Welcome to the Lexington Natural Health Center!

Dr. Belanger is looking forward to meeting you at your first appointment and will work hard to help you.

Please read the following information to gain a better understanding of what your appointments will be like. Once you have read the below information, please sign, and return the signed copy to us. Your signature does NOT commit you to follow-up visits; it is for the sole purpose of acknowledging that you have read this letter. In addition to signing this letter, please complete and sign the attached medical history and consent forms prior to your appointment.

FIRST APPOINTMENT

During your first visit, Dr. Belanger will take a full history and may do a brief physical exam. He may also recommend laboratory testing from various labs to determine the underlying causes of your health condition. On your first visit he may suggest that you take certain nutritional supplements and make certain changes to your diet.

SECOND APPOINTMENT

Approximately two to four weeks after your first appointment, you will be scheduled for a second appointment to discuss the results of any laboratory testing and/or to follow up on your diet/nutritional supplement regimen. Dr. Belanger may recommend some additional nutritional supplements to help correct any abnormalities seen in your laboratory tests. He will then answer any questions you may have on diet.

ADDITIONAL APPOINTMENTS

After your second appointment, the frequency of your follow-up appointments will depend on your condition and response to therapy. Generally, Dr. Belanger may suggest that you repeat some of the lab tests to confirm that the treatment regimen is helping. When the results of these tests are back, Dr. Belanger may make some changes to your supplement list if the labs are not more favorable.

OFFICE VISIT OR TELEPHONE CONSULT RATES

First office visits (in office) with Dr. Belanger cost $320.00, for one hour. If the visit runs over one hour, $80.00 will be added for each additional 15 minutes**.** First telephone consults with Dr. Belanger cost $360.00, for one hour. If the phone consults runs over one hour, $90.00 will be added for each additional 15 minutes**. Note: an additional 15 minutes may be added to account for time spent typing, e-mailing the treatment plan, and preparing the lab orders and lab kits. This additional charge will be $90.**

The second in office visits and additional visits cost $160.00**. If these visits run over 30 minutes, $80.00 will be added for each additional 15 minutes.**

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The second phone consults and additional phone consults cost $180.00**. If these consults run over 30 minutes, $90.00 will be added for each additional 15 minutes. Note: an additional 15 minutes may be added to account for time spent typing, e-mailing the treatment plan, and preparing the lab orders and lab kits. This additional charge will be $90.**

Dr. Belanger also charges $55 for drawing blood at his office. Shipping blood to laboratories often costs between $12-25.

CANCELLATION POLICY: A 48-business hour cancellation notice is required, or a cancellation fee will be charged to your account. The cancellation fee will be the amount of the scheduled visit.
I acknowledge that I have read and agree to the cancellation policy.
Patient Signature: _____

EMAILS

Email responses to patients from the doctor that require extensive research or time (10+ minutes) will be charged at the rate of $80.00 per 15 minutes. Patients will be notified prior to see if they would like an appointment instead.
I acknowledge that I have read and agree to the e-mail policy.
Patient Signature: _____

NUTRITIONAL SUPPLEMENT COSTS

Costs for nutritional supplements are separate from office visit costs. Dr. Belanger uses laboratory tests to help determine which nutritional supplements you will need. Costs are hard to predict and can vary from month to month and person to person. If there are multiple laboratory test abnormalities one may need more supplements than someone with a few imbalances. We at the Lexington Natural Health Center offer competitive prices on our nutritional supplements. Nutritional supplements can range from $50.00 to over $1000 a month.

RETURN POLICY & REFUNDS ON NUTRITIONAL SUPPLEMENTS: **We only accept returned unopened items only that were purchased less than 30 days ago. All returns are subject to a 10% restocking fee. Special formulas and refrigerated items are nonrefundable. Laboratory tests are nonrefundable. Payments made for consultations with LNHC are also nonrefundable.**
I acknowledge that I have read and agree to the refund policy.
Patient Signature: _____

LABORATORY TESTING

Dr. Belanger uses LabCorp and Quest as his primary labs and other labs such as Vibrant America, Sanesco, Diagnos-Techs, Immunolabs, Boston Heart and Meridian Valley for other testing. LabCorp and Quest often bill insurance companies, **but we cannot guarantee that the labs will be covered.** The other labs listed need to be prepaid.

PAYMENT OPTIONS

Payment for the office visits and telephone consults are required at the time of the visit. Cash, checks and major credit cards are accepted forms of payment.

Patient Signature
_____Date_____

We hope that having this information prior to your visit is helpful. If you have any questions or need additional information, please send an email to contact@lexingtonnaturalhealth.com and we will be glad to help. Remember, you have an incredible healing ability deep within your body! If you replenish your body with the help of naturopathic medicines, it can do amazing things!

PATIENT PROFILE DATE_____

The following information is critical to your health and Lexington Natural Health Center's treatment of you. Please take the time to fill out this form fully and accurately.

NAME_____ AGE_____

BIRTHDATE_____ SEX___

STREET_____CITY_____STATE_____ZIP_____HT___WT_____

PHONE (home)_____(work)_____

SS#_____

Can we call you or leave a message at your home number? Y N Work number? Y N

OCCUPATION_____EMPLOYER_____

_____

E-MAIL (for communication and sending labs)_____

NAME IN CASE OF EMERGENCY_____PHONE#_____

How did you hear about our center?

_____

Please list your primary care doctor on line one and any specialist you are seeing (line 2) and their location

1. Dr.'s

Name_____Address_____Phone_____

2. Dr.'s

Name_____Address_____Phone_____

PRESENT HEALTH CONCERNS: Please list in their order of significance.

1)_____

_____

2)_____

_____

3)_____

_____

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MEDICATIONS: (Please list current medications, including dosages)

_____

_____

_____

SUPPLEMENTS (Please list current vitamins, herbs &/or homeopathic remedies, including dosages)

_____

_____

_____ALLERGIES (Including medications, environmental &/or food)

_____

_____

PAST MEDICAL HISTORY (Please check all relevant conditions)

Alcoholism		Epilepsy		Liver Disorder	
Allergies		Gout		Mental Illness	
Arthritis		Heart Disorders		Skin Disorder	
Asthma		Hepatitis		Stroke	
Cancer		High Blood Pressure		Thyroid Disorder	
Colitis		Hypoglycemia		Tuberculosis	
Diabetes		Injury (Serious)		Venereal Disease	

Others:

_____

____

LEXINGTON NATURAL HEALTH CENTER

Date of last complete physical exam_____ Date of last blood tests_____

Date/result of last Pap Smear_____ Date/result of last bone density_____

Date/result of last mammogram _____Date/result of last colonoscopy_____

HOSPITALIZATIONS (Dates & type of illness/operation)

_____

_____

SOCIAL HISTORY

Please circle those that apply single married significant other.
Do you have children? Yes No How many? _____

Ages_____

SAMPLE DIET: (Please be descriptive)

Breakfast_____

_____

Lunch_____

_____

Dinner_____

_____

Snacks & Beverages

_____

PERSONAL HABITS

Circle any of these substances that you use regularly: tobacco caffeine alcohol recreational drugs.

Do you exercise regularly? If so, what type, how long & how often?

_____

_____

_____

Do you: Sleep Well? ____Y____N Wake rested? ____Y____N Average hours of sleep is _____

How many times do you wake up during the night?

FAMILY HISTORY

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	Y	Who		Y	Who		Y	Who
Alcoholism			Epilepsy			Mental Illness		
Allergies			Gout			Osteoporosis		
Arthritis			Heart Disease			Skin Disorder		
Asthma			Hepatitis			Stroke		
Cancer			Hypertension			Thyroid Disease		
Colitis			Hypoglycemia			Tuberculosis		
Diabetes			Liver Disease			Venereal Disease		

I acknowledge that this information is true and correct to the best of my knowledge. I will notify Lexington Natural Health Center, Inc (LNHC) of any changes in my health status or above information.

I, the undersigned, am directly responsible for all payments for fees incurred on my behalf at this office. These are due and payable at the time services are rendered. If I do not meet my obligation of timely payments, I further understand that a late charge will be added to any overdue balance. If the account is not paid within 90 days of the date of service I understand I will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting my account. I am aware that my practitioner may charge for telephone consultations and charge accordingly for office visits that extend past the time the office visit has been originally booked. I understand that the payment provided for consults with LNHC is nonrefundable.

Date_____ Signature_____ Printed Name_____

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INFORMED CONSENT FOR TREATMENT

Printed Patient's Name: _____

I hereby authorize the Naturopathic Doctors and other practitioners of the Lexington Natural Health Center (hereinafter referred to as "LNHC") to perform specific therapies and/or procedure(s) as necessary to facilitate my evaluation and treatment included but not limited to the following:

- **Common Lab procedures:** e.g. venipuncture, pap smears, laboratory evaluation of blood, urine, stool and saliva.
- **Physical exam:** e.g. general, gynecological, musculoskeletal, neurological.
- **Minor office procedures:** e.g. dressing a wound, ear cleansing.
- **Medicinal use of nutrition:** therapeutic nutrition, nutritional supplementation of vitamins, minerals, amino acids, and other nutritional or therapeutic substances.
- **Botanical medicine:** botanical substances (herbal medicines) may be prescribed as teas, extracts, capsules, tablets, powders, essential oils, suppositories, crèmes, plasters, or other topical preparations.
- **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, fasting, elimination diets, promoting of wellness including recommendations for exercise, sleep, stress, reductions, and balancing of work and social activities.
- **Physical medicine:** e.g. hydrotherapy (use of hot and cold water)

Potential Risks include, but are not limited, to allergic reactions to prescribe herbs and supplements, side effects of natural medicine, inconvenience of life style changes, and venipuncture for lab evaluation.

Potential benefits include, but are not limited to, restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must inform the treating practitioner if they know or suspect that they are pregnant as some of the therapies and/or procedures described above may present a risk to the pregnancy.

Notice to Nursing Mothers: All female patients must inform the treating practitioner if they are breast feeding as some of the therapies and/or procedures described above may present a risk to the nursing child.

I understand that the therapies and/or procedures recommended by LNHC are not all accepted by the United States Food and Drug Administration.

I understand the practitioners of LNHC are not primary care physicians or MD's. They are licensed ND's, naturopathic doctors. I understand the therapies and/or procedures that I will be receiving at LNHC are supplementary care to my primary care physician and/or medical doctor ("M.D.") and/or ("D.O.") specialist(s).

Over

I understand that the therapies and/or procedures recommended by LNHC are not intended to replace those treatments prescribed by my M.D. and/or D.O.

I recognize that there are potential risks and benefits of the therapies and/or procedures. I understand it is my right and responsibility to ask questions and discuss, to my satisfaction, the potential risks and benefits as well as reasonable alternatives to the therapies and/or procedures before I begin any therapies and/or procedures offered to me by the LNHC.

With this knowledge, I voluntarily consent to the above therapies and/or procedure(s) realizing that there are no guarantees and/or warrantees in using the above therapies and/or procedure(s) that will be administered to me by LNHC or any of its personnel regarding the improvement or cure of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these therapies and/or procedure(s) at any time.

I consent to the observation or participation of students in the care provided to me for educational purposes.

I understand that LNHC may recommend changes to my therapeutic plan as necessary to facilitate my treatment. I intend this informed consent form to cover the entire course of treatment(s) for my present condition and any future conditions for which I seek treatment at LNHC.

I certify that I have read and fully understand this consent. I further certify that I have full authority and accept full responsibility to execute this consent for and on behalf of the above-named patient and that I am signing freely and voluntarily.

_____ _____

Date Signature of Patient

_____

Signature of Patient Representative or Guardian

_____ _____

Date Signature of Doctor

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Privacy Notice Acknowledgement

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996(HIPAA),we are required to supply you with a copy of our privacy policies and procedures.We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Dr. James Belanger or Dr. Karen Braga (Lexington Natural Health Center) *Notice of Privacy for Protected Health Information.*

I, the undersigned, certify that I have read and understand the above notice and that I am directly responsible for all payments of fees incurred on my behalf at this office

_____ _____

Patient Name, Printed Date

_____

Patient Signature

_____ _____

Personal Representative, Printed Personal Representative, Signed

_____

Description of personal representative's authority to act for the patient.

Name: _____ Date:_____

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Review of Symptoms

Please complete this questionnaire as thoroughly as possible. This is a confidential record of your medical history and will not be released except when you have authorized us to do so.

Please check Y = Yes, N = No

General
Y N
☐ ☐Fatigue
☐ ☐Night Sweats

Skin
Y N
☐ ☐Infections
☐ ☐Growths
☐ ☐Rashes/Inflammation
☐ ☐Changes in hair or nails

Head
Y N
☐ ☐Headaches
☐ ☐Dizziness

Eyes
Y N
☐ ☐Eye pain
☐ ☐Impaired Vision ☐ Glasses ☐ Contacts
☐ ☐Excessive tearing
☐ ☐Excessive dryness

Ears
Y N
☐ ☐Ringing
☐ ☐Earaches
☐ ☐Itching

Nose
Y N
☐ ☐Chronic Nose Bleeds
☐ ☐Chronic Stuffiness
☐ ☐Chronic Sinus Problems
☐ ☐Chronic Post Nasal Drip

Mouth & Throat
Y N
☐ ☐Frequent Sore Throat
☐ ☐Sores in Mouth
☐ ☐Sores on Lips
☐ ☐Gum or Dental Problems

Neck
Y N
☐ ☐Chronic Pain or Stiffness
☐ ☐Chronic Swollen Glands

Blood
Y N
☐ ☐Have you ever been diagnosed with anemia?

Respiratory
Y N
☐ ☐Chronic Cough
☐ ☐Shortness of Breath
☐ ☐Wheezing
☐ ☐Positive TB Test ever?
☐ ☐Cough up blood ever?

Heart/Circulation
Y N
☐ ☐Chest pain or Tightness
☐ ☐Palpitations, Fluttering
☐ ☐Varicose Veins
☐ ☐Swelling of Ankles
☐ ☐Cold Hands/Feet
☐ ☐Deep Leg Pain
☐ ☐Heart Murmer
☐ ☐Ever diagnosed with Rheumatic Fever?

Digestion
Y N
☐ ☐Heartburn
☐ ☐Stomach pain
☐ ☐Chronic Nausea
☐ ☐Chronic unexplained Vomiting
☐ ☐Daily Bowel Movements
☐ ☐Blood in Bowel Movement
☐ ☐Mucus in Bowel Movement
☐ ☐Chronic Belching
☐ ☐Chronic Gas
☐ ☐Hemorrhoids

Urinary
Y N
☐ ☐Pain on urination
☐ ☐Increased Frequency
☐ ☐Inability to hold urine
☐ ☐Chronic bladder infections

Please Continue on Other Side

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Female Reproduction:
Age menses began _____
No. of days of Menstrual Flow _____
Length of Complete Cycle _____
Date of Last Menstrual Period _____
Y N
☐ ☐Are your Cycles Regular?
☐ ☐Bleeding in between periods?
☐ ☐Midcycle pain
☐ ☐Cramps with your period
☐ ☐Excessive Menstrual flow
☐ ☐PMS Symptoms
Y N
☐ ☐Bloating/Swelling
☐ ☐Irritability/Anger
☐ ☐Depression
☐ ☐Anxiety
Y N ☐ ☐Excessive Hunger
☐ ☐Pain during intercourse
☐ ☐Ever suffer from any Venereal Diseases?
Which one(s): _____
☐ ☐ Ever been pregnant?
No. of Pregnancies _____
No. of Live Births _____
No. of Miscarriages _____
No. of Abortions _____
☐ ☐ Birth control?
What type? _____
☐ ☐Menopausal signs/symptoms
Y N
☐ ☐Hot flashes
☐ ☐Night Sweats
☐ ☐Insomnia
☐ ☐Heart palpitations
☐ ☐Urinary Dysfunction
☐ ☐Changes in Sex Drive
☐ ☐Hair loss
☐ ☐Facial Hair

Male Reproduction
Y N
☐ ☐Testicular masses
☐ ☐Testicular pain
☐ ☐Ever any prostate problems
☐ ☐Abnormal discharge or sores of penis
☐ ☐Veneral Disease
Which one(s): _____
☐ ☐Sexual Difficulties
☐ ☐Difficulty starting and stopping urine
☐ ☐Birth control
What type? _____
Neurological
Y N
☐ ☐History of Fainting
☐ ☐History of Seizures
☐ ☐Numbness or Tingling
Musculoskeletal
Y N
☐ ☐Joint pain or stiffness
☐ ☐Muscle spasms or cramps
☐ ☐Muscle weakness
☐ ☐Hernias
Endocrine
Y N
☐ ☐Ever any thyroid problem
☐ ☐Heat or cold intolerance
☐ ☐Excessive thirst
☐ ☐Excessive hunger
☐ ☐Easy weight gain

☐ ☐Acne
☐ ☐Vaginal dryness

Breasts

Y N

☐ ☐Do you do self exam regularly
☐ ☐Lumps
☐ ☐Pain or tenderness
☐ ☐Nipple discharge