Welcome to Natural Medicine Plus,

We are pleased that you chose our clinic to provide your medical care. Enclosed you will find an intake form as well as our financial options. Please review and fill out these documents and bring with you to our appointment. Your appointment is scheduled for one hour.

Our mission at Natural Medicine *Plus*:

- First to listen and to understand the patient's symptoms and immediate needs
- To teach about diagnosis
- To explore the patient's options for wellness and for treatment
- To share our resources and networks of referral
- To provide the context in which the patient can make informed decisions in keeping with individual needs, values, goals and priorities

Our intention is to offer kindness and ease at every level of interaction and transaction. Integrity, transparency, compassion, service, information, education and follow up are the cornerstones of our patient, professional and business relationships.
Our approach to your visit and possible treatments set us apart. First we work hard to understand your experience. We take the time to listen, and work with you to develop a plan to achieve your health goals.
Our extensive medical training, including physical, clinical and laboratory diagnosis, enables us to understand your condition. In this way we are similar to all physicians. We distinguish ourselves by the time we give you and by the care with which we support you after and between visits. Our website will give you more details of specific therapies.

We are excited and looking forward to meeting you!

Sincerely,

Natural Medicine Plus

Natural Medicine Plus
33 Neill Ave
Helena, MT 59601
(406-442-8508)

Intake Form

DATE _____ / _____ / _____

Name _____ **DOB** _____ / _____ /_____

☐ **Male** ☐ **Female** **SSN**:_____-_____-_____

Address _____ **City** _____**State** ____ **Zip** _____

Phones*(check preferred)* ☐ **Home**_____-_____-_____ ☐ **Cell**_____-_____-_____ ☐ **Work**_____-_____-_____

Email _____

Occupation _____

Employer_____

Emergency Contact _____ **Phone** _____-_____-_____ **Relation** _____

How did you hear about us?_____

INSURANCE INFORMATION

Insurance Name_____ **Relation to Insured: Self Spouse Other**_____

Policyholder Name (other than "self") _____
DOB:_____

Policyholder Address_____
City/State_____

Zip_____ **Phone**_____

Subscriber ID_____
Group#_____

I understand that my insurance coverage is an agreement between my insurance company and myself. I also understand that I am responsible for any balance not paid/covered by my insurance company within 30 days from date of service, regardless of a contract Natural Medicine Plus may have with the insurance company. I assign any benefits payable to be paid directly to Natural Medicine Plus, Dr. Jeff Roush. I authorize the release of any information necessary to process my medical claims as allowed by law.

X_____ _____
(Signature Patient OR Parent of Minor) (Date)

SERVICES NOT BILLABLE TO INSURANCE

Some of the services offered at Natural Medicine Plus are not "accepted" as reimbursable therapies by insurance carriers. These treatments will not be covered by your insurance company and therefore you will be held responsible for full payment of these services, as they will not be submitted to insurance companies. Some of these services include prolotherapy, trigger point injections, vitamin IV (intravenous) therapy, chelation therapy, HCG weight loss therapy and vitamin/ herbal/ homeopathic supplements.

I understand that I am financially responsible for the payment of these services if I agree to them as part of my treatment plan with my doctor.

X_____ _____
(Signature of Patient OR Parent of Minor) (Date)

GUARANTOR (if different from patient)

Name_____ **Relation to Patient**_____

Address_____

Phone_____

MEDICAL INFORMATION

What is your primary health concern? _____

What additional concerns would you like to address? _____

In general how would you describe your health?

_____

To what extent are you open to changes in lifestyle to address your concerns?

☐ I will do whatever it takes ☐ I am willing to make some changes ☐ I am willing to consider changes

MEDICAL HISTORY

List all medications you are currently taking: _____

List all herbs/vitamins/supplements you are currently taking: _____

List all allergies: *(food/environmental /drug)* ☐ None Known

_____

FAMILY HISTORY *Please list all diseases, ages of death, and causes of death (if appropriate)*

Mother _____

Father _____

Siblings_____

Please describe your health habits (Check all that apply)

☐ Caffeine _____ # cups per day ☐ Alcohol _____ # (8oz beer – 6oz wine – 1.5oz liquor) per (day – week – month)

☐ Water _____ # cups per day ☐ Tobacco _____ # (cigarettes – cigars – pipes – dips) per day

CHECK ALL THAT APPLY: Do you currently have or have been previously diagnosed with?

☐ Abnormal pap
☐ Alcoholism
☐ Anemia
☐ Ankle swelling
☐ Anorexia
☐ Arthritis
☐ Bleeding disorder
☐ Bloating
☐ Blood in urine
☐ Blurred vision
☐ Breakthrough bleeding
☐ Breast lump
☐ Bowel changes
☐ Bulimia
☐ Cancer
☐ Chemical dependency
☐ Chest pain
☐ Chills
☐ Cold Hands/Feet
☐ Cold sores
☐ Constipation
☐ Depression
☐ Dizziness
☐ Diabetes
☐ Diarrhea
☐ Difficulty swallowing
☐ Eczema
☐ Emphysema
☐ Erectile difficulties
☐ Excessive hunger
☐ Excessive thirst
☐ Fainting
☐ Forgetfulness
☐ Frequent urination
☐ Glaucoma
☐ Goiter
☐ Gout
☐ Headache
☐ Heart disease
☐ Hemorrhoids
☐ Hepatitis
☐ HIV/AIDS
☐ High blood pressure
☐ High cholesterol
☐ Hoarseness
☐ Hot flashes
☐ Infections
☐ Irregular heartbeat
☐ Keloid scars
☐ Kidney disease
☐ Liver disease
☐ Loss of sex drive
☐ Loss of sleep
☐ Melanoma
☐ Menstrual pain
☐ Mental disorder
☐ Migraines
☐ Miscarriage
☐ Mononucleosis
☐ Nausea
☐ Nervousness
☐ Nipple discharge
☐ Numbness
☐ Painful intercourse
☐ Painful urination
☐ Penile discharge
☐ Poor appetite
☐ Poor bladder control
☐ Prostate problems
☐ Rapid heartbeat
☐ Sinus problems
☐ STDs
☐ Stomach pain
☐ Stroke
☐ Sweats
☐ Testicular lump
☐ Thyroid problems
☐ Ulcers
☐ Vaginal discharge
☐ Varicose veins
☐ Vomiting
☐ Vomiting blood
☐ Weight gain
☐ Weight loss

☐ Other(s) _____

ACKNOLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been notified and/or received a copy of Natural Medicine Plus's Notice of Privacy Practices (HIPAA).

Print Name of Patient/Guardian **DOB**

Signature of Patient/Guardia **Date Signed**

Relationship to Patient (Self, Parent, Guardian, Power of Attorney

Clinic Witness **Date Signed**