Michael Uzick, N.M.D.
Nancy Aton, N.M.D.
Butch Levy, M.D., Dipl.Ac.
3920 N. Campbell Avenue
Tucson, AZ 85719
Phone: (520) 495-4400
Fax: (520) 495-5400

New Patient Intake

Name _____**Today's date:** ____/____/_____

Address_____**City**_____**State**_____**Zip**_____

Birthdate ____/____/_____ **Age** _____ **Sex** _____ **E-mail** _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Domestic Partner ☐ Other_____

Spouse/Partner name *(if applicable)* _____

Do you have children? ☐ Yes ☐ No **Ages:** _____

Would you like to be added to our email list? We do not share your information and typically use it so you know about upcoming classes or lectures at Genesis!
☐ YES ☐ NO

PHONE NUMBERS

Home	**Cell**	**Work**

Primary Care Physician _____**Phone**_____

Employer _____**Occupation** _____

EMERGENCY CONTACT INFORMATION

Contact is: ☐ Parent ☐ Guardian ☐ Spouse ☐ Domestic Partner ☐ Other_____

Name _____ **Phone Number** _____

How did you hear about us?_____

Insurance: Medicare ☐ Other: ☐ *If other, please provide to front office to make a copy*

Preferred Pharmacy: _____ Cross Streets: _____ Ph #: _____

(over)

Patient History

Chief Complaints:

1. _____
2. _____
3. _____
4. _____

Other physicians or those caring for you:

1. _____
2. _____
3. _____

Past Medical History: (Major illnesses, surgeries or injuries) Date

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

Current Prescription Medications:

	Drug Name:	Dosage:	Taking since:
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Natural supplements: (vitamins, minerals, herbs, homeopathics etc.)

	Supplement Name:	Dosage:	Taking since:
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Allergies: (medications, inhalants, foods, others)

1. _____
2. _____
3. _____
4. _____

Date of last complete physical exam: _____

Tobacco use: Current _____ Past_____ How long? _____

Quit when? _____ How many cigarettes daily? (on average) _____

Current occupation? _____

Have you had any jobs that have involved exposure to chemicals/fumes/toxic metals?

_____

Do you have a water filter or buy filtered drinking water? _____

Family history of: Diabetes _____ Heart disease/stroke _____ Cancer _____

Arthritis _____ Other_____

Currently sexually active? _____ Birth Control? Y/N If yes, type(s): _____

Women Only: Difficulty with periods? _____ Date of last period? _____

Number of live births? _____ Miscarriages?_____ Abortions? _____

Currently using birth control? _____ Have you in the past? _____

Date of last PAP smear? _____ Mammogram?_____

Anything else you would like to tell the doctor:

_____

_____

_____

_____

_____

(over)

Review of Systems

Please circle any of the conditions or symptoms below, if you have experienced them significantly within the last 6 months.

General
Fatigue Weight change Fever / chills
Weakness Night sweats Insomnia

Skin
Itching Rashes Hair/Nail changes

Head
Headache Trauma Dizziness

Nose
Bleeding Discharge Sinus infections Allergies
Post nasal drip

Eyes
Double vision Blurring Pain Discharge
Poor vision

Mouth/Throat
Sores Gums bleeding Hoarseness
Taste Silver Fillings Pain swallowing

Lungs/Breathing
Wheezing Cough Pain
Shortness of breath Coughing blood

Breasts
Masses Pain Discharge

Cardiovascular
Rapid heartbeat Swollen ankles Pain
Angina High-blood pressure Calf pain

Muscles, Joints & Bones
Trauma Pain Arthritis
Osteopenia Osteoporosis

Gastrointestinal
Appetite Nausea/Vomiting Indigestion
Constipation Diarrhea Hemorrhoids
Blood in stool Gas/belching Pain

Urinary/Urination
Pain Waking at night Incontinence
Frequent Urgency Blood

Sexually Transmitted Diseases
Syphilis Gonorrhea Chlamydia
Herpes Sores / discharge Pelvic pain

Female-Menses
Heavy bleeding Pain Irregular cycle
Menopause Spotting PMS

Male
Testicular pain Swelling Masses Discharge

Endocrine
Thyroid conditions Hormone medications
Heat / Cold intolerance Diabetes

Blood-Lymphatic system
Anemia Bleeding tendencies
Swollen lymph nodes Transfusions

Neurologic
Fainting Seizures In-coordination
Numbness/tingling Speech problems
Paralysis/Weakness Tremor

Psycho-social
Anxiety Depression Drug/alcohol abuse
Phobia Memory loss

Do you exercise? _____ If yes, please list the types of exercise and the frequency.

1. _____
2. _____
3. _____
4. _____

List the foods you typically consume for breakfast, lunch and dinner.

Breakfast	Lunch	Dinner

How many times each week do you eat desserts (e.g. cookies, cakes, ice cream, candy etc.)? _____

Do you drink soda? _____ If yes, how many times each week? _____

Do you drink fruit juice? _____ If yes, how many times each week? _____

Do you drink coffee? _____ If yes, how many cups each day? _____

Do you drink alcohol? _____ If yes, how many drinks each week? _____

Patient Financial Policy

Thank you for choosing Genesis Natural Medicine Center as your naturopathic health care provider. We are committed to walking with you on your road to good health. It is important to us that you understand your financial responsibility to Genesis to ensure there will not be any misunderstanding regarding payment for services rendered. Please ask us if you have any questions about our policies or your responsibilities. Carefully review the following information and return this form to us with your signature and today's date.

Our doctors require that all patients complete the New Patient Intake Form prior to seeing the doctor. This information needs to be updated annually or at the time of an appointment if there are information changes (i.e. address, name, email, insurance information, etc.).

PAYMENT: We require full payment at the time of service. We accept cash, Visa, MasterCard and Discover. Our policy is to take credit card information before a phone consult unless other arrangements were made prior to the appointment.

INSURANCE: It is the patient's responsibility to provide Genesis Natural Medicine Center with current, accurate insurance information. Our doctors use your insurance information when working with one of our labs so they can submit the claim for payment. There are some insurance plans that do not cover labs when ordered by a naturopath (i.e. Medicare, AHCCA, Tricare, etc.). When your insurance changes please give the front office your new insurance card.
Genesis understands how expensive health care can be for our patients. We have partnered with Ronnette's Medical Billing and Coding to provide to you an excellent referral service to enable you to file your claim for reimbursement. Ronnette's Medical Billing and Coding charges our patients $10 to file a claim. She accepts cash and checks only. If you choose to use her service, we will collect the payment during checkout and provide you with her information. Ronnette picks up receipts to begin the reimbursement process once a week. She will contact you to discuss the details of her service with you.

MEDICARE: *Only* our Chiropractor accepts Medicare. If you are a Chiropractic patient and a Medicare recipient, please provide us with your current Medicare card. You will be charged the Medicare allowable rate at the time of service. Our Medical Biller and Coder will file your claim for reimbursement. Your reimbursement will be mailed directly to you. If you have any questions, please speak to our front office.

GYNECOLOGY VISITS: If a Pap test has been ordered, the lab bill will either be submitted to your insurance, or billed directly to you.

DISCOUNTS: Genesis Natural Medicine offers discounts to patients. After the first initial appointment, any follow up visits reflect only the time spent with the doctor. We do not charge a flat rate for follow up visits as is the practice of many medical offices. We charge based on 15 minute increments, this gives our patients a considerable savings.
Many patients do not have insurance. We offer lab work at doctor pricing. This is a significant savings for our patients.
At Genesis Natural Medicine Center the more expensive a supplement is, the deeper the discount. It is important to us to offer supplements that are Rx quality at the best possible rate.

CANCELLATION POLICY: Genesis Natural Medicine Center has a 24 hour cancellation / rescheduling policy. The doctor has reserved your appointment time specifically for you. For your convenience, we will call you 48 hours in advanced to remind you of your appointment.

If you miss your appointment, cancel or change your appointment with less than 24 hours notice, you will be charged $50.

Thank you for understanding our Financial Policy. We appreciate the opportunity to provide our services for your medical needs. If you have any questions, we encourage you to speak with the front office.

I have read and understand the Genesis Natural Medicine Center Financial Policy.

Print Name **Sign Name** **Date**

Naturopathic Informed Consent to Treat

Consent: I hereby request and voluntarily consent to the performance of naturopathic treatments and/or other services related to naturopathy, including various modes of physical therapy and diagnostic procedures, on me (or on the patient named below, for whom I am legally responsible) by doctors and practitioners at Genesis Natural Medicine Center.

I understand that this office utilizes many forms of diagnosis and therapy including but not limited to:

- **Physical exam:** e.g. general, musculoskeletal, cardiovascular, gynecological, abdominal, respiratory, neurological, and urological.
- **Medicinal use of nutrition:** therapeutic nutrition, nutritional supplementation
- **Botanical medicine:** botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters or suppositories.
- **Homeopathic medicine:** the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.
- **Lifestyle counseling and hygiene:** diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
- **Psychological counseling**
- **Colon Hydrotherapy**
- **Hydrotherapies:** e.g., hydrocolator, contrast treatments, wet sheet wrap, WAON therapy
- **LED light therapy**
- **Far Infra-red Sauna**
- **Acupuncture**
- **Soft tissue manipulation:** massage, neuro-muscular technique, muscle energy stretching, visceral manipulation.
- **Contraception and hormone replacement therapies**
- **Intravenous, Intramuscular and Subcutaneous injections:** nutritional supplementation, therapeutic nutrition, pain management, joint care
- **Chiropractic**
- **Gynecology**

No Guarantee: I understand that results are not guaranteed.

Recital of Risks: I understand and am informed that, in the practice of medicine, there is some degree of risk to treatment. Within the general healthcare setting for services from doctors and practitioners, the possible outcomes of these practices range from minor to fatal.

I understand that some herbs and supplements may be inappropriate during pregnancy, and I will notify the doctor if I am or become pregnant or have another condition of which he is unaware.

I will inform the doctor and or practitioner if I experience any gastrointestinal upset (nausea, gas, stomach ache, vomiting), allergic reactions (hives, rashes, tingling of the tongue, difficulty breathing, headache), or any unanticipated or unpleasant effects associated with the herbs, supplements or other treatment prescribed by the doctor or practitioner. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I do not expect the doctor or practitioner to be able to anticipate and explain all risks and complications, but I wish to rely on the doctor and practitioner to exercise judgment during the course of any treatment or therapy and act in my best interest.

Agreement and Continuous Effect: I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by 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 treatment.

I, _____ , am of sound mind and able to understand the naturopathic services offered to me in relation to my health care at *Genesis Natural Medicine Center*.

_____

Sign Name ***Date***

HIPAA Compliance Form

How We Collect Information About You: Genesis Natural Medicine Center, PLC ("Genesis ") and its employees collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, sell, lend, or disseminate any information about applicants or clients who are treated by Genesis as it is considered confidential and is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to provide you with health or counseling services (including notification of health lectures, seminars, events, etc.) which may require communication between other health care providers, medical product or service providers, pharmacies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need; or to obtain or purchase any type of medical supplies, devices, or medications.

_____

Print Name ***Sign Name*** ***Date***