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

PEDIATRIC-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

Pediatric Intake Form

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications?

____

Mother's age at child's birth? ___________

Mother's health during pregnancy?

____ Bleeding
____ Nausea
____ Diabetes
____ Thyroid problems
____ Medications:
____ Illnesses
____ Hypertension
____ Physical or emotional trauma
____ Cigarettes, alcohol, drug consumption

____

BIRTH HISTORY

Weight at birth __________________

Length at birth___________________

Term ____ Full ____ Premature ____ Late How long? ________________________________

Birth ____ Induced ____ Vaginal ____ C-Section ____ V-Bac

Length of labor ______________ Complications? ________________________________

Did your child have any of the following problems shortly after birth?

____ Birth defects
____ Cerebral palsy
____ Colic
____ Brain injuries
____ Seizures
____ Fever
____ Blue baby
____ Jaundice
____ Rashes

Other____

MEDICAL HISTORY

____ Chicken Pox
____ Measles
____ Mumps
____ Rheumatic Fever
____ Scarlet fever
____ Pneumonia
____ Frequent colds
____ Other
____Tonsillitis, approx. no. ___________
____ Ear Infections, approx no.________
____ Rubella

Other____

Has your child had any of the following tests?

____ Electroencephalogram Date______________
____ Psychological evaluation Date______________
____ Hearing Date______________
____ Speech/Language Date______________
____ Injuries/Surgeries/Hospitalizations Date______________

Please explain____

CHILD DEVELOPMENT

Age began Sitting _________ Crawling __________ Walking __________ Talking __________

Child's sleep patterns (first year)

____

Food intolerances

____

Feeding ____ Breast fed How long ____

____ Formula Milk/soy/other _______________________________________

Age began solids ____Years Old Which foods? ____

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

Pediatric Intake Form

FAMILY HISTORY

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

Indicate if there have been any of the following diseases in the child's family:

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

IMMUNIZATIONS

____ Measles ____ Polio ____ MMR ____ Smallpox
____ Mumps ____ DTaP ____ Tetanus booster ____ Influenza
____ Pertussis ____ Chickenpox ____ Hib ____ HPV
____ Meningococcal ____ Flu ____ Hep A ____ Hep B
____ Rotavirus ____ COVID

Other ____

Any adverse reactions____

ALLERGIES

Is your child hypersensitive or allergic? ____ Yes ____ No

List food triggers____

List environmental triggers____

MEDICATIONS

Check medications (prescribed or over the counter), your child has taken or is presently taking.

___Aspirin ___Antibiotics ___ Anti-epileptic
___Tylenol ___Anti-histamine ___Decongestant
___Ibuprofen

Other (Please list) ____

Allergies to medicines (Please list) ____

SUPPLEMENTS

List herbs, vitamins, supplements, etc. that your child is currently taking.

1. ________________________ Dose________ 4. ________________________ Dose________
2. ________________________ Dose________ 5. ________________________ Dose________
3. ________________________ Dose________ 6. ________________________ Dose________

REVIEW OF SYMPTOMS:

P for PAST
N for NOW

___Acne	___Anemia	___Anxiety	___Asthma
___Bedwetting	___Belching	___Bleeding gums	___Bleeding tendency
___Bloody urine	___Body/ breath odor	___Bronchitis	___Burning with urination
___Canker sores	___Chronic rash	___Constipation	___Cough
___Cries easily	___Diarrhea	___Diarrhea	___Dizzy spells
___Earaches	___Easy bruising	___Eczema	___Excessive fatigue
___Excessive hunger	___Excessive thirst	___Eye dryness	___Eye pain
___Fatigue	___Flat feet	___Frequent colds	___Frequent sore throat
___Frequent urination	___Gas	___Hair loss	___Hay fever
___Head injury	___Headaches	___Hearing loss	___Heart disease
___Heart murmur	___Heat/Cold intoler.	___High blood sugar	___High fevers
___Hives	___Hyperactivity	___Impaired hearing	___Irritability
___Itching	___Jaundice	___Joint pains	___Low blood sugar
___Mood swings	___Motion/car sick	___Muscle spasms	___Nervous
___Night sweats	___Nightmares	___No appetite	___Nose bleeds
___Sensitive to light	___Sinus problems	___Sleep problems	___Sore throats
___Stomach aches	___Stomach aches	___Stuffiness	___Unusual fears
___Vomiting spells	___Wheezing		

....

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 _______________________

....

CONSENT TO TREATMENT A MINOR

I, _______________________, am parent and/or legal guardian of ____________________, hereby give
Parent's Name Child's Name

permission to Ileana Tecchio ND. L.Ac., and/or Glenn Finley ND to treat my child.

Signature _____________________ Relationship to Child_________________ Date____________

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

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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.

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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 ________________________________