New Leaf Holistic Health

31 Broadway, Kingston NY. 160 Benmont Ave. Suite 30, Bennington VT.
Tel 845.331.2235 Fax 845.943.4483
NewLeafHolisticHealth.com & NewLeafHolisticHealth@Gmail.com

Welcome to our practice.
We are pleased that you have chosen Naturopathic Medicine as an option to reach optimal health.

OFFICE HOURS:

Office hours below are by appointment only. A 24-hour notice for cancellation is appreciated.

Monday	VERMONT ONLY
Tuesday	CLOSED
Wednesday	1 pm to 6 pm
Thursday	1 pm to 6 pm
Friday	9 am to 2 pm

CONTACT:

To reach the doctors, please call the office. If we are unable to answer during regular business hours because we are with patients, please leave a voice message. We are diligent about returning every phone call we receive within the same day. Please note that E-mails are not a secure way to communicate with us about your health.

MEDICINARY ITEMS:

You may stop by the office during regular business hours to pick up your supplements, however it is always best to call before you do so. If we do not have the item you need, we are usually able to order it within a week. As a general rule please call one week before your supplement runs out, so we may make arrangements for you to pick it up. We must have a credit card on file to place an order, request out of stock products or order special-order items.

LABORATORY WORK:

As a general rule we prefer to review laboratory results during office visits. We do not feel it is professional to review results over the telephone, unless prior arrangements have been made. We often will give our patients "KITS" for private laboratory testing. We require payments for kits at the time of visit.

If kits are not completed within 3 months, fees will be forfeited.

INSURANCE BILLING:

Please see the Financial Form in the intake questionnaire for details. However, as a general rule the following apply:

1) NEW YORK
   a) Insurance plan must cover out of network acupuncture benefits if you see Dr. Tecchio.
2) VERMONT
   a) Dr. Finley is a preferred provider for BCBS and Cigna.
   b) Dr. Tecchio is an out of network provider and may bill any insurance, however coverage may vary from plan to plan.

OUR POLICY IS TO KEEP A CREDIT CARD ON FILE
IF YOU WANT US TO BILL YOUR INSURANCE

Please complete the attached intake to the best of your knowledge and sign all forms.

We look forward to working with you.

Patient's Name _____ Patient's Signature _____

Glenn R Finley ND
Ileana Tecchio ND LAc

ADULT-New Patient Health History Questionnaire

New Leaf Holistic Health
160 Benmont Ave Suite 30, Bennington VT.....31 Broadway, Kingston NY
Tel. 845.331.2235 Fax. 845.943.4483 NewLeafHolisticHealth@gmail.com

Today's Date_____

Full Legal Name _____
Last Name First Name Middle Initial

Address _____
Street/PO Box City State Zip Code

Telephone _____
Home Work Cell Phone

E-mail address _____

Emergency Contact _____
Name Telephone Relationship

Date of Birth _____ Age_____ Female _____ Male _____ Other_____

Single _____ Married_____ Other_____ Partner's Name_____

Occupation _____ Full-time Part-time Student Retired

Is there a number you prefer us NOT to leave a message? _____

Who can we thank for your referral? _____

Who is your primary care physician?

_____
Doctor's Name Name of Practice Telephone if Known

For what concern did you last receive health or medical care? _____

MAIN CONCERNS

What are the concerns for which you are seeking care?

1. _____ Date of onset _____
2. _____ Date of onset _____
3. _____ Date of onset _____
4. _____ Date of onset _____
5. _____ Date of onset_____

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

FAMILY HISTORY

	Father	Mother	Brother	Sister	Children	Maternal GParent	Paternal GParent
Age if Living							
Current Health							
Age at Death							
Cause of Death							

Indicate if you or your family has had any of the following diseases:

___ Cancer ___ Diabetes ___ Glaucoma ___ Heart Disease
___Stroke ___ Epilepsy ___ Anemia ___ Allergies
___ Kidney Disease ___ Asthma ___ Mental Illness
___ Arthritis ___ Dementia ___ High Blood Pressure

PAST MEDICAL HISTORY

Indicate if you have had any of the following Childhood Illnesses:
Scarlet fever ___ Diphtheria ___ Rheumatic Fever ___ Mumps___ German measles___ Mono___
Have you had any immunizations? ___Yes ___No
Have you had any negative reactions from immunizations?
_____

HOSPITALIZATIONS, SURGERY, X-RAY AND SPECIAL STUDIES

What hospitalizations, surgeries, x-rays, or special studies have you had?

1. _____ Year_____
2. _____ Year_____
3. _____ Year_____
4. _____ Year_____
5. _____ Year_____
6. _____ Year_____

INFECTIOUS DISEASES

Do you have any known contagious diseases at this time? ___ Yes ____No
If yes please list:
_____

ALLERGIES

Are you hypersensitive or allergic to foods, drugs, or environmental substances? Please list:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

REVIEW OF SYMPTOMS:

P for PAST
N for NOW

SKIN
___Rashes
___Eczema, Hives
___Acne, Boils
___Itching
___Fungal Infections
___Color change
___Hair Loss
___Dry skin/ scalp
___Lumps
___Night Sweats
___Slow healing ulcerations
___Flushing or hot flashes
___Excessive sweating

NOSE AND SINUSES
___Frequent colds
___Nose Bleeds
___Stuffiness
___Hay fever
___Sinus problems
___Loss of smell
___Loss of balance

EYES AND EARS
___Itchy eyes
___Watery eyes
___Dry eyes
___Swollen/ painful eyes
___Red Eyes
___Impaired vision
___Floaters in vision
___Cataracts
___Color blindness
___Double Vision
___Glaucoma
___Hearing difficulty
___Ringing
___Earaches/ Infection
___Cold hands/ feet

MOUTH AND THROAT
___Sore throat
___Copious saliva
___Teeth grinding
___Sore tongue/ lips
___Gum problems
___Hoarseness
___Gagging/choking
___Difficulty swallowing

HEAD/ NECK
___Headache/ migraine
___Faintness
___Dizziness
___Jaw Pain
___Goiter
___Pain or stiffness
___TMJ

RESPIRATORY
___Chest congestion
___Wheezing
___Asthma
___Bronchitis/ Pneumonia
___Emphysema
___Difficulty/Pain Breathing
___Shortness of breath
___Tuberculosis
___Cough __Wet or __Dry
___Coughing blood

CARDIOVASCULAR
___Heart disease
___Angina/Chest pain
___High/Low Blood Pressur
___Murmurs
___Blood clots
___Irregular heart beat
___Palpitations/ Fluttering
___Swelling in ankles
___Color blindness

CIRCULATION
___Easy bleeding or bruising
___Anemia
___Deep leg pain
___Varicose veins
___Hemorrhoids
___Itchy/ Burning Anus

ENDOCRINE
___Hypothyroid
___Heat or cold intolerance
___Hypoglycemia
___Diabetes
___Excessive thirst
___Excessive hunger
___Fatigue
___Seasonal depression

IMMUNE
___Chronic Fatigue Syndrome
___Chronic infections
___Chronically swollen glands
___Slow wound healing

MUSCLES/ JOINTS/ BONES
___Joint pain
___Muscle pain
___Muscle spasms/ cramps
___Restless Leg Syndrome
___Sciatica
___Osteoporosis

NEUROLOGIC
___Seizures
___Paralysis
___Muscle weakness
___Numbness or tingling
___Easily stressed
___Vertigo or dizziness
___Loss of balance
___Tics

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

REVIEW OF SYMPTOMS

P for PAST
N for NOW

DIGESTION
___Trouble swallowing
___Heartburn/ Acid Reflux
___Change in thirst/ appetite
___Ulcer
___Nausea/ Vomiting
___Gas/ Bloating
___Belching or passing gas
___Diarrhea
___Constipation
___Pain or cramps
___Mucous in stools
___Black/ Bloody stool
___Hemorrhoids
___Itchy/ Burning Anus
___Rectal Pain
___Liver/ Gall Bladder trouble
___Jaundice (yellow skin)
Bowel Mvnt: How often? _____
Is this a change? _____
Stools ___Hard ___Firm
___Soft ___Loose

URINARY
___Pain on urination
___Increased frequency
___Frequency at night
___Frequent infections
___Inability to hold urine
___Kidney stones
___Blood in urine

MALE ONLY
___Hernias
___Testicular masses
___Testicular pain
___Prostate disease
___Sexually transmitted Infect.
___Discharge or sores

MALE ONLY
___Sexual dysfunction
Are you sexually active? Yes No
Sexual orientation? _____
Birth control? Type? _____

FEMALE ONLY
___Irregular cycles
___Bleeding between cycles
___Pain during intercourse
___Clotting
___Heavy or excessive flow
___PMS
___Endometriosis
___Difficulty conceiving
___Painful menses
___Vaginal discharge? Color? ___
___Vaginal Odor
___Ovarian cysts
___Menopausal symptoms
___Abnormal PAP
___Sexually transmitted disease
___Breast pain/tenderness
___Nipple discharge
___Breast Lumps
Age at which menses began_____
Age/Year of menopause_____
Length of Cycle _____
Duration of Flow _____
Date of last period _____
Are you sexually active? Yes No
Sexual orientation? _____
Birth control? Type? _____
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Number of abortions _____
___Difficult or premature births

FEMALE ONLY
Do you do breast self-exams? Yes No
Date of last Pap smear_____
Date of last mammogram _____
Could be pregnant now? Yes No
Any other feminine difficulties? _____

MENTAL/ EMOTIONAL
___Mood Swings
___Anxiety or nervousness
___Considered/Attempted suicide
___Depression
___Poor concentration
___Poor Memory
Other_____

GENERAL
___Poor Sleep/ Insomnia
___Dream disturbed Sleep
___Fatigue/ Low Energy
___General feel Hot
___General feel Cold
___Chills
___Fevers
___Poor Appetite
___Constant Hunger
___Low Libido
___High Stress
Cravings _____
Peculiar taste in mouth _____
Coffee How much _____
Alcohol How much _____
Cigarettes How many _____

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

LIFESTYLE:

FILL IN WITH A CHECK MARK

_____ Weight
_____ Height
_____ Average 8 hrs. of sleep
_____ Have a supportive relationship
_____ History of abuse
_____ Major trauma
_____ Use recreational drugs
_____ Treated for drug dependence
_____ Use Alcoholic beverages? How much? _____
_____ Treated for alcoholism
_____ Do you exercise

_____ Drink coffee
_____ Drink black or green tea
_____ Drink cola or soda
_____ Enjoy your work
_____ Spend time outside
_____ Watch TV? How much? _____
_____ Read? How often? _____
_____ Use tobacco currently
_____ Used tobacco in the past
_____ How many Years? ____
_____ How many packs? ____

How often do you exercise? _____
What kind of exercise? _____

List your main interests and hobbies

1. _____
2. _____
3. _____
5. _____
6. _____
7. _____

MEDICATIONS AND SUPPLEMENTS

What medications (prescribed or over the counter), herbs, vitamins, supplements, etc. are you currently taking?

1. _____ Dose_____
2. _____ Dose_____
3. _____ Dose_____
4. _____ Dose_____
5. _____ Dose_____
6. _____ Dose_____
7. _____ Dose_____
8. _____ Dose_____
9. _____ Dose_____
10. _____ Dose_____

Check each that you currently use:

___Laxatives ____Thyroid Medication ____Pain Reliever ___Cortisone
___Antibiotics ____Heart/ Blood Medication ____Allergy Medicine ___Antacids

……

By signing below, I verify that the above information is correct and true to the best of my knowledge.

Patient Name (Please print) _____ Patient Signature _____

Legal Guardian Signature_____ Today's Date _____

OPTIONAL CONTEXT OF CARE OVERVIEW

I would like to take a moment to welcome you to New Leaf Holistic Health. Whether you are here for a one-time visit, or are looking for a longer-term comprehensive health solution, I look forward to my role in your care. Below are a few questions that will assist me in understanding how I can best support your health.

1) 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, with 10 being 100% committed)

0% 0 1 2 3 4 5 6 7 8 9 10 100%

If you answered less than "10", what stands between your current commitment and 100%?

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

3) What do you love most about your life at this time?

4) 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 that are undermining your health and in adhering to the therapeutic protocols which I will be sharing with you?

6) What are your top three expectations of me?

NEW LEAF HOLISTIC HEALTH FINANCIAL POLICIES

Unless prior arrangement is made, full payment is appreciated at the time of service.

- Your payment options are: cash, check, or credit/debit cards. We accept Visa, MasterCard, and Discover.
- Twenty-four-hour cancellation notice is appreciated.

Insurance Billing

- If you would like us to bill your insurance, we will contact your insurer(s) and bill them based upon the **non-guaranteed** information they provide to us.
- You are responsible for all co-payments, deductibles and other adjustments made by your insurer(s).
- Insurance companies may reimburse differently than the information they initially provide to us.
- You are responsible for and will be billed for any resulting unpaid balance.
- We may use your health care information and may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize the use of my signature an all-insurance submission. I certify that I have read and understand the above information.
- IF WE HAVE NOT BILLED YOUR INSURANCE COMPANY BEFORE WE WILL ASK YOU TO LEAVE A CREDIT CARD ON FILE WITH US TO BE CHARGED, IF NECESSARY, AS WE DO NOT COLLECT UNTIL INSURANCE CLAIMS ARE PROCESSED. _____Initials
- IF YOUR INSURANCE IS BILLED AND AN EXPLANATION OF BENEFITS (EOB) IS SENT DIRECTLY TO YOU, YOU HAVE 2 WEEKS TO FORWARD THE EOB AND ANY CHECK AMOUNTS YOU RECEIVED TO US. IF WE DO NOT RECEIVE THE EOB YOUR CREDIT CARD ON FILE WILL BE CHARGED FOR THE BALANCE DUE. _____Initials

Laboratory Kits:

If we provide you with laboratory "KITS" for private testing, we require payments for kits at the time of visit.
IF KITS ARE NOT COMPLETED WITHIN 3 MONTHS, FEES WILL BE FORFEITED. _____Initials

Past Due Accounts

- **Accounts greater than 30 days past due will be charged a $5.00/month administrative fee.**
- **Accounts greater than 90 days overdue will be sent to a collection agency.**

Below is our Fee Schedule

- **New Patient**

Initial Comprehensive Consultation 50 Min	275.00

- **Established Patient**

Acupuncture/Cupping 50 Min	95.00
Follow Up Visit 50 Min	145.00
Focused Follow Up 30 Min	90.00

……..

I have read, understood and agree to the policies described above.

Patient Name (Please print) _____ Patient Signature _____

Legal Guardian Signature _____ Today's Date _____

PATIENT RIGHTS

Right to request restrictions on uses and disclosures: To request a restriction, please write a request to New Leaf Holistic Health. Upon receiving your request, we will put the limits and terms in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required to make.
Right to receive confidential communications: This includes the right to direct where communications are sent. For example, you may request that information be sent to our work address rather than your home address or via Email than by regular mail. To verify or modify where or how you would like communication sent, contact New Leaf Holistic Health. Unless requested otherwise, we will direct mailings and telephone messages to the address/telephone number we have on record.
Right to inspect and copy. Includes the rights to see and get copies of your information that we maintain. Submit your request in writing to New Leaf Holistic Health and we will respond to you within 30 days of receipt of your written request.
Right to amend: If you believe there is a mistake or missing information, you have the right to request that we correct or add to your file. You must provide the request in writing to New Leaf Holistic Health. We will respond within 30 days of receipt of your written request. We may deny your request in writing if your information is 1) not correct and complete, 2) not created by us, 3) not allowed to be disclosed, or 4) not part of our records. Upon approval, we will make the changes, inform you when the changes are complete, and inform others that need to know about the change in a timely manner. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. You also have the right to request that copies of your initial request and our denial be attached to all future disclosures of your information.
Right to receive an accounting of disclosures. This will not include uses or disclosures made for treatment, payment or health care operations, disclosures made directly to you, those you have already authorized, those made for national security reasons or to law enforcement that has lawful custody over you. We will respond within 30 days of receiving written request. Please include the time period for which you want the accounting (can be no longer than 6 years and may not include dates before April 14, 2003). The accounting will include the date of the disclosure, to whom information was sent, a brief description of the information disclosed, and a brief statement of the purpose for the disclosure. We will provide the first accounting at no charge. For additional accountings, we may charge you a fee but will inform you of that fee in advance.
Right to get a paper copy of this Notice. At any time even if you previously agreed to receive an electronic copy.
Right to file a complaint. If you believe your health information has been improperly used or disclosed, or that your privacy rights have been violated, you may file a privacy complaint with us. Contact New Leaf Holistic Health to file a complaint. You also have the right to file a complaint with the Secretary of the US Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint with us or the DHHS.

I acknowledge having carefully read this copy of the Notice of Privacy Practices.

Patient Name (Please print) _____ Patient Signature _____

Legal Guardian Signature_____ Today's Date _____

Note: If this acknowledgement is being signed by a legal representative, you must provide a copy of the power of attorney or other relevant document(s) designating you as the legal representative.

INFORMED CONSENT

ILEANA TECCHIO N.D., L.Ac., Dipl.Ac., M.S.O.M.

Ileana Tecchio N.D., L.Ac. is licensed to practice acupuncture by the states of New York and Vermont. Ileana Tecchio N.D., L.Ac. is licensed to practice Naturopathic Medicine by the state of Vermont. She is Board Certified in Oriental Medicine by the National Certification Commission for Colleges of Acupuncture and Oriental Medicine (NCCAOM). Ileana Tecchio N.D., L.Ac. has a Master degree in the Science of Oriental Medicine and a Doctorate degree in Naturopathic Medicine from the National College of Natural Medicine. She is a member of the American Association of Naturopathic Physicians. Ileana Tecchio N.D., L.Ac. use disposable-sterilized needles. She has passed the "Clean Needle Technique" examination of the Council of College of Acupuncture and Oriental Medicine (CCAOM). Ileana Tecchio N.D., L.Ac. does not provide after hour services, and in case of an emergency I understand I should contact the appropriate licensed health care provider.

Naturopathic Medicine in the state of New York

A Naturopathic Doctor is trained as a primary care provider and is a board-certified physician in states where licensure is applicable. However, currently licensure for Naturopathic Doctors is not available in the state of New York. Therefore, Ileana Tecchio N.D., L.Ac. does not practice medicine, and does not diagnose or treat diseases or medical conditions in the state of New York. In the state of New York Ileana Tecchio N.D., L.Ac. focuses her practice on the enhancement of health. The services Ileana Tecchio N.D., L.Ac. provides are not meant to substitute or replace those of a licensed physician. Patients seeking her consultation are advised to also be under the care of a licensed New York state physician.

Naturopathic Medicine in the State of Vermont

As a Naturopathic Doctor in the state of Vermont, Ileana Tecchio N.D., L.Ac. is licensed to practice as a primary health care provider and as a board-certified physician.

.....

I hereby request and consent to acupuncture, herbal treatments and other procedures associated with Oriental Medicine on me (or on the patient named below, for which I am legally responsible) by Ileana Tecchio N.D., L.Ac. I understand that methods of treatments may include, but are not limited to:

- Acupuncture – whereby special sterilized fine needles are inserted through the skin into the underlying tissues and muscles at specific points on the body.
- Moxibustion - whereby indirect herbal heat is applied to specific acupuncture points.
- Cupping – whereby suction cups are applied to specific points on the body and on occasion are moved from point to point.
- Electrical Stimulation - whereby the needles are electrically stimulated at 9 volt or less to cause relaxation of the muscles and analgesia of the area of pain involved.
- Herbal Medicine - whereby herbs and nutritional supplements, which are from plant, animal and mineral sources are recommended.
- Oriental Nutritional Counseling – whereby a healthful diet is individually tailored and recommended.

Acupuncture has the effect of normalizing physiological functions, modifying the perception of pain, and of treating certain diseases and imbalances of the body. Most people experience a sense of well-being and relaxation during and after the treatment. I have been informed that acupuncture is a safe method of treatment, but that occasionally bruising, numbness or tingling at the site of needle insertion may occur after treatment. Bruising is also a possible side effect of cupping. Burns on the skin are a potential risk of indirect moxibustion. Rare side effects include dizziness or fainting, especially if the patient is overdue for a meal. There have been extremely rare instances of spontaneous miscarriage and pneumothorax – collapsed lung.

_____ Initials

I understand that while this document describes the major risks of treatment, other side effects may occur. I do not expect Ileana Tecchio N.D., L.Ac. to be able to anticipate all risks and complications. I wish to rely on Ileana Tecchio N.D., L.Ac. to exercise judgment during the course of the procedure which Ileana Tecchio N.D., L.Ac. feels at the time, based on the facts then known, and is in my best interests.
_____Initials

Herbal and nutritional supplements are traditionally considered safe in the practice of Oriental Medicine. I understand the same herbs and nutritional supplements may be inappropriate during pregnancy and **will inform Ileana Tecchio N.D., L.Ac. immediately of pregnancy status**. If I experience any gastro-intestinal reactions or any adverse effects, I will inform Ileana
Tecchio N.D., L.Ac. immediately.
_____Initials

I state that in addition to not being pregnant; I do not have the following conditions: bleeding disorders, pacemaker, local infections, diabetes, cancer, and I am not taking anti-coagulant drugs.
_____Initials

While Oriental Medicine has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, it is recommended that you consult a physician regarding any condition or conditions for which you are seeking acupuncture or herbal medicine treatment. To comply with Article 160, Section 8211.1 (b) of NYS Education Law, Ileana Tecchio N.D., L.Ac. requests that you read and sign the following statement:

I/We, the undersigned, do affirm that _____ (patient) has been advised by Ileana Tecchio, N.D., L.Ac., to consult a physician regarding the condition(s) for which such patient seeks acupuncture and/or herbal medicine treatment(s).

I understand that all my records will be kept confidential and will not be released without my written consent.
I understand it may be necessary for Ileana Tecchio N.D., L.Ac. to contact another one of my health care providers in order to discuss any emergency situation. My signature gives Ileana Tecchio N.D., L.Ac. permission to release my medical records for the reason listed above.

I have been informed that I have the right to refuse any form of treatment. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. 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 have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures.

_____
Ileana Tecchio N.D., L.Ac., M.S.O.M., Dipl.Ac.

Patient Name _____ Patient Signature _____

Legal Guardian _____ Today's Date _____

INFORMED CONSENT

GLENN FINLEY N.D.

Glenn Finley N.D. is licensed to practice Naturopathic Medicine in the state of Vermont. Glenn Finley N.D. has a Doctorate degree in Naturopathic Medicine from the National College of Natural Medicine. He is a member of the American Association of Naturopathic Physicians. Glenn Finley N.D. does not provide after hour services and in case of an emergency I understand I should contact the appropriate licensed health care provider.

Naturopathic Medicine in the state of New York

A Naturopathic Doctor is trained as a primary care provider and is a board-certified physician in states where licensure is applicable. **Currently licensure for Naturopathic Doctors is not available in the state of New York**. Therefore, Glenn Finley N.D. does not practice medicine, and does not diagnose or treat diseases, or medical conditions in the state of New York. In the state of New York, Glenn Finley N.D. focuses his practice on the enhancement of health. The services he provides are not meant to substitute or replace those of a licensed physician. Patients seeking his consultation are advised to also be under the care of a licensed New York state physician.

Naturopathic Medicine in the State of Vermont

As a Naturopathic Doctor in the state of Vermont, Glenn Finley N.D. is licensed to practice as a primary health care provider and is a board-certified physician.

…

I hereby request and consent to a naturopathic consultation, herbal and nutritional supplement suggestions for me (or for the patient named below, for which I am legally responsible) by Glenn Finley N.D.

I understand that all my records will be kept confidential and will not be released without my written consent.

I understand it may be necessary for Glenn Finley N.D. to contact another one of my health care providers in order to discuss any emergency situation. My signature gives Glenn Finely N.D. permission to release my medical records for the reason listed above.

I have been informed that I have the right to refuse any suggestions given by Glenn Finley N.D. I have read, or have had read to me, the above consent. I intend this consent form to cover all the suggestions Glenn Finley N.D. will provide me for my present condition and for any future condition(s) for which I seek assistance with. I have also had an opportunity to ask questions about this consent, and by signing below I agree to the above.

Patient Name _____ Patient Signature _____

Legal Guardian _____ Today's Date _____