bloom
NATURAL HEALTHCARE

Practitioner:
☐ Dr. Ashley Haywood
☐ Dr. Molly O'Neill

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ **Date**: _____
PLEASE PRINT (Last) (First) (Middle)

*Natural medical healthcare is possible only when the physician completely understands the patient's physical, mental and emotional condition. The information you provide helps the doctor understand your needs and how to help you reach your health goals. Please answer each question completely. Print all information and mark anything you have a question about.

Address _____
STREET/ PO Box
_____
CITY, STATE, ZIP
Phone _____
HOME
_____
MOBILE
_____
WORK WITH EXTENSION
Email _____

Best Reached At: (circle one) Home Mobile Work E-mail

E-mail with healthcare info allowed? □ Yes □ No
Voicemail with healthcare info allowed? □ Yes □ No

SSN _____

Date of Birth _____ Age _____

Gender identity: _____

Preferred pronouns: _____

Sex on birth certificate/insurance: _____

Occupation _____

Emergency Contact _____
NAME
_____
PHONE NUMBER
_____
RELATIONSHIP

How many children do you have? _____

Marital Status □ Single □ Married
□ Separated □ Divorced
□ Other _____

With whom do you live? □ Spouse □ Friends
□ Parents □ Alone □ Children
□ Other _____

What are your top three concerns for which you are seeking health care?
(List Primary concern first)

1. _____
Date of onset: _____

2. _____
Date of onset: _____

3. _____
Date of onset: _____

Other current Providers:
Name Specialty Date seen
_____
_____
_____
_____

Prescriptions/Supplements & Dosage:
_____
_____
_____
_____

Drug/Food/Environmental Allergies:
_____
_____

How did you hear about Bloom Natural Healthcare?
_____

_____ _____
Signature - Patient (or Guardian - if a minor) Date
Relationship to Patient (if other than self): _____

INFORMED CONSENT

The purpose of this form is to present risks & benefits of the therapies offered with **Bloom Natural Healthcare**.
This must be signed before treatment is rendered.
Ask your practitioner about any questions or concerns at any time.

NATUROPATHIC MEDICINE

Naturopathy combines safe and effective traditional therapies with the most current advances in modern medicine by attempting to find the underlying cause rather than focusing on symptomatic treatment. The doctors in our clinic treat a variety of conditions including woman's health, stress, pain, organ dysfunction, infections, and much more. There is risk of pharmaceutical/supplement interaction, so inform your ND of current medications. Your ND may suggest hydrotherapy, which encourages circulation, enhanced immune function and relaxation. Side effects are minimal, but may include dizziness, fatigues, detoxification reactions and irritated skin.

ACUPUNCTURE

Acupuncture involves using very thin needles and/or pressure to stimulate special points on the body that affect different organ systems. Our acupuncturists are gentle and effective and combine traditional Chinese bodywork and other techniques to aid in energy flow. Uncommon side effects may be bruising, minor bleeding, fainting and discomfort. More commonly, relaxation and pain relief are experienced. Your acupuncturist may use acupressure and Chinese bodywork, which stimulates or sedates the points by hand.

MANIPULATION

Manipulation is an effective therapy that aims to restore joint motion and neurological function. A proper screening is required and performed to ensure you do not have risks or contraindications to adjustments. Different techniques are used depending on the individual. Uncommon risks include fracture, sprain, and cerebral vascular accidents. More commonly, pain relief, increased range of motion, and alignment correction are experienced.

SUPPLEMENTS, HERBALS, HOMEOPATHICS, ORTHOPEDIC EQUIPMENT

These are products that can aid in healing by nutritional, energetic, and mechanical support; they can be effective for many conditions. Be sure to inform your practitioner about all medications you currently take to minimize drug/supplement interactions. Some side effects may be gas, bloating, and less commonly allergic reaction. If biomechanical support is needed, back braces, cervical pillows, cervical traction, orthotics may be suggested for your particular case.

IMAGING, REFERRALS

Further lab work (X-rays, MRI, blood work, urine analysis, etc.) may be necessary. When co-management or referral is indicated, a prompt referral to another specialist for evaluation or alternative therapy will be suggested. The following are examples: medical management, physical therapy, vestibular testing, psychological evaluation, injection therapy, surgery, naturopathic, chiropractic, acupuncture, massage, etc.

We will inform you of alternatives to the therapies offered within or external to Bloom Natural Healthcare. Our first concern is your health/well being.

Please inform your practitioner of any changes in symptoms, medications, diagnoses by other doctors and if there is a chance of pregnancy at any time during your care.

I, _____ have had the opportunity to read this form and my questions are answered to my satisfaction. I hereby consent to the treatments above.

_____
Patient Name (Please Print)

_____ _____
Signature - Patient (or Guardian - if a minor) Date

INFORMED CONSENT

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT and HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Bloom Natural Healthcare for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Bloom Natural Healthcare. I understand that diagnosis or treatment of me by my physician(s) at Bloom Natural Healthcare may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Bloom Natural Healthcare is not required to agree to the restrictions that I may request. However, if Bloom Natural Healthcare agrees to a restriction that I request, the restriction is binding on Bloom Natural Healthcare and my physician(s) at Bloom Natural Healthcare.

I have the right to revoke this consent, in writing, at any time, except to the extent that my physician(s) at Bloom Natural Healthcare has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Bloom Natural Healthcare uses Office Ally as its insurance billing clearinghouse; I understand this and do hereby give my consent to have my insurance information processed by this company.

I understand I have a right to review Bloom Natural Healthcare's Notice of Privacy Practices prior to signing this document. Bloom Natural Healthcare's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Bloom Natural Healthcare. This Notice of Privacy Practices also describes my rights and Bloom Natural Healthcare's duties with respect to my protected health information.

Bloom Natural Healthcare reserves the right to change the privacy practices that are described in The Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I, _____ have had the opportunity to read this form and my questions are answered to my satisfaction. I hereby consent to the treatments above.

_____

Patient Name (Please Print)

_____ _____

Signature - Patient (or Guardian - if a minor) Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please specify)

INSURANCE INFORMATION, BUSINESS AGREEMENT and PAYMENT POLICY FORM

BUSINESS AGREEMENT

1. I understand that all responsibility for Naturopathic, Exercise Therapy and/or Acupuncture services provided in this office for myself or my dependents is entirely mine, due and payable at the time services are rendered unless other arrangements have been made with Bloom Natural Healthcare. In the event that payments are not paid in full within 30 days of the treatment date, I understand that a 1.5% service charge (*i.e.* 18% per annum) shall be added to my account. I further understand that any dishonored checks will be assessed a statutory handling and collection fee of $25.00 and any related bank fee incurred.
2. I have signed and understand the authorized consent form given by Bloom Natural Healthcare for the modalities used within the office.
3. I acknowledge that no guarantee, warranty or assurance has been given by anyone as to the treatment results that may be obtained.
4. I grant my permission to Bloom Natural Healthcare agents to telephone me at my home or at my workplace to discuss matters related to this consent, my treatment, or my account.
5. I hereby authorize Bloom Natural Healthcare to release any information necessary to process my family's medical claims.
6. I understand that the "courtesy notice" for cancellations and/or rescheduling of my appointments is 48 hours. I acknowledge that I will give at least 24 hours notice for cancellation of appointments and that I will be charged a late fee for all broken appointments, no shows and short notice cancellations. I understand that if I break an appointment for a third time that I will not be rescheduled and will be provided with medical care for 30 days only, to allow time to find another health care practitioner.
7. The Fee Schedule is based on "Time of Service" payments, and varies according to the complexity of visit and/or treatment length.
   **Prices are subject to change.*
8. Insurance Companies are billed according to the total amount of code fees (associated with services provided, and type of office visit) that are considered "usual and customary" for practitioners in the local area. These fees may be different than the "Time of Service" fee schedule.

_____ _____

Signature - Patient (or Guardian - if a minor) Date

_____

Patient Name (Please Print)

PAYMENT POLICY

By signing below, I understand that full payment for all services and products I receive from Bloom Natural Healthcare and its practitioners is required at the time of service, except that portion billed to my insurance company. Further, I understand that Bloom Natural Healthcare may submit my bill to my insurance carrier, if I so request, and that I am responsible for any services not covered by my insurance company, as well as, any co-pay, coinsurance or deductible required by my insurance.

_____ _____

Signature - Patient (or Guardian - if a minor) Date

_____

Patient Name (Please Print)