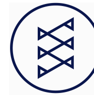
dr. patricia arcuri
naturopathic doctor



Modern Health
CHIROPRACTIC & WELLNESS

Adult Naturopathic Intake Form

Prior to your visit, please complete the following form with as much detail as possible so that I can better understand your health needs.

PATIENT INFORMATION		
Name: ______________________ (First) ___________________ (Middle) _________________________ (Last)		
Age:	DOB: _______ /_______/_______ (MM DD YY)	Sex:
Marital Status:	Occupation:	
CONTACT INFORMATION		
Home Address:		
City:	Postal Code:	
Home Phone:	Cell Phone:	Work Phone:
May we leave messages at the above phone numbers? If so, please circle which ones. Please note that no confidential information is left on voicemails. Home Cell Work		
Email address:		
Preferred Method of Contact:		
EMERGENCY CONTACT INFORMATION		
Primary Contact:		
Relationship:		
Phone Number(s) for emergency contact:		
OTHER HEALTHCARE PROVIDERS		
Medical Doctor:	Location:	Date of Last Visit:
Specialist:	Location:	Date of Last Visit:
Specialist:	Location:	Date of Last Visit:

Dr. Patricia Arcuri, ND
Modern Health Chiropractic & Wellness
12 King St. Unit 3, St. Catharines, Ont., L2R3H3
905.682.6500

CLINIC INFORMATION
How did you hear about Patricia Arcuri, ND? If you were referred by another patient of the ND, who referred you? If you found the clinic on the internet, how did you find it? (search terms, websites etc) Have you been to a Naturopathic Doctor before?

HEALTH CONCERNS	
What are your most important health concerns? Please list in order of importance to you.	
1. 2. 3. 4.	5. 6. 7. 8.
Please list any diagnoses you have received (presently or in the past), who diagnosed the condition and any relevant dates.	

MEDICATIONS AND SUPPLEMENTS	
Please list any prescription medications, over-the-counter medications, as well as any vitamins or supplements you are taking. If possible, please include dosages and frequency.	
1. 2. 3. 4.	5. 6. 7. 8.

ALLERGIES (Please list below)

GOALS OF TREATMENT
What are the top 3 goals that you hope to accomplish through naturopathic treatment? 1. 2. 3.

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LIFESTYLE
On a scale of 1-10 (10 being intolerable), how would you rate the level of personal stress that you are experiencing? What are your main stressors? (financial, relationship, job, health etc)

GENERAL INFORMATION			
Height: Weight:	Please rate each of the following on a scale of 1-10, 10 being the best: Sleep: Energy: Mood:	On average, how many hours do you sleep per night? Do you wake feeling well rested?	Do you exercise regularly? If so, what form of exercise?

FAMILY HISTORY		
Condition	**Y/N**	**Family Member**
Allergies		
Auto-immune		
Asthma		
Cancer		
Depression/Mental Illness		
Diabetes		
Heart Disease		
Infertility		
Kidney Disease		
Other		
Family History Unknown		

DIET & PERSONAL HEALTH HABITS			
Please describe your typical daily diet, including water and other beverages.			
Breakfast:	**Lunch:**	**Dinner:**	**Snacks:**

Do you use any of the following?		
Substance	**Y/N**	**Frequency/Amount/Type**
Alcohol		
Cigarettes/Tobacco		
Recreational Drugs		
Aspirin		
Laxatives		
Antacids		
Coffee		
Birth Control Pill		
Mercury Fillings		

PERSONAL HEALTH HISTORY
Providing a chronological timeline of your personal health history can help to establish any trends that may be relevant to your current health concerns. Please indicate any past illnesses, hospitalizations, surgeries, injuries, accidents, or emotional traumas (death, divorce, loss of job, etc)
Age <5:
Age 5-10:
Age 11-20:
Age 21-30:
Age 31-40:
Age 41-50:
Age 51-60:
Age 61-70:
Age 71-80:
Age 81-90:
Any addition information:

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Informed Consent

Please note that this form must be signed prior to your first appointment.

Naturopathic medicine promotes wellness and aims to prevent disease by addressing the root cause of illness. Dr. Patricia Arcuri, ND will take a detailed case history and perform any relevant physical examinations. It is very important that you inform Dr. Patricia Arcuri, ND of any medical concerns, medications and/or supplements that you may be taking, as well as if you are pregnant, suspect you are pregnant or if you are breastfeeding. As a patient, you will receive information about your diagnosis and/or treatment, any alternative options available, the material effects/costs, expected benefits, risks, side effects and in each case, the consequences of not having the diagnosis and/or treatment acted upon. As with any form of medical intervention there can be health risks associated with treatment by naturopathic medicine. Possible health risks of naturopathic medical treatment include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising, fainting or injury from acupuncture
- The staff are trained to handle emergencies should the need arise.

I understand:

- An electronic medical record will be kept of the health services provided to me. This record will be kept in strict confidentiality and will not be released to others unless law requires it or I give my written consent.
- Dr. Patricia Arcuri, ND will have to report me in the following instances: when I am in imminent danger of harming myself or others, when there is reasonable suspicion that I am neglecting and/or emotionally, physically or sexually abusing a minor, and if I engage in sexual relations with any of my healthcare providers.
- I may access my medical records at any time and can request a copy by paying the required fee.
- Dr. Patricia Arcuri, ND does not guarantee treatment results. I do not expect the naturopathic doctor to be able to anticipate and explain all risks and potential complications.

I recognize that this consent form covers the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I have read this statement and agree to work within its guidelines, including the limits of confidentiality.

Patient Name: (Please print): ____

Signature of Patient or Guardian: ____

Date: ____

ND Signature: ____

PATIENT CONSENT FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy and protecting your personal information in an important part and consideration of my practice as a naturopathic doctor. This privacy policy outlines what I do to ensure that:

- Only necessary information is collected about you;
- I only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols (this includes cloud-based electronic medical records that are housed within Canada and are compliant with such legislation and privacy protocols);
- Privacy protocols comply with privacy legislation and standards of naturopathic doctor's regulatory body

We are committed to collecting, using and disclosing your information responsibly and do so for the following purposes:

- To assess your health concerns, provide health care and advise you of treatment options;
- To establish and maintain contact with you;
- To remind you of upcoming appointments;
- To efficiently follow-up with you for treatment;
- To complete claims for insurance purposes;
- To invoice for goods and services;
- To process credit card payments;
- To collect unpaid accounts and follow up on billing, as required;
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others;
- To be used for educational and research purposes (this includes case summaries and reports, photographs, lab results and other pertinent medical information). Your identity will be protected at all times and if necessary, identifying information will be altered to protect your privacy in all the above instances.

Patient Consent

I, ____ have reviewed the above information that explains how Dr. Patricia Arcuri, ND, will use my personal information and the steps that are taken to protect my information. I agree that Dr. Patricia Arcuri, ND, can collect, use and disclose personal information about my case as set out above regarding privacy policies.

Patient Signature:____

Date: ___________________________

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Naturopathic Payment & Policy Agreement

Please read the following agreement, as it explains the policies regarding cancellations and your financial obligations while under the care of Dr. Patricia Arcuri, Naturopathic Doctor.

Payment Agreement:

- Payment is always due at the time of service.
- Naturopathic visits are not covered by OHIP; however naturopathic care is covered under most extended health benefit plans.
- We accept the following forms of payment: cash, debit card, Visa, Mastercard
- We do not offer direct billing to insurance companies. However, we will gladly provide you with a receipt to submit to your insurance company to request reimbursement.
- Naturopathic visits are exempt from HST.
- Laboratory testing and supplements are not included in the fees below.
    - Prices vary and are subject to HST.

Visit Type	Length	Fee
Adult Initial Visit	60 minutes	$165
Pediatric Initial Visit (12 or under)	60 minutes	$140
Follow Up Visits	60 minutes	$125
	45 minutes	$100
	30 minutes	$75
	15 minutes	$45
Acupuncture Treatment	30 minutes	$75

Policies:

- **Cancellation Policy:** If you need to reschedule or cancel an appointment, we require a minimum of 24hr notice prior to the appointment date. Patients with less than 24hr notice, or no shows, will be charged half of their original appointment fee. For the first offence only, the missed appointment fee is waived.
- **On-Time Policy:** Your time is valuable to us and we take pride in seeing you on time. Should you arrive late, you will be seen for the remaining time allocated to your scheduled appointment; however, you will be billed for the full amount of time that you were originally scheduled.
- **Extended appointments (when required):** Dr. Arcuri, ND believes in taking the time to cover all of your concerns without rushing you. She will do her best to keep to the original appointment length; however, issues may arise that require additional time. We bill for the time spent with the doctor if the appointment extends beyond the time allotted.
- **Email Reply & Phone Consults:** Email and phone communications involving treatment clarifications will not be billed; however if additional research and access to your patient file are required, then we will request that you schedule a phone consult or in-person visit. Any phone calls that address new concerns need to be scheduled and will be billed at the same rate as appointments. Phone consults can only be scheduled if at least one in-person visit has occurred.

By signing this payment agreement & cancellation policy, you are indicating that you understand and agree to the terms of service explained above.

Print Name:___________________________ Signature:________________________________

Date:____

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