



Medication Form

Name: _____ Date Completed: _____

Address: _____

Phone Number: _____ Birth Date: _____

Emergency Contact/ Phone: _____

E-Mail _____

(We give notice of all our sales and your birthday gift certificate through e-mail.)

Allergies and Drugs to Avoid/Adverse Reactions:

Please list any other special dietary information, or foods you can or will not eat. (ex: vegan, vegetarian, etc.)

Current Medications:

List all medications you are taking, include over-the-counter (e.g. supplements, prescriptions, aspirin, antacids).

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Date Started: _____ Date Discontinued: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Date Started: _____ Date Discontinued: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Date Started: _____ Date Discontinued: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Date Started: _____ Date Discontinued: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Date Started: _____ Date Discontinued: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Date Started: _____ Date Discontinued: _____

Name: _____

Medication: _____ Dosage: _____
Reason for Taking: _____ Directions: _____
Date Started: _____ Date Discontinued: _____

Medication: _____ Dosage: _____
Reason for Taking: _____ Directions: _____
Date Started: _____ Date Discontinued: _____

Medication: _____ Dosage: _____
Reason for Taking: _____ Directions: _____
Date Started: _____ Date Discontinued: _____

Medication: _____ Dosage: _____
Reason for Taking: _____ Directions: _____
Date Started: _____ Date Discontinued: _____

Medication: _____ Dosage: _____
Reason for Taking: _____ Directions: _____
Date Started: _____ Date Discontinued: _____

Medication: _____ Dosage: _____
Reason for Taking: _____ Directions: _____
Date Started: _____ Date Discontinued: _____

Medication: _____ Dosage: _____
Reason for Taking: _____ Directions: _____
Date Started: _____ Date Discontinued: _____

Medication: _____ Dosage: _____
Reason for Taking: _____ Directions: _____
Date Started: _____ Date Discontinued: _____

Immunization Record:
(Include dates administered)

- Tetanus _____ Pneumonia Vaccine _____ Flu Vaccine _____
 Hepatitis Vaccine _____ Other _____



FINANCIAL POLICY

Thank you for trusting Integrative Medical Specialists where we are committed to providing the best health care possible. The following statement explains our financial policy. Please read the policy, sign and return to us prior to your treatment. Payment is due at the time services are provided. All supplements, health products, services and labs sales are final. We gladly accept cash, debit cards, Visa, MasterCard, and Discover. We do not accept checks.

Naturopathic Medicine may be covered by some PPO plans. Please check with your insurance company to determine if this is a covered benefit. Integrative Medical Specialists does not submit billing claims. A superbill will be provided for you to send attached to a claim form (provided by your insurance company) into your insurance company for reimbursement. Most HMOs do not reimburse for services provided by Doctors of Naturopathic Medicine.

Missed Appointments

Integrative Medical Specialists has a 24-hour cancellation/reschedule policy for established patients. If you DO NOT call within 24 hours prior to your scheduled appointment, you will be charged a \$75.00 fee for the appointment.

CONSENT TO TREAT

I consent to the use and/or disclosure of my protected health information by Integrative Medical Specialists for purposes of diagnosing or providing treatment to me or obtaining payment for my health care bills. I consent to treatment and understand that my health care provider is a Doctor of Naturopathic Medicine. I understand and agree that diagnosis or treatment of me by Integrative Medical Specialists and my doctor may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I am financially responsible for the charges that I incur during my treatment under the care of Integrative Medical Specialists. I have read and agree to the financial policy. As the child's parent or guardian I understand that I am consenting for the child to be treated.

Please request a copy of our Privacy Practices if you have any questions or concerns.

I UNDERSTAND AND AGREE THAT INTEGRATIVE MEDICAL SPECIALISTS IS A CASH OFFICE. I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED AT THE TIME OF EACH OFFICE VISIT. THIS INCLUDES ALL NATUROPATHIC THERAPIES, SUPPLEMENTS, OFFICE VISITS, AND LABORATORY CHARGES.

Name of Patient/Guardian _____
Sign

Date _____

Name of Patient/Guardian _____
Print

Relationship _____



CANCELLATION POLICY

New Patient Deposit

Integrative Medical Specialists requires a \$100.00 deposit for initial visits. We have a large number of new patients who would like to be seen by our office and we make every effort to schedule each one as soon as possible. When someone fails to keep a new patient appointment without prior notice, we are unable to schedule someone else in that time slot.

We have found that financial commitment keeps no shows and last minute cancellations to a minimum. It is our policy to require a deposit of \$100.00 in order to hold your appointment. A credit or debit card number will be required when scheduling your appointment. The deposit amount will be applied to your charges at the time of the initial visit. The minimum charge for an initial visit is \$130.00.

We require 48 hours notice to cancel or reschedule an initial visit. If the visit is cancelled prior to 48 hours your deposit will be refunded. If your appointment is not canceled or rescheduled prior to the 48 hours, your deposit will not be refunded or applied to your initial visit. If you have previously scheduled and lost your deposit, a new deposit will be required upon rescheduling your initial appointment.

Cancelling and Rescheduling Return Visits

Integrative Medical Specialists has a 24-hour cancellation/reschedule policy. If you DO NOT call within 24 hours prior to your scheduled appointment, you will be charged a \$75.00 fee for the appointment.

I HAVE READ AND UNDERSTOOD THIS POLICY.

Name of Patient/Guardian _____

Date _____

Sign

Name of Patient/Guardian _____

Relationship _____

Print