants	_____
Anti-Diabetics	Laxatives	Sleeping Pills	_____
Aspirin/Tylenol/Advil	Lithium	Thyroid	_____

Do You:

(Circle day or week, as appropriate)

- ❑ Use Tobacco ____Packs Per day/week How many Years?_____
- ❑ Drink Coffee ____Cups Per day/week

- ❑ Drink Black Tea ____Cups Per day/week
- ❑ Drink Alcohol ____Cups Per day/week
- ❑ Drink Soda ____Cups Per day/week
- ❑ Use Artificial Sweeteners ____Packets Per day/week

Use Margarine ____Pats per day/week

How many times a week do you eat in a restaurant? Breakfast_____ Lunch_____ Dinner____

What types of restaurants?_____

What are you favorite foods: _____

Do you crave sweets? At what time? Do you salt your food at the table? _____

Are there other foods you crave? (Please Circle) Bread Pasta Dairy Meat Other?

What foods do you really dislike? _____

Are you on any specific diet? If so, please specify: _____

Would you like to increase or decrease you weight? If so, by how much: _____

When did you last have a significant (more then 10 pounds) change in weight? _____

What exercise do you do and how often? _____

How many hours of sleep do you get each night?_____ Do you wake rested?_____

Are you presently sexually active?____ Any difficulties?____ Method of BC _____

Rate your current stress level from 1-10_____ How much does this affect you(1-10)?_____

What are the major stress factors in your life now? _____

Rate your current emotional health (circle): Excellent Good Fair Poor Unstable Crisis

Are you currently in psychotherapy?_____ Do you have a good support network/team?_____

Does your home environment have a supportive effect on your health? _____

How many hrs of relaxation (not including sleep) do you give yourself during the work week?____Weekends?_____ Favorite recreation activities? _____

When was your last eye exam?_____ Do you wear contacts?_____ Hard or soft_____

Do you drink purified or bottled water?_____ If so, what brand? _____

Do you have an air purifier in the room you sleep in?_____ What brand?_____

Do you have amalgam (silver) fillings?_____ Any other dental problems?_____

Do you make an effort to eat organically grown foods?_____ What % of your diet?_____

Are you on a restricted diet? Please explain_____

Are you considering any elected surgery or medical procedures in the near future?_____

Family Health History

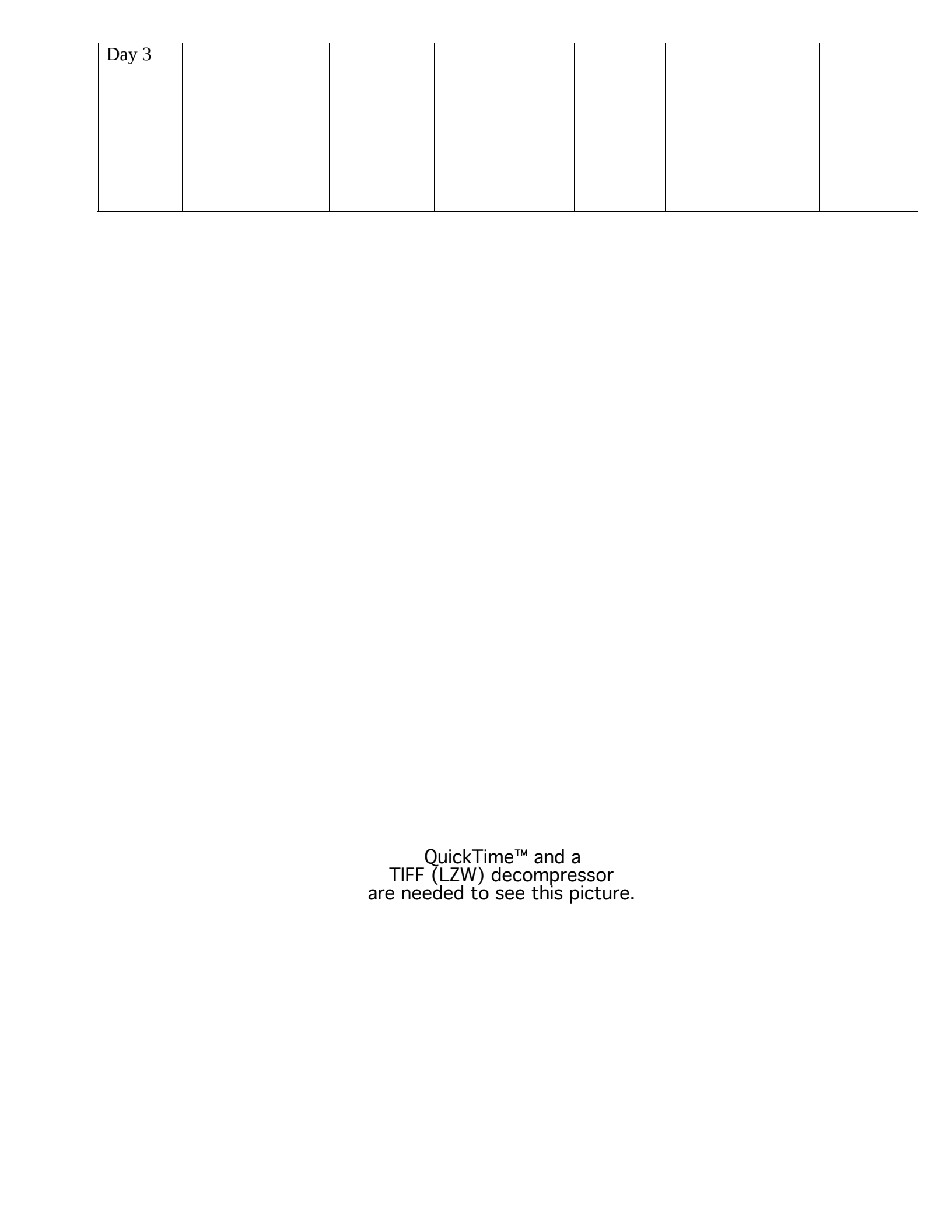
Relation	Age	State of Health (if living)	Age at Death	Cause of Death	Check (x) if your blood relatives have/had Disease		Relationship
Father						Arthritis, gout	
Mother						Asthma, hay fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Stroke	
Sisters						High Blood Pressure	
						Syphilis, Gonorrhea	
						Tuberculosis	
						Other	

Diet Survey

Please list everything you eat and drink for 2-3 Days

Time	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						

Day 3						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Patient's Name:

Non-Covered Service Waiver

NOTE: You need to make a choice about receiving these health care items or services.
The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

YOUR INSURANCE may not pay for the item(s) or service(s) that are described below. Insurances have criteria and strict definitions on what is 'Medically Necessary'. Many insurance companies do not define or cover particular natural therapies or alternative types of testing. The fact that private insurances may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Below is a list of many services that may not be covered by your insurance.

You have the right to ask, and have answered to the best of your practitioner's ability any questions about these services including:

- The description of treatment or procedure
- Explanation of risks known by practitioner
- Explanation of any side effects
- Explanation of alternative procedures
- Consequences of not receiving treatment or avoiding diagnosis

By signing this form, you acknowledge that you have discussed, and have received answers to any questions you had in regards to the below services.

Items or Services: **B12** **Meyer's** **Allergy Testing** **Genetic Testing**
Non-covered diagnostic testing **Weight Loss** **Prolozone**
Neuralprolo **LDA/LDI injections** **Prolo Therapy**

May Be: **Considered Investigational by Insurance** **Genetics non-covered (NC) service**
Vitamin Therapy Not 'Medically necessary' **Weight loss NC service**
NC Manual Therapy

The services listed above will cost approximately $ _____

I would like to receive these services, and have had all my questions answered regarding the non-covered services listed above. I understand that my insurance will not be billed by my provider due to non-payment and/or incorrect payment, so I agree to pay for these services myself. I will not hold my practitioner or their office responsible for billing my insurance company directly.

Signature of patient or guardian: _____ **Date:** _____