Simplicity
Health Associates

CONFIDENTIAL HEALTH INFORMATION

Name:_____ **Today's Date**:_____
How did you hear about us? ☐ AANP ☐ NYANP ☐ Yelp

☐Social Media (specifiy) _____ ☐Internet (specifiy) _____

☐ Referred by_____ ☐Other _____

Age:_____**Date of Birth**:_____**Marital Status**:_____

Permanent Address:_____

Mailing Address:_____

EmailAddress:_____

Phone (home):_____(cell):_____(work):_____

Occupation: _____Employer: _____

Employer contact:_____ _____
Name Phone or email

Name of spouse (or parent for minor child):_____

Whom may we contact in case of emergencies? **Name**: _____

Relationship to client:_____**Phone**:_____

CLINIC POLICY REQUIRES PAYMENT AT THE TIME OF SERVICES.
We accept cash, credit card and check. Phone consultations, missed appointments and late cancellations will be billed by credit card. All services, service plan payments and products are non-refundable and non-transferrable. We do not bill to insurance.

At the time of payment you can request a bill from our office. This will show the diagnosis, services, and charges for that day. You can submit this form directly to your insurance company for reimbursement. The following insurance information will assist our office in dealing with any possible follow up inquiries from your insurance company regarding your claims.

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. I hereby authorize Dr. Ivy Branin, N.D. to furnish medical information to my insurance carriers should it be necessary. 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, any fees for professional services rendered me 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.

Client's Signature:_____**Date**:_____

Signature of Parent or Guardian (for minors): _____

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CONFIDENTIAL CLIENT INFORMATION

Please fill in all portions of this form. If you need help, please ask.

Name :_____D.O.B. _____Today's Date:_____

Please list the main reason(s) for your visit: _____

_____

Symptoms: Please check all that apply

GENERAL
☐ Chills
☐ Fever
☐Sleep Disturbance
☐ Sweats

EMOTIONAL
☐ Anxiety
☐ Depression ☐Eating Disorder
☐ Fear/Panic
☐High Strung
☐ Irritability
☐Psychiatric Disorder
☐ Suicidal

NEUROLOGICAL
☐Carpal Tunnel
☐ Dizziness
☐ Fainting
☐ Forgetfulness
☐ Numbness/Tingling
☐ Paralysis
☐ Sciatica
☐ Seizures

SKIN
☐Bruise Easily ☐Change in Moles ☐Dry Skin
☐ Itching
☐ Rash
☐Sores that Won't Heal
☐Warts

HEENT
☐Bleeding Gums
☐Blurred Vision
☐ Cataracts ☐Difficult Swallowing ☐Double Vision ☐Dry Eyes
☐ Earache
☐Ear Discharge
☐Hair Loss
☐ Headache ☐Hearing Loss
☐ Hoarseness
☐ Glaucoma
☐Gum Disease
☐ Migraine
☐Mouth Sores ☐Nasal Congestion
☐ Nosebleeds
☐Persistent Cough
☐ Post Nasal Drip
☐Ringing in Ears ☐Sinus Problems
☐Swollen Lymph Nodes

MUSCULOSKELETAL
☐Joint Pain
☐Lack of Coordination ☐ Stiffness
☐ Tremors
☐ Weakness

GI
☐Bad Breath
☐ Bloating
☐Bowel Changes
☐ Change in Appetite
☐ Constipation
☐ Diarrhea
☐ Excessive Thirst
☐ Gas
☐ Heartburn
☐ Hemorrhoids
☐ Indigestion
☐ Nausea
☐ Rectal Bleeding
☐Stomach Pain ☐Vomiting

HEART/LUNGS
☐Chest Pain
☐High Blood Pressure
☐Irregular Pulse
☐Low Blood Pressure
☐ Murmur
☐Pain Breathing
☐Palpitations
☐Poor Circulation
☐Rapid Heart Beat
☐Short of Breath
☐Suffocating Feeling
☐ Swelling Ankle
☐Varicose Veins
☐ Wheezing

MALE ONLY
☐Breast Lump
☐Discharge from Penis
☐Erection Difficulties
☐Lump in Testicle
☐Sore on Penis
☐Testicular Pain
☐Testicular Swelling
☐ Other:_____ _____

FEMALE ONLY
☐Abnormal Pap Smear
☐Bleeding between Periods
☐Breast Lump
☐Heavy Bleeding
☐Hot Flashes
☐Nipple Discharge
☐Painful Intercourse
☐ PMS
☐Vaginal Discharge
☐Vaginal Dryness
☐ Other
Last Menstrual Period:_____
Last Pap:_____
Have you had a Mammogram?_____

URINARY
☐Blood in Urine
☐Difficult Urination
☐Frequent Infections
☐Frequent Urination
☐Lack of Bladder Control
☐PainfuL Urination

MEDICATIONS:
Please List all medications and dosages
☐_____
☐_____
☐_____
☐_____
☐_____

ALLERGIES:
Please List
☐_____
☐_____
☐_____
☐_____

HEALTH HABITS:
Please check any you use & indicate how much
☐ Coffee: _____
☐ Alcohol: _____
☐ Tobacco:_____
☐ Marijuana:_____
☐ Drugs:_____
☐ Other:_____

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CONDITIONS

Please check (✓) any conditions you have had. Highlight or circle any conditions that you currently have or have had in past year.

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

FAMILY HEALTH HISTORY

Please check if any of the following conditions applied to the above relatives:

	Mother	Father	Sibling	Grandparent (maternal)	Grandparent (paternal)
Alcoholism	☐	☐	☐	☐	☐
Autoimmune	☐	☐	☐	☐	☐
Cancer (specify type)	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐

PREGNANCY HISTORY

Number of Pregnancies:_____

Number of Live Births:_____

Check if you've had any of the following: ☐Abortion ☐Miscarriage ☐Premie

SLEEP HISTORY

How many hours per night?_____

Please check if you have any of the following:

☐Frequent Waking ☐Nightmares ☐Snoring ☐Nap during day ☐Sleep walk ☐Grind Teeth

OCCUPATION

Check if you are exposed to: ☐Stress ☐Heavy Lifting ☐Hazardous Substances

EXERCISE

How often do you exercise?_____

What type?_____

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

Signature: _____Date: _____

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CLIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives clients the right to request a restriction on the uses and disclosures of their protected health information (PHI). The individual is also given the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's residence. We would like to respect those rights in every way possible and request that you fill in the following:

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone_____
- ☐O.K. to leave message with detailed information
- ☐Leave message with name and call-back number only

☐WorkTelephone_____
- ☐O.K. to leave message with detailed information
- ☐Leave message with name and call-back number only

☐ Written Communication
- ☐O.K. to mail to my home address
- ☐O.K. to mail to my work address
- ☐O.K. to email to my email address
- ☐O.K. to fax to this number:

_____

☐ Other:_____

_____

_____

_____ _____

Signature **Date**

_____ _____

Printed Name **Date of birth**

Date	Disclosed to Whom Address/Fax	(1)	Description of Disclosure Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if Disclosure is authorized
(2) Type Key: T= Treatment RecordsP= Payment Information
(3) Enter how disclosure was made: F=Fax; P= Phone ; E= Email; M= Mail; O= Other

Privacy regulations generally require healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary. These provisions do not apply to uses or disclosures requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided above constitutes an adequate record.

Note: Uses and disclosures for PHI may be permitted without prior consent in an emergency.

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Complementary and Alternative Health Client Bill of Rights

As a valued client of Simplicity Health Associates it is important that you are fully aware of the laws surrounding Naturopathic Medicine. If you have any questions or concerns please talk with myself, Dr. Ivy Branin, N.D. I will be more than happy to discuss them with you.

The state of New York do not regulate Naturopathic Doctors, or the use of the title "N.D." For this reason it is especially important to verify your Naturopathic Doctor's training and certification. I attended a fully accredited four-year post graduate program at Bastyr University in Kenmore, WA. I passed board exams in the State of Washington and I hold a current and valid Vermont license. New York does not license Naturopathic Doctors at this time.

Due to lack of State licensing in New York, I am not legally able to prescribe pharmaceutical drugs, perform minor surgeries, administer injections, diagnose or treat disease. I AM able to use natural methods like supplements, homeopathy, herbs and lifestyle changes to improve your health as a whole person. **The goal is to increase your overall health and vitality as a whole person thereby decreasing the symptoms you suffer and encouraging vibrant health.** If you are interested in learning more about naturopathic medicine and current licensing efforts please see our national association, the AANP at www.naturopathic.org or our state association, NYANP at www.nyanp.org.

I stand firmly behind the quality of care you will receive. Please do not hesitate to ask questions or give feedback. I look forward to being your partner in health.

The fee schedule is as follows: All plans, services and products are non-refundable and non-transferrable.

New Clients:

Standard New Client Visits (up to 1 hour): $399.00

Established Clients:

Patients who wish to continue with choose from a 3, 6, or 9 month plan. At the completion of a plan, patients can set up single follow ups at the rate of $275/visit. See details on following page.

Phone or Email Questions or Check-Ins:

General questions (less that 5 minutes): Free in regards to current plan as I consider this to be part of our relationship. Questions outside of the scope of the current plan or calls or emails that are frequent or extremely complicated will be billed or a follow-up appointment will be recommended.
Complicated calls (up to 15 minutes) or emails (up to 2 per week): $55
Questions requiring more time: Billed as regular visits.

Because Naturopathic Doctors are not yet licensed in the State of New York, I require that you maintain a relationship with your primary care physician.

_____ _____

Signature of Client or Guardian **Date**

_____

Printed Name of Client or Guardian

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Monthly Naturopathic Plans

After your first visit, you can choose from a 3, 6, or 9 month plan if you want to continue with naturopathic care. The initial visit fee of $399 is applied to the purchase of that plan. At the completion of the plan, you have the option of renewing or choosing another plan or continue on a visit-by-visit basis at the fee of $275 per visit.
All plans are non-refundable and non-transferrable.

3 Month Plan $699
1 visit per month
Must be used within 4 months from the initial visit
One visit extension of $20 may be applied

6 Month Plan $1299
1 visit per month
Must be used within 7 months from the initial visit
Two visit extensions of $20 may be applied

9 Month Plan $1899
1 visit per month
Must be used within 10 months from the initial visit
Three visit extensions of $20 may be applied

I understand and agree with the monthly naturopathic plans and payments as stated.

_____ _____
Signature of Client or Guardian **Date**

_____
Printed Name of Client or Guardian

CONTEXT OF CARE

1. Why did you choose to come to this clinic?

What do you know about our approach?

2. What three expectations do you have from this visit to our clinic?

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

What expectations do you have of me personally as your physician?

3. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

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

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

5. 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?

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

7. What do you LOVE to do?