Dr. Alice Holman, N.D., L.Ac.
Naturopathic Medicine and Acupuncture
1755 Prospector Ave., Park City, Utah 84060 Phone: 435-655-7243 Fax: 1-888-977-1975

CONFIDENTIAL PATIENT INFORMATION

Today's Date _____

Name_____ Age_____Birth Date _____ Sex **M F**

Address_____ APT# _____ City _____ State___Zip_____

Cell Phone (____)_____ Work Phone (____)_____ Home Phone (____)_____

Is it ok to leave personal medical information on your message machine? Yes_____ No_____

Which phone number is ok to call and leave messages on_____

Email Address _____ Would you like to receive information via email? Y N

Employer _____Occupation _____Student? **Y N Full** or **Part time**

Marital Status S M D W Number of Children _____Ages_____

Person to contact in case of emergency _____ Phone # (____)_____

Primary Care Physician _____ Phone # (____)_____

How did you hear about our Clinic? _____

INSURANCE INFORMATION

We require payment for your visit at the time of service. In the State of Utah, many insurance plans and health savings accounts will reimburse you for a percentage of your visits with Dr. Holman as an Out of Network provider. We will provide you with a receipt for your visit that you may submit to your insurance company. Please call the number on the back of your insurance card to understand your plan's coverage. Thank you.

Insurance Company_____ Name of subscriber _____

Subscribers address if different from patient _____

Please call your insurance company (number on back of card) ask for the following information:

Do you have medical insurance with Naturopathic Medical and Acupuncture Coverage? **Y N**

Do you need a referral before coming to our clinic? **Y N** (You are responsible for obtaining a referral) Is there a deductible? **Y N** (If yes) Individual $_____Family $_____ Amount paid to date $_____

Is there a Co-Pay? Y N $_____ What percent will your policy cover for treatment? _____

PLEASE BRING YOUR CARD WITH YOU SO WE CAN MAKE A COPY FOR YOUR FILE

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. I hereby authorize the undersigned physician the right to furnish medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable. Furthermore, any charges, fees, or court costs incurred as a result of collection efforts will be added to my account balance. Permission is hereby given for any medical treatment and any diagnostic procedures required for my health care, or (when patient is a minor child) for the health of my minor child.

_____ _____ _____

Patient's Signature Parent or Guardian's Signature Date

CLINIC POLICY REQUIRES PAYMENT AT THE TIME OF SERVICE

We gladly accept: Cash • Check • Visa • MasterCard

HEALTH HISTORY

Name _____ **Birth date** _____ **Age** _____ **Date** _____

Date of last physical exam: _____ **What is reason for visit?** _____

SYMPTOMS Check (□) symptoms you currently have or have had in the past year

GENERAL
- □ Chills
- □ Depression
- □ Dizziness
- □ Fainting
- □ Fever
- □ Forgetfulness
- □ Headache
- □ Loss of sleep
- □ Loss of weight
- □ Nervousness
- □ Numbness
- □ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- □ Arms
- □ Back
- □ Feet
- □ Hands
- □ Hips
- □ Legs
- □ Neck
- □ Shoulders

GENITO-URINARY
- □ Blood in urine
- □ Frequent urination
- □ Lack of bladder control
- □ Painful urination

GASTROINTESTINAL
- □ Appetite poor
- □ Bloating
- □ Bowel changes
- □ Constipation
- □ Diarrhea
- □ Excessive hunger
- □ Excessive thirst
- □ Gas
- □ Hemorrhoids
- □ Indigestion
- □ Nausea
- □ Rectal bleeding
- □ Stomach pain
- □ Vomiting
- □ Vomiting blood

CARDIOVASCULAR
- □ Chest pain
- □ High blood pressure
- □ Irregular heart beat
- □ Low blood pressure
- □ Poor circulation
- □ Rapid heart beat
- □ Swelling of ankles
- □ Varicose veins

EYE, EAR, NOSE, THROAT
- □ Bleeding gums
- □ Blurred vision
- □ Crossed eyes
- □ Difficulty swallowing
- □ Double vision
- □ Earache
- □ Ear discharge
- □ Hay fever
- □ Hoarseness
- □ Loss of hearing
- □ Nosebleeds
- □ Persistent cough
- □ Ringing in ears
- □ Sinus problems
- □ Vision - Flashes
- □ Vision - Halos

SKIN
- □ Bruise easily
- □ Hives
- □ Itching
- □ Change in moles
- □ Rash
- □ Scars
- □ Sore that won't heal

MEN only
- □ Breast lump
- □ Erection difficulties
- □ Lump in testicles
- □ Penis discharge
- □ Sore on penis
- □ Other

WOMEN only
- □ Breast Lump
- □ Nipple discharge
- □ Abnormal Pap Smear
- □ Painful intercourse
- □ Hot flashes
- □ Vaginal discharge
- □ Extreme menstrual pain
- □ Clotting with menses
- □ Bleeding between periods
- □ Spotting
- □ PMS
- □ Cramps
- □ Currently Pregnant?

CONDITIONS Check (□) conditions you have or have had in the past

- □ AIDS
- □ Alcoholism
- □ Anemia
- □ Anorexia
- □ Appendicitis
- □ Arthritis
- □ Asthma
- □ Bleeding Disorders
- □ Breast Lump
- □ Bronchitis
- □ Bulimia
- □ Cancer
- □ Cataracts
- □ Chemical Dependency
- □ Chicken Pox
- □ Diabetes
- □ Emphysema
- □ Epilepsy
- □ Glaucoma
- □ Goiter
- □ Gonorrhea
- □ Gout
- □ Heart Disease
- □ Hepatitis
- □ Hernia
- □ Herpes
- □ High Cholesterol
- □ HIV Positive
- □ Kidney Disease
- □ Liver Disease
- □ Measles
- □ Migraine Headaches
- □ Miscarriage
- □ Mononucleosis
- □ Multiple Sclerosis
- □ Mumps
- □ Pacemaker
- □ Pneumonia
- □ Polio
- □ Prostate problem
- □ Psychiatric Care
- □ Rheumatic Fever
- □ Scarlet Fever
- □ Stroke
- □ Suicide Attempt
- □ Thyroid Problems
- □ Tonsillitis
- □ Tuberculosis
- □ Typhoid Fever
- □ Ulcers
- □ Vaginal Infection
- □ Venereal Disease

MEDICATIONS List medications you are currently taking:	**ALLERGIES** To medications or substances:

FAMILY HISTORY Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death	Check (√) If, your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brother(s)					Cancer	
					Chemical Dependency	
					Diabetes	
Sister(s)					Heart Disease, Strokes	
					High Blood Pressure	
					Kidney Disease	

HOSPITALIZATIONS

Year	Hospital	Reason and Outcome

Serious Illness / Injuries	Date	Outcome

Have you ever had a blood transfusion? ☐Yes ☐No
If yes, please give approximate dates: _____

LIFESTYLE / ENVIRONMENT

What is your major stressor?

How do you cope with your stress?

Do you have any difficulties sleeping?

How many hours of sleep do you get each night?

How do you relax?

Any Hobbies?

Do you exercise regularly?

Do you have an exercise program? Please describe

Do you live in a new home or recently remodeled?

Does your home have new carpet? Paint? Furniture?

Do you have sensitivities to certain smells or environments?

Do you use perfume or cologne?

FEMALE HEALTH HISTORY

Age of first menses	
Date of last period	
Date of last pap smear	
Date of last breast exam	
Date of last mammogram	
Type of Birth control used	
Other	

HEALTH HABITS Check (√) which substances you use and describe how much you use.

	Caffeine
	Tobacco
	Drugs
	Other

OCCUPATIONAL CONCERNS Check (√) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

DIET

	YES	NO
Do you perceive your diet as healthful?		
Do you follow a particular diet?		
Are you a Vegetarian?		
Do you drink soda?		
What kind? How much?		
How much water do you drink?		
Is it filtered water or from the tap?		
Do you take nutritional supplements		
Please List:		

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for errors or omissions that I may have made in the completion of this form.

_____ _____
Signature Date

Dr. Alice Holman, N.D., L.Ac.
Naturopathic Medicine and Acupuncture

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Welcome and thank you for choosing Holman Health.

Financial and Clinic Policy

All services are payable at the time they are received.
We accept cash, checks, Visa and MasterCard.

Insurance Policy

Knowing what your insurance plan covers prior to your visit will prevent any unwanted confusion. It is important that you understand your policy and any possible limitations of coverage. Many insurance plans will cover naturopathic and acupuncture visits with Dr. Holman as an out of network provider. Medicare and Medicaid plans do not cover visits with Dr. Holman.

You will be responsible for paying for your visit and supplements at the time of service. As a courtesy to you, we will provide you with a receipt, which you may submit to your insurance company. This does not guarantee reimbursement by your insurance company.

Lab services, imaging and other third party orders we be billed directly from the third party vendor. Holman Health has no affiliation with third party vendors. Most specialized labs such as food allergy testing and heavy metal testing are not covered by insurance.

Rates

Please call our office for our rates.

Cancellation and Late Arrival Policy

In the event that you are late, the time will be deducted from your visit rather than delaying the next patient's visit. If you need to cancel and/or reschedule your appointment, please allow at least 24 hours prior to your scheduled appointment time to reschedule. Missing or canceling your appointment without giving at least 24-hour notice will result in you being charged a **$60.00** fee. This fee will be your responsibility and will not be billed to your insurance company.

Prices & fees are subject to change without notice. Any unpaid balances on the account(s) for which I am liable will bear interest at the highest allowable rate per month if not paid within 30 business days.

Late cancellation/no show fee $60____ (**Please initial**)

I acknowledge that I have read and fully understand this financial policy. I agree to the above stated fees and charges. All of my questions have been answered.

_____ _____

Signature of responsible party Date signed

Informed Consent

I, (print your name)_____
request care by the practitioners of Holman Health, Inc. I have sought care of my own free will and hereby authorize the performance of diagnostic procedures and treatments described to me by Dr. Holman, or any practitioner of Holman Health, Inc.

Dr. Alice Holman is a licensed Naturopathic Medical Doctor and Licensed Acupuncturist. She obtained her medical training from Bastyr University in Washington State.

Naturopathic Medicine utilizes natural therapies as mainstays for restoring one's health and natural balance. These include the use of vitamins and minerals, enzymes, amino acids, fatty acids, natural hormones, concentrated food preparations, botanicals, homeopathic medications, hydrotherapy, therapeutic exercises, dietary modifications, counseling, and other techniques which support the natural processes of the human body.

By law, the Department of Health wants you to know the **scope of practice** of a licensed acupuncturist (also known as East Asian medicine practitioner).

- Acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians; Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians; Moxibustion; Acupressure; Cupping; Dermal friction technique; Infra-red; Sonopuncture; Laserpuncture; Point injection therapy (aquapuncture); and Dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements; Breathing, relaxation, and East Asian exercise techniques; Qi gong.

- I understand that if I have been diagnosed by an oncologist as having any form of cancer, that by Utah State Law, I am required to also be under the care of a Medical Doctor. If you have cancer, we are here for adjunctive and supportive care. If you have had any labs done or requested by the doctors of Holman Health, we require a consultation to be scheduled to review these labs unless the results are within normal limits. There is a great deal of education done by the doctors regarding your lab values.

- With this knowledge, I voluntarily consent to treatments by Dr. Holman and her staff. I realize that, as is the case with any medical treatment, no guarantees can or have been given to me by the doctor or staff regarding any cure for my conditions. I have been informed of potential risks or side effects involved in any of the diagnostic or treatment procedures. I have read and understand all of the above.

_____ _____
Signature of Patient or Person Authorized to Consent for Patient Date