Dr. Alice Holman, N.D., L.Ac.
Naturopathic Medicine and Acupuncture
228 West 200 South, Suite 2B, Kamas, UT 84036 Phone: 435-615-2020 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.

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

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

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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, MasterCard and American Express.
Please make all changes to appointments by calling the office NOT by email or text.

Insurance Policy

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.

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. Some 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.

Lab services, including bloodwork, imaging and other third-party (the lab/imaging company) orders will be billed directly from that third-party vendor. Holman Health has no affiliation with third party vendors. Thus, Dr. Holman has no responsibility to guarantee what is covered by your insurance company. Most specialized labs such as food allergy testing and heavy metal testing are not covered by insurance and you as the patient will pay the lab directly.

Rates

Please ask for a copy of our rates, or call our office for our rates.

Cancellation and Late Arrival Policy

*****Please call rather than email if you have to reschedule or cancel your appointment.**

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.
For new patients, you will be charged a $150.00 nonrefundable fee to hold an appointment. This fee will go toward your first visit cost.
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**) if cancel within 24 hours.
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

Dr. Alice Holman
Naturopathic Physician
Acupuncturist

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH INFORMATION

I hereby authorize:

Facility____
Address_____________________________________Phone:__________________
City/St/Zip______________________________________Fax:_________________

To release information from the health records of:

Patient Name____
Date of Birth_____________________________
Date of Service From:________________________To:_______________________

Information to be released:

______Copy of Complete health records____
______Lab/Test results (specify)____
______X-ray reports and/or films (specify)_____________________________________
______Other (specify)____

Information is to be released to:

Dr. Alice Holman
228 W 200 S Suite 2B
Kamas, UT 84036
Phone: 435-615-2020. Fax: 888-977-1975

This authorization is valid for 90 days from the date signed. I understand that I can revoke this consent at any time, unless disclosure has already accured in compliance with this consent.

Unless specifically excluded, this authorization includes release of specifically protected information requiring written consent. This includes referral diagnosis and treatment related to substance abuse, mental health conditions and sexually transmitted disease including HIV(CFR 42, part 2). Release of certain information also requires a minor's consent. This applies to person aged 13-18 for information pertaining to sexually transmitted disease and HIV/AIDS.

I also understand that my information and records are protected under states and federal regulations regarding confidentiality and cannot be released or discussed without my written consent, unless otherwise provided by law.
I understand that if I request records for personal use, to hand-carry to another health provider, or for parties not involved in patient care, there may be a charge. There is no charge for records mailed directly to another Health provider.

A non-emergency records release takes up to 15 working days. "Emergency" status can apply to those records released directly to another health provider.

Patient / Guardian Signature:____**Date:**________________

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
- □ Hips
- □ Back
- □ Legs
- □ Feet
- □ Neck
- □ Hands
- □ 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

Daily Record of Food Intake | Your diet may be the key to better health.

WHOLE FOOD NUTRIENT SOLUTIONS

Each day, record all the items you eat and drink. Be sure to include the approximate amount of each item. When you have completed this form, return it to your health care professional for evaluation.

Name:

Day 1—Date:

BREAKFAST Time:	**LUNCH** Time:	**DINNER** Time:
Meat and dairy:		
Vegetables and fruits:		
Breads, cereals, and grains:		
Fats (butter, margarine, oil, etc.):		
Candy, sweets, and junk food:		
Water intake (fl. oz.):		
Other drinks:		
MIDMORNING SNACK Time:	**MIDDAY SNACK** Time:	**NIGHTTIME SNACK** Time:
Snack:		
Bowel movements (number & consistency) :	**Hours of sleep:**	**Quality of sleep:** (good) 1 2 3 4 5 (poor)

Day 2—Date:

BREAKFAST Time:	**LUNCH** Time:	**DINNER** Time:
Meat and dairy:		
Vegetables and fruits:		
Breads, cereals, and grains:		
Fats (butter, margarine, oil, etc.):		
Candy, sweets, and junk food:		
Water intake (fl. oz.):		
Other drinks:		
MIDMORNING SNACK Time:	**MIDDAY SNACK** Time:	**NIGHTTIME SNACK** Time:
Snack:		
Bowel movements (number & consistency) :	**Hours of sleep:**	**Quality of sleep:** (good) 1 2 3 4 5 (poor)

Day 3—Date:

BREAKFAST Time:	**LUNCH** Time:	**DINNER** Time:
Meat and dairy:		
Vegetables and fruits:		
Breads, cereals, and grains:		
Fats (butter, margarine, oil, etc.):		
Candy, sweets, and junk food:		
Water intake (fl. oz.):		
Other drinks:		
MIDMORNING SNACK Time:	**MIDDAY SNACK** Time:	**NIGHTTIME SNACK** Time:
Snack:		
Bowel movements (number & consistency) :	**Hours of sleep:**	**Quality of sleep:** (good) 1 2 3 4 5 (poor)

Notes:

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Day 4—Date:

BREAKFAST Time:	**LUNCH** Time:	**DINNER** Time:
Meat and dairy:		
Vegetables and fruits:		
Breads, cereals, and grains:		
Fats (butter, margarine, oil, etc.):		
Candy, sweets, and junk food:		
Water intake (fl. oz.):		
Other drinks:		
MIDMORNING SNACK Time:	**MIDDAY SNACK** Time:	**NIGHTTIME SNACK** Time:
Snack:		
Bowel movements (number & consistency) :	**Hours of sleep:**	**Quality of sleep:** (good) 1 2 3 4 5 (poor)

Day 5—Date:

BREAKFAST Time:	**LUNCH** Time:	**DINNER** Time:
Meat and dairy:		
Vegetables and fruits:		
Breads, cereals, and grains:		
Fats (butter, margarine, oil, etc.):		
Candy, sweets, and junk food:		
Water intake (fl. oz.):		
Other drinks:		
MIDMORNING SNACK Time:	**MIDDAY SNACK** Time:	**NIGHTTIME SNACK** Time:
Snack:		
Bowel movements (number & consistency) :	**Hours of sleep:**	**Quality of sleep:** (good) 1 2 3 4 5 (poor)

Day 6—Date:

BREAKFAST Time:	**LUNCH** Time:	**DINNER** Time:
Meat and dairy:		
Vegetables and fruits:		
Breads, cereals, and grains:		
Fats (butter, margarine, oil, etc.):		
Candy, sweets, and junk food:		
Water intake (fl. oz.):		
Other drinks:		
MIDMORNING SNACK Time:	**MIDDAY SNACK** Time:	**NIGHTTIME SNACK** Time:
Snack:		
Bowel movements (number & consistency) :	**Hours of sleep:**	**Quality of sleep:** (good) 1 2 3 4 5 (poor)

Day 7—Date:

BREAKFAST Time:	**LUNCH** Time:	**DINNER** Time:
Meat and dairy:		
Vegetables and fruits:		
Breads, cereals, and grains:		
Fats (butter, margarine, oil, etc.):		
Candy, sweets, and junk food:		
Water intake (fl. oz.):		
Other drinks:		
MIDMORNING SNACK Time:	**MIDDAY SNACK** Time:	**NIGHTTIME SNACK** Time:
Snack:		
Bowel movements (number & consistency) :	**Hours of sleep:**	**Quality of sleep:** (good) 1 2 3 4 5 (poor)