Patient Contact Information

Name of Patient _____ Date of First Visit _____

Name of Parent(s)/Guardian(s) (if applicable) _____

Relationship to patient _____

Address _____

City _____ State _____ Zip Code _____

Telephone # (cell) _____

(home) _____

(work) _____

Please check this box if you consent to receive text communications ☐

Please check this box if it is OK to leave a detailed message about your health ☐

Email address _____

Age _____ Date of Birth _____ Gender: Female _____ Male _____

Married _____ Separated _____ Divorced____ Widowed ___ Single _____ Partnership _____

Live with: Spouse _____ Partner____ Parents _____ Children ___ Friends _____ Alone _____

Occupation _____ Hours per week _____ Retired _____

Employer _____

Insurance carrier_____

Preferred pharmacy phone_____

How did you hear about Dr. Vreeland?

Friend _____ (name)
Doctor/health provider _____ (name)
Internet_____ (website)
Other _____(please specify)

Next of Kin or other to reach in an emergency _____

Relationship _____ Phone _____

Address _____

Important Patient Information

APPOINTMENTS

- There is a 48-hour cancellation policy.
- There is a $75.00 fee for missed appointments with less than 48-hours notice.
- As a courtesy to our patients, appointments will be confirmed prior to the appointed time. It is however, the patient's responsibility to keep the scheduled appointment or reschedule.
- Initial consultation with Dr. Vreeland - $300 for 60 minutes
- Follow-up appointments to review lab results or treatment programs in person or by phone - $150 for 30 minutes.
- There is no charge for reasonable e-mails or phone calls. For non-urgent matters that would be best attended to during an appointment Dr. Vreeland will request you either a) schedule an appointment or b) hold your question until your next appointment (this generally applies to questions that change the course of care or take longer than 5 minutes to respond to either by phone or email).

LAB TESTS

- Primex laboratory is available to provide phlebotomy services at Newport Integrative Health. Primex is an independent company from Newport Integrative Health. Primex performs its own billing and staffing. Any billing or customer service concerns will need to be addressed with them directly.
- At your initial or follow–up consultations, lab tests and/or diagnostic tests may be ordered.
- Testing recommendations and cost(s) per test will be reviewed.
- Fees for such tests are billed directly by the lab to the patient. In many cases, the lab will work directly with the patient's insurance care provider.
- Some lab tests take up to 4 weeks to be finalized and sent to the office, Dr. Vreeland cannot guarantee turn-around time on laboratory testing.
- You will receive a copy of your lab test in the mail or via the portal.
- Dr. Vreeland does not mark up or profit in any way from the sale of lab testing kits that she orders for her patients.

BILLING/INSURANCE

- Payment for the office visit or phone appointment is expected at time of service and can be in the form of check, cash or credit card payments. All credit card payments will be processed the same day of the visit or phone call.
- You will receive an invoice at the completion of your visit.
- Dr. Vreeland does not accept insurance or Medicare. You can request a bill of services rendered that you can submit to your insurance provider who may reimburse you for some or the entire fee at their discretion. Please note that your insurance carrier may not reimburse phone visits.

PATIENT INITIALS _____

After signing, you are entitled to a copy of this consent.
Please request this copy from the staff.

Important Patient Information

SUPPLEMENTS

- Nutritional supplements are available for patient convenience at Newport Integrative Health.
- Patients are under no obligation to purchase their supplements at the office.
- Newport Integrative Health will ship supplements to your home at standard shipping fees (most typically $8-10).
- Return policy: all sales are final. We are unable to return any supplements.

PATIENT AWARENESS AND RESPONSIBILITY

- Any therapy, no matter how well appointed, might fail to resolve your symptoms and improve your health.
- Dr. Vreeland will inform you of the therapies most relevant to your condition both conventional and alternative.
- You have the choice to accept, refuse or terminate these therapies at any time.
- By agreeing to make every effort to implement an agreed upon program, you will receive the full benefit of your visits with Dr. Vreeland.
- You are responsible for seeking professional medical attention from Dr. Vreeland or another facility for a worsening of your condition.
- You are aware that many medical conditions require additional treatment and that follow-up visits are often necessary.
- You are aware that you may be referred to another physician for treatment when needed.

EVENING AND WEEKEND CALLS

- Dr. Vreeland does not maintain regular call on the evenings and weekends.
- If you have a non-urgent question please call during clinic hours or feel free to message Dr. Vreeland directly through the portal or call and leave a message at the office and she will respond to your question during the work week.

EMERGENCIES

- In the event of an emergency you are responsible to obtain medical attention, call 911 or go to the nearest emergency room.

PATIENT SIGNATURE _____ Date_____
(or Patient Representative)

Indicate relationship if signing for patient_____

After signing, you are entitled to a copy of this consent.
Please request this copy from the staff.

Consent for Naturopathic Treatment

Dr. Lauren Vreeland ND
1831 Orange Ave., #A
Costa Mesa, CA 92627
Tel: (949) 574-4978
Fax: (949) 574-9854

I, _____ (or the patient named below for whom I am legally responsible), hereby request and consent to receive naturopathic medical care by the above named California licensed naturopathic doctor and/or other licensed naturopathic doctors who now or in the future may treat me while working at or associated with or serving as back-up for the above named doctor, whether signatories to this form or not.

I understand that the methods of treatment are permitted under the California Naturopathic Doctors Act,[1] which may include but are not limited to nutritional counseling, western herbs, homeopathy, nutritional supplements, pharmaceuticals, oral chelation, hydrotherapy, LDA therapy, PRP therapy, intramuscular injections, and IV therapy.

I have had the opportunity to discuss with the naturopathic doctor named above the nature and purpose of naturopathic treatments and procedures. I am aware that all existing methods of diagnosis and treatment, including naturopathic healthcare, pose some level of risk. Within the general healthcare setting, the possible outcomes of these practices by a naturopathic doctor range from minor to fatal.

The herbs, homeopathic medicines and nutritional supplements (which are from plant, animal, mineral and other sources) that have been recommended, are considered safe when taken as instructed in the practice of naturopathic medicine. It is extremely important that one follow the prescribed recommendations when taking herbs and nutritional supplements because they may be toxic when taken in large doses. I understand that some herbs and supplements may be inappropriate during pregnancy, and I will immediately notify the doctor if I become aware that I am pregnant.

I will immediately inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment or the herbs or other supplements prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. In order to properly treat the medical condition, the doctor must be contacted promptly if an adverse reaction or condition occurs. In any event, **if an emergency medical condition arises, please seek treatment immediately from a trauma center or call 9-1-1**.

I have read, or have had read to me, the above information and I consent. I have also had an opportunity to ask questions about the consents content, and by voluntarily signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

PATIENT NAME, (printed) _____

PATIENT SIGNATURE _____ **Date:** _____
(or Patient Representative)
Indicate relationship if signing on behalf of patient _____

After signing, you are entitled to a copy of this consent.
Please request this copy from the staff.

TeleHealth Consent

Dr. Lauren Vreeland ND
1831 Orange Ave., #A
Costa Mesa, CA 92627
Tel: (949) 574-4978
Fax: (949) 574-9854

"TeleHealth" means that you may be evaluated and treated by a healthcare provider from a distant location via electronic communication. The information may be used for diagnosis, therapy, follow-up, and/or education, and may include any of the following: patient medical records, medical images, live two-way audio and video, and/or output data from medical devices and sound and video files.

Since this may be different than the type of consultation with which you are familiar, it is important you understand and agree to the following statements:

- The consulting healthcare provider will be at a different location from me. Additional medical or registration personnel may also be present in the room with the Provider.
- I understand there are potential risks to this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties, and call termination. I understand there are alternatives and limitations to this type of care. I understand that my healthcare provider or I can discontinue the telemedicine consultation/visit if it is felt that the videoconferencing connections are not adequate for my situtation.
- I understand that I may be released before all my medical problems are known or treated, and it it is my responsibility to make such conditions or symptoms known to the medical provider as well as to make arrangements for follow-up care.
- I understand that payment will be collected at the time of service.

Authorizations

The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees as follows:

- By signing below, I am granting permission to Lauren Vreeland, ND to perform and administer care and treatment of the patient via telehealth.
- I grant permission to release to third party payor(s), such as private insurance companies, their representatives, and/or other physician(s) involved in the patient's care, any information needed in connection with all care rendered to the patient (for example, recommended laboratory testing or imaging performed for which the patient is submitting the lab/imaging fee to insurance).
- If the patient is under the age of 18, or lacks capacity, the signing party affirms that they are either the parent or legal guardian of such patient and has the full legal authority to seek medical assistance on behalf of the patient.

Printed name_____ Relationship to Patient_____
Signature _____ Date_____

After signing, you are entitled to a copy of this consent.
Please request this copy from the staff.

Your Health Information Privacy Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

• For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
• To protect the public's health, such as reporting when the flu is in your area.
• To make required reports to the police, such as gunshot wounds.
• Obtain payment from third party payers.

Email Communication: Dr. Vreeland occasionally utilizes email to correspond with her clients. However, such email correspondences are not secure. They could theoretically be intercepted, read and information could be misused. I understand that such communications are not secure and hereby release Dr. Vreeland from any responsibility or liability in connection with using unsecured email for communication. I understand that I can choose not to provide an email address or to request, in writing, that my email be removed from my file and Dr. Vreeland will no longer use email correspondence with me. Regardless, if at any time I email a question to Dr. Vreeland, I hereby authorize a reply via unsecured email and agree not to hold Dr. Vreeland responsible for any interception or misuse of such information.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our notice is available upon request. We encourage you to read it carefully before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices at any time by contacting: Newport Integrative Health 1831 Orange Ave, Suite A Costa Mesa, CA 92627 P: 949.574.4978 F: 949.574.9854

Right to Revoke: You have the right to revoke this consent at any time by giving written notice of your revocation submitted to the contact above. Please understand that revocation of this consent will not affect action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

I, _____, have had full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment and healthcare operations.

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ **Patient Signature** _____/_____/_____ **Date**

HEALTH HISTORY QUESTIONNAIRE

Successful health care and preventive medicine are made possible when Dr. Vreeland has a comprehensive understanding of her patients. Please complete this questionnaire as thoroughly as possible. If a section or question does not apply to you or your child skip it and proceed to the next question.

Are you currently receiving healthcare? Y N

If yes, where and from whom?_____
If no, when and where did you last receive medical or health care?

_____

What was the reason? _____
What are your most important health problems? List in order of importance.

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

Do you have any known contagious diseases at this time? Y N If yes, what?_____
Current Medications
Please list any **prescription** or **over-the-counter medications** you are taking, with dosages.

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Please list any **vitamins** or other **supplements** you are taking, with dosages.

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

Allergies - Are you hypersensitive or allergic to...

Any drugs? _____

Any foods? _____

Any environmental? _____

Lauren Vreeland, N.D.

Patient name (Last, First)

HOSPITALIZATION AND SURGERY

List hospitalizations or surgeries you have had:

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

X-RAYS AND SPECIAL STUDIES

X-rays, CT scans, or other studies you have had:

_____

_____

_____

FAMILY HISTORY

	FATHER	MOTHER	CHILD	SPOUSE	SISTERS	BROTHERS
Age (if living)						
Health (G=good P=poor)						
Age at death (if deceased)						
Check (√) those applicable						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma/Hayfever/Hives						
Autoimmune Disorder						
Kidney Disease						
Glaucoma						
Thyroid Disease						
Cause of Death						

GENERAL

When during the day is your energy the best? _____ Worst? _____

Main interests and hobbies?_____

Do you exercise? ☐

If yes, what kind? _____ How often? _____

Average 6-8 hrs. sleep? ☐

Sleep well? ☐

Awaken rested? ☐

Spend time outside? ☐

Do you use tobacco? ☐

Smoked previously? ☐

How many years? _____ How many packs per day? _____

Lauren Vreeland, N.D.

Patient name (Last, First)

MENTAL/ EMOTIONAL

Treated for emotional problems?	☐	Depression?	☐
Mood Swings?	☐	Anxiety or nervousness?	☐
Memory problems?	☐	Poor concentration?	☐

ENDOCRINE

Hypothyroid?	☐	Heat or cold intolerance?	☐
Hyperthyroid?	☐	Diabetes?	☐
Excessive thirst?	☐	Excessive hunger?	☐
Fatigue?	☐	Hypoglycemia	☐

IMMUNE

Chronic Fatigue Syndrome?	☐	Chronic/recurrent infections?	☐
Chronically swollen glands?	☐	Slow wound healing?	☐

NEUROLOGIC

Seizures?	☐	Paralysis?	☐
Numbness or tingling?	☐	Vertigo or dizziness?	☐

SKIN

Rashes or Itching?	☐	Eczema, Hives?	☐
Acne, Boils?	☐	Lumps?	☐
Color Change?	☐	Perpetual Hair Loss?	☐

HEAD

Headaches?	☐	Head Injury?	☐
Migraines?	☐	Jaw/TMJ problems	☐

EYES

Spots in Eyes?	☐	Cataracts?	☐
Impaired vision?	☐	Glasses or contacts?	☐
Tearing or dryness?	☐	Glaucoma?	☐

EARS

Impaired hearing?	☐	Ringing?	☐
Earaches?	☐	Dizziness?	☐

NOSE AND SINUSES

Frequent colds?	☐	Nose Bleeds?	☐
Stuffiness?	☐	Hayfever?	☐
Sinus problems?	☐	Loss of smell?	☐

MOUTH AND THROAT

Frequent sore throat?	☐	Teeth grinding?	☐
Gum problems?	☐	Hoarseness?	☐

NECK

Lumps?	☐	Swollen glands?	☐
Goiter (enlarged thyroid)?	☐	Pain or stiffness?	☐

Lauren Vreeland, N.D.

Patient name (Last, First)

MUSCULOSKELETAL

Joint pain/stiffness/arthritis?	☐	Broken bones?	☐
Weakness?	☐	Muscle spasms or cramps?	☐

BLOOD / PERIPHERAL VASCULAR

Easy bleeding or bruising?	☐	Anemia?	☐
Deep leg pain?	☐	Cold hands/feet?	☐

RESPIRATORY

Cough?	☐	Spitting up blood?	☐
Asthma?	☐	Bronchitis?	☐
Pneumonia or Tuberculosis?	☐	Emphysema?	☐
Pain or Difficulty breathing?	☐	Shortness of breath?	☐

CARDIOVASCULAR

Heart disease?	☐	High/Low Blood Pressure?	☐
Murmurs?	☐	Palpitations/Fluttering?	☐
Blood clots?	☐	Fainting?	☐
Chest pain/angina?	☐	Swelling in ankles?	☐

GASTROINTESTINAL

Trouble swallowing?	☐	Heartburn?	☐
Change in appetite?	☐	Nausea/vomiting?	☐
Vomiting blood?	☐	Bowel Movements: How often? _____	
Blood in stool?	☐	Is this a change?_____	
Pain or cramps?	☐	Constipation?	☐
Belching or passing gas?	☐	Diarrhea?	☐
Gall Bladder disease?	☐	Ulcer?	☐
Jaundice (yellow skin) or liver disease?	☐	Hemorrhoids?	☐

URINARY

Pain on urination?	☐	Frequency at night?	☐
Incontinence?	☐	Frequent infections?	☐
Kidney stones?	☐		

Lauren Vreeland, N.D.

Patient name (Last, First) _____

FEMALE REPRODUCTION / BREASTS

Age of first menses? _____
First day of last menses? _____
# of days in between menses? _____ days
# of days your menses lasts? _____ days
Painful menses? ☐
Heavy or excessive flow? ☐
Are you sexually active? ☐
Pain during intercourse? ☐
PMS? ☐
If yes, what are your symptoms?
_____
_____
Endometriosis? ☐
Menopausal symptoms? ☐
Sexually transmitted infection? ☐
Herpes? ☐
Do you do breast self exams? ☐
Breast pain/tenderness? ☐

Are cycles regular? ☐
Bleeding between cycles? ☐
Clotting? ☐
Discharge? ☐
Sexual difficulties? ☐
Birth control? ☐
What type? _____
Difficulty conceiving? ☐
Number of pregnancies _____
Number of live births _____
Ovarian cysts? ☐
Abnormal PAP? ☐
Genital warts? ☐
Breast lumps? ☐
Nipple discharge? ☐

MALE REPRODUCTION

Hernias? ☐
Testicular pain? ☐
Discharge or sores? ☐
Are you sexually active? ☐
Impotence? ☐
Premature ejaculation? ☐

Testicular masses? ☐
Prostate disease? ☐
Sexually transmitted infections? ☐
Birth control? Type? _____
Genital warts? ☐
Herpes? ☐

DIETARY

Typical Food Intake

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
To drink: _____

Weight: _____ lbs. Weight 1 year ago: _____ lbs.

Maximum Weight: _____ When? _____ Height: _____

Patient name (Last, First)

CONTEXT OF CARE

What three expectations do you have from this visit?

What long-term expectations do you have from working with this clinic?

What expectations do you have of me personally as your naturopathic doctor?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 1 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list)

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits: (Please list)

What potential obstacles do you foresee in addressing the lifestyle factors, which are undermining your health, and in adhering to the therapeutic protocols, which we will be sharing with you?

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

What do you LOVE to do?

Please write any additional information

Newport Integrative Health Patient Portal

This is your way of digitally communicating safely and securely with your doctor.

Please fill in your username and password here (please print clearly):

Username _____

Password (at least 8 characters) _____

Email _____

In your favorite web browser, visit us at https://npihealth.phiportal.com and enter your username and password. Click the message tab and start email communication.

The patient portal website is a convenient way to access your medical information and communicate with your doctor.

Features:
Private and secure – fully HIPAA compliant messaging
View demographic information and request corrections
Access to lab results

The patient portal is suitable for brief clarification questions that take the doctor 5 min or less to read and respond. For any questions that take longer than 5 min to respond or significantly change the course of treatment, please schedule an appointment. The patient portal is neither suitable nor intended for any sort of emergency communication. Your doctor will reply within 1-2 business days. Her response may be delayed over weekends, holidays or due to technical difficulties or high volume of messages. Please be aware your communication with your doctor will become part of your medical records.