



Dr. Kristina Taylor Lewis, ND
Dr. Eric Lewis, ND

16 Sterling Street
Asheville, NC 28803
828-298-4800
LewisNaturalHealth.com

Dear Patient,

We want to thank you for choosing us as your naturopathic healthcare provider. In order to give you the best possible care, please review the following information before your first appointment.

Your First Appointment(s) with Kristina Lewis, ND

- **Patient name:** _____
- **Part I appointment:** _____
- **Part II appointment:** _____

Please fill out the following forms and provide them to our office at least 2 days *BEFORE* your first appointment. You may fax (866-400-9118), mail, or personally deliver these forms to our office.

- A completed New Patient Information Form
- A completed Homeopathic Information Form

Please bring to your first appointment:

- Any forms not yet completed
- A completed 5-Day Diet Diary
- All current medications, supplements, and/or vitamins (in their original bottles, if possible)
- Copies of any previous medical records (including lab work). To request records from another physician, please use the "Records Release" form included in this packet. If you do not have records to share, you can leave this form blank.

To change your appointment, please contact us **48-hours in advance**, and we will be happy to reschedule you to a more convenient time. In order to reserve your first appointment, we require a **\$100 deposit**. This deposit is refundable minus a \$15 processing fee with a 48-hour cancellation notice. ***Missed appointments with no notice given in person or by phone are subject to a charge for the full amount of the scheduled visit.*** Please review our office policies and the end of this packet for more details.

If you have any questions before your appointment, please do not hesitate to call us at **828-298-4800**. Thank you!

***We are looking forward to providing you with
excellence in naturopathic healthcare!***



Confidential New Patient Information

PLEASE PRINT

Today's Date _____

Patient's Name: _____

Gender: M F Birthdate: ___/___/___ Age: _____

Mailing Address: _____
Street City State Zip

Primary Phone: _____ Alternate Phone: _____

Email address: _____ Alternate Email: _____

Relationship Status: Single Married Partnership Separated Divorced Widow(er)

Spouse/Partner's Name _____

Children (Names/Ages) _____

Parent/Guardian Name (if patient under 18): _____

Occupation _____ Employer: _____

Hobbies/Interests: _____

Emergency Contact: Name _____ Relationship _____ Phone _____

Primary Care Physician: Name: _____ Office: _____

How did you hear about us?

[] Referral from an existing patient: (who?) _____

[] Referral from another health care provider: (who?) _____

(If you were referred, may we have your permission to thank the individual?)
Yes, please! Yes, but please keep my name anonymous No

[] Internet search [] Yellow Pages [] Newspaper/Magazine: _____

[] Speaking Event (which one?): _____

[] Other (please specify): _____

What made you decide to make an appointment with Lewis Family Natural Health?

List, in order of importance, your major health concerns/what you wish us to address today:

1. _____
2. _____
3. _____
4. _____
5. _____

What treatments have you already tried?

- Conventional Medicines Surgery Diet/Nutrition Chiropractic Massage
 Herbal Medicines Homeopathy Acupuncture Vitamins Fasting/Detoxification
 Other: _____

Current Medications: (include all prescription and over-the-counter medications; don't forget birth control, hormones, etc.)

<i>Medication</i>	<i>Dose/Frequency</i>	<i>For how long?</i>	<i>For what reason?</i>

Current Supplements: (include all vitamins, herbs, homeopathy, or other supplements)

<i>Supplement</i>	<i>Brand</i>	<i>Dose/Frequency</i>	<i>For how long?</i>	<i>For what reason?</i>

Family History: Please circle "Y" for Yes if YOU or your PARENTS, SIBLINGS, CHILDREN, or GRANDPARENTS have had any of the following conditions.

	You	Father	Mother	Siblings	Grandparents	Children
Cancer	Y	Y	Y	Y	Y	Y
High blood pressure	Y	Y	Y	Y	Y	Y
Heart disease	Y	Y	Y	Y	Y	Y
Heart attack	Y	Y	Y	Y	Y	Y
Stroke	Y	Y	Y	Y	Y	Y
Diabetes	Y	Y	Y	Y	Y	Y
High Cholesterol	Y	Y	Y	Y	Y	Y
Autoimmune disease	Y	Y	Y	Y	Y	Y
Thyroid disease	Y	Y	Y	Y	Y	Y
Obesity	Y	Y	Y	Y	Y	Y
Osteoporosis	Y	Y	Y	Y	Y	Y
Arthritis	Y	Y	Y	Y	Y	Y
Alcoholism	Y	Y	Y	Y	Y	Y
Drug addiction	Y	Y	Y	Y	Y	Y
Eating disorder	Y	Y	Y	Y	Y	Y
Anxiety	Y	Y	Y	Y	Y	Y
Depression	Y	Y	Y	Y	Y	Y
Suicide/Suicidal	Y	Y	Y	Y	Y	Y
Allergies	Y	Y	Y	Y	Y	Y
Asthma	Y	Y	Y	Y	Y	Y
Skin disease	Y	Y	Y	Y	Y	Y
If deceased, please list age & cause of death:						

Other (please describe): _____

Describe cancer (if any): _____

Please list any known allergies (Medications, Foods, Environmental, Chemical):

**Review of Systems: Please indicate if you have had problems with any of the following:
Circle P for Past or C for Current**

HEAD:		
Headache	P	C
Migraine	P	C
Head injury	P	C
Dizziness/Vertigo	P	C
EYES/EARS/NOSE/THROAT:		
Seasonal allergies	P	C
Blurry vision	P	C
Double vision	P	C
Cataracts	P	C
Glaucoma	P	C
Other eye disorder	P	C
Ear aches/infections	P	C
Hearing disorder	P	C
Tinnitus (ringing in ears)	P	C
Sinus pain/infection	P	C
Nasal congestion	P	C
Nose bleeds	P	C
Frequent colds	P	C
Sore throat	P	C
Voice hoarseness	P	C
RESPIRATORY:		
Asthma	P	C
Bronchitis	P	C
Coughing	P	C
Shortness of breath	P	C
Wheezing	P	C
CARDIOVASCULAR:		
Heart disease	P	C
High blood pressure	P	C
Low blood pressure	P	C
Chest pain	P	C
Palpitations	P	C
Murmurs	P	C
Edema (swelling)	P	C
Rheumatic fever	P	C
Stroke	P	C
Vascular disease	P	C
URINARY TRACT:		
Frequent urinary infections	P	C
Pain with urination	P	C
Discharge/ blood in urine	P	C
Frequent urination/urgency	P	C
Kidney stones	P	C
Urinary incontinence	P	C
GASTROINTESTINAL:		
Heartburn/Acid reflux/GERD	P	C
Ulcer	P	C
Bloating	P	C
Excessive flatulence	P	C
Nausea/Vomiting	P	C
Constipation	P	C
Diarrhea	P	C
IBS	P	C
Crohn's/Ulcerative Colitis	P	C
	P	C

Gall stones	P	C
Gall bladder disease	P	C
Hepatitis	P	C
Cirrhosis	P	C
Pancreatitis	P	C
SKIN:		
Dry skin	P	C
Acne	P	C
Rash	P	C
Hives	P	C
Eczema	P	C
Psoriasis	P	C
Moles	P	C
Recent skin changes	P	C
Skin cancer	P	C
MUSCULOSKELETAL:		
Arthritis	P	C
Joint pains	P	C
Joint stiffness	P	C
Gout	P	C
Muscle aches/pains	P	C
Back pain	P	C
Neck pain	P	C
Weakness	P	C
Tremors	P	C
NERVOUS SYSTEM:		
Tingling/numbness	P	C
Paralysis	P	C
Seizures	P	C
Sciatica	P	C
Carpel tunnel syndrome	P	C
Insomnia	P	C
ENDOCRINE:		
Diabetes (Type I or II)	P	C
Thyroid disease	P	C
Hormonal problems	P	C
MENTAL/EMOTIONAL:		
Anxiety	P	C
Depression	P	C
Bipolar disorder	P	C
Suicidal	P	C
Anger	P	C
Fearful	P	C
Panic attacks	P	C
Mood swings	P	C
Poor memory	P	C

Gynecological History

Circle which best describes your current menstrual status?

- Premenopause (before menopause; having periods)
- Amenorrhea (before menopause, but not having periods)
- Perimenopause/transition towards menopause (I have seen changes in my period and think menopause is coming soon, but I have not gone 12 months in a row without a period)
- Postmenopause (I have not had a period in 12 months)

Age of first menstrual period: _____ Date of last menstrual period: _____

Are your periods (or were your periods) usually: Regular Irregular

How many days between periods?: _____ How many days does your period last?: _____

Are your periods painful? _____ Do you have spotting or bleeding between periods? _____

Have you experienced any recent changes in your menstrual cycle? Y N

- Please describe any changes in how often you have periods: _____
- Please describe any changes in how many days you bleed: _____
- Please describe how your flow is heavier, lighter, or different in any way: _____
- Any other changes? _____

Have your periods stopped? _____ Age at onset of Menopause: _____

Was your menopause: *Spontaneous/Natural* *Surgical/After a hysterectomy*

Do you use or have you used Hormone Replacement Therapy? Please describe your experience:

Do you have a uterus? Y N Do you have your ovaries? Y N

Have you experienced any of the following? Circle P for Past or C for Current.

Frequent yeast infections	P	C
Fibrocystic breasts	P	C
Hair growth on face	P	C
Endometriosis	P	C
Uterine fibroids	P	C
Ovarian cysts	P	C

Female Cancer	P	C
Pelvic inflammatory disease	P	C
Sexually transmitted disease	P	C
Osteoporosis	P	C
Osteopenia	P	C

When was your last:

Pap smear: _____ Mammogram/Breast Exam: _____ Bone Density Test: _____

Have you ever had any abnormal results from any of these tests? _____

Obstetrical History

Please indicate the method of birth control you are currently using or have used previously.
Circle P for Past or C for Current.

Birth control pill, patch, or ring	P	C
Injectable or implanted hormone	P	C
Condoms	P	C
Diaphragm, cervical cap, foam/gel	P	C
Sterilization ("Tubes tied")	P	C
Male partner had vasectomy	P	C

IUD	P	C
Natural family planning/rhythm method	P	C
Other	P	C

How many children do you have? _____ How many times have you been pregnant? _____

of Births: _____ # of Miscarriages: _____ # of Abortions: _____ # of Adoptions: _____

Have you had difficulty conceiving or carrying a pregnancy to term? _____

Any complications during pregnancy, delivery, or postpartum? _____

Sexual History

Are you currently sexually active? *Yes No*

Are you sexually active with: *A man (or men)* *A woman (or women)* *Both men & women*

Are you currently in a mutually monogamous relationship? _____

How long have you been with your current sex partner? _____

Do you have concerns about your sex life? _____

Do you have a loss of interest in sexual activities (libido, desire)? _____

Do you have any concerns with the physical sensations of sex (vaginal dryness, pain, orgasm, etc.)?

If you have pain, please describe the pain: *Pain with penetration* *Pain inside* *Feels dry*

Do you have a history of (please circle) sexual, mental, emotional, and/or physical abuse? At what age(s)? _____

Premenstrual Syndrome (PMS), Menstrual Cycle, and Menopausal Symptoms Checklist

The following section is designed to understand the symptoms you experience related to your menstrual cycle. This includes PMS symptoms, symptoms that are experienced during or after your period, and/or changes you are experiencing due to perimenopause or menopause.

Please rank the symptoms on the following page according to the degree of severity with which you experience them. Please also indicate when in your menstrual cycle you experience these symptoms (before, during, and/or after your period). If you are no longer having periods and are in menopause, or if you are having periods but suspect that some of these symptoms are specifically related to an approaching menopause, please indicate below.

Please use the following system to rank your symptoms. You may choose more than one option when appropriate. If you do not experience a symptom, please leave it blank.

Severity:

- 1 = Mild
- 2 = Moderate
- 3 = Severe

Timing:

- B = Week BEFORE period
- D = DURING period
- A = Week AFTER period
- M = MENOPAUSE

Anxiety	1	2	3	B	D	A	M
Irritability	1	2	3	B	D	A	M
Mood swings	1	2	3	B	D	A	M
Depression	1	2	3	B	D	A	M
Crying easily	1	2	3	B	D	A	M
Crying often	1	2	3	B	D	A	M
Trouble concentrating	1	2	3	B	D	A	M
Poor memory	1	2	3	B	D	A	M
Trouble falling asleep	1	2	3	B	D	A	M
Trouble staying asleep	1	2	3	B	D	A	M
Fatigue	1	2	3	B	D	A	M
Appetite changes	1	2	3	B	D	A	M
Headaches	1	2	3	B	D	A	M
Migraines	1	2	3	B	D	A	M
Dizziness/Fainting	1	2	3	B	D	A	M
Palpitations	1	2	3	B	D	A	M
Skin crawling	1	2	3	B	D	A	M
Feeling hot	1	2	3	B	D	A	M
Hot flashes	1	2	3	B	D	A	M
Feeling cold	1	2	3	B	D	A	M
Night sweats	1	2	3	B	D	A	M
Urinary changes	1	2	3	B	D	A	M
Incontinence	1	2	3	B	D	A	M
Pain with urination	1	2	3	B	D	A	M
Bladder infections	1	2	3	B	D	A	M
Vaginal dryness	1	2	3	B	D	A	M

Vaginal infections	1	2	3	B	D	A	M
Vaginal discharge	1	2	3	B	D	A	M
Pain with sex	1	2	3	B	D	A	M
Change in libido	1	2	3	B	D	A	M
Weight gain	1	2	3	B	D	A	M
Swollen arms/legs	1	2	3	B	D	A	M
Breast tenderness	1	2	3	B	D	A	M
Breast swelling	1	2	3	B	D	A	M
Abdominal bloating	1	2	3	B	D	A	M
Oily skin	1	2	3	B	D	A	M
Acne	1	2	3	B	D	A	M
Other skin changes	1	2	3	B	D	A	M
Constipation	1	2	3	B	D	A	M
Diarrhea	1	2	3	B	D	A	M
Gas	1	2	3	B	D	A	M
Menstrual cramps	1	2	3	B	D	A	M
Low back pain	1	2	3	B	D	A	M
Pain in thighs	1	2	3	B	D	A	M
Heavy flow	1	2	3	B	D	A	M
Light flow	1	2	3	B	D	A	M
Spotting	1	2	3	B	D	A	M
Prolonged bleeding	1	2	3	B	D	A	M
Short bleeding	1	2	3	B	D	A	M
Pelvic pain	1	2	3	B	D	A	M

Any other symptoms?: _____

Health Habits:

Do you regularly use any of the following?:

- Antacids Pain medicines (Prescription or Over-the-counter, i.e. Advil, Tylenol)
 Steroids (Prednisone, Cortisone, etc.) Laxatives Antibiotics
 Tobacco: Current? _____ Past? _____ Amount per day: _____ Since when?: _____

Does anyone smoke in your household? _____

- Alcohol: Number of drinks per day: _____ Recreational Drugs _____

Have you ever had addiction for alcohol or drugs? _____ Did you receive treatment? _____

What special diet do you follow, if any? (Vegetarian, Vegan, Food allergy, Atkins, etc.) _____

Eating Habits:

- Skip breakfast Graze (small, frequent meals) Generally eat on the run
 3 meals a day Food rotation Crave sweets
 2 meals a day Eat constantly whether hungry or not Crave salt

What do you drink during the day and how much? (Coffee, tea, soda, water, juice, etc.)

Exercise:

Do you exercise? _____ What type of exercise do you do? _____

How often do you exercise? _____ For how long do you exercise? _____

Weight:

Your weight today: _____ Your height: _____ Your ideal weight: _____

Do you consider yourself: Overweight Underweight Just right

Have you experienced any unintentional weight loss or gain in the past 6 months? _____

Sleep:

How long do you sleep each night? _____ Do you have difficulty falling asleep? _____

Do you wake during the night? If so, why? _____ Do you wake feeling refreshed? _____

General Energy level (1=low, 10=high): 1 2 3 4 5 6 7 8 9 10

Do you experience fatigue? If so, when?: Morning Afternoon Evening

Does fatigue limit your daily activities? _____

Stress:

Stress level (1=low, 10=high): 1 2 3 4 5 6 7 8 9 10

What are your major sources of stress? _____

Do you enjoy your work? _____ How many hours a week? _____

Is your home or job associated with potentially harmful chemicals (pesticides, herbicides, solvents, radioactivity, etc.)?: _____

How can we best be of service to you? What are you hoping to gain from this relationship? Do you have any specific wishes or requests regarding your treatment that you would like us to know about?

How thirsty are you in general?

Not at all Very
1 2 3 4 5 6 7 8 9 10

Do you notice any specific tastes in your mouth (e.g., metallic, bitter, foul, etc.)?

Mental and Emotional State:

Where do you fall on the continuum of the following personality traits. Answer as honestly as you can.

Stingy Overly generous
1 2 3 4 5 6 7 8 9 10

Hurried, impatient Slow
1 2 3 4 5 6 7 8 9 10

Messy Clean and organized
1 2 3 4 5 6 7 8 9 10

Calm Restless
1 2 3 4 5 6 7 8 9 10

Lazy Always busy
1 2 3 4 5 6 7 8 9 10

Shyness/Timid/Bashful Outgoing
1 2 3 4 5 6 7 8 9 10

Mild Angry/Temper
1 2 3 4 5 6 7 8 9 10

Never feels guilty Always feels guilty
1 2 3 4 5 6 7 8 9 10

Not religious Very religious
1 2 3 4 5 6 7 8 9 10

Stubborn Yielding
1 2 3 4 5 6 7 8 9 10

Reckless Cowardice
1 2 3 4 5 6 7 8 9 10

Aversion to company Desire for company
1 2 3 4 5 6 7 8 9 10

Indecisive Quick to decide
1 2 3 4 5 6 7 8 9 10

Unselfish Selfish
1 2 3 4 5 6 7 8 9 10

Quarrelsome Yielding
1 2 3 4 5 6 7 8 9 10

Bossy/Dictatorial Yielding/Fawning
1 2 3 4 5 6 7 8 9 10

Not trusting Trusting
1 2 3 4 5 6 7 8 9 10

Gullible Suspicious
1 2 3 4 5 6 7 8 9 10

Quiet Talkative
1 2 3 4 5 6 7 8 9 10

How much do you worry about the following things:

Your physical health
Never *Sometimes* *Always*

Your mental health
Never *Sometimes* *Always*

Your emotional health
Never *Sometimes* *Always*

The health of your loved ones (family and close friends)
Never *Sometimes* *Always*

Financial security
Never *Sometimes* *Always*

Morals/Past indiscretions
Never *Sometimes* *Always*

Religion
Never *Sometimes* *Always*

Social life
Never *Sometimes* *Always*

Social position
Never *Sometimes* *Always*

The future
Never *Sometimes* *Always*

Work
Never *Sometimes* *Always*

List any other worries that you have:

Fears:

How fearful in general are you?

Frightened Easily Never Afraid
1 2 3 4 5 6 7 8 9 10

Are you afraid/fearful of any of the following? Please circle all that apply:

- Animals
- Being alone
- Death (your own)
- Death of a loved one
- Impending disease
- Downward motion
- Evil
- Failure
- Falling
- Ghosts
- Heights
- Insanity
- Misfortune/Bad Luck
- Crowds
- People
- Robbers/Intruders
- Snakes
- Spiders
- Strangers
- Having a stroke/heart attack
- That something will happen
- Darkness
- Thunderstorms
- Water
- Wind

Circle the expression that best describes your feelings about the following issues.

Circle which best expresses your general mood.

- Morose
- Sad
- Apathy/Indifferent
- Excitement
- Exhilaration

Feeling towards people close to you:

- Loving
- Affectionate
- Indifferent
- Resentment
- Hatred

Feeling toward spouse/lover:

- Loving
- Affectionate
- Dissatisfaction
- Disappointed
- Indifferent
- Resentment
- Hatred

Feeling towards significant past emotionally traumatic events:

- Resolved Grief
- Dwells on Past
- Inconsolable
- Remorse
- Guilt

Feeling toward disease/condition:

- Optimistic
- Doubtful of recovery
- Discouraged
- Fearful
- Despair of recovery

Feeling toward life

- Love life
- Indifferent
- Bored
- Weary of life
- Loathing of life
- Suicidal

Emotional State:

How often to you experience the following emotions:

Irritability
Never Sometimes Always

Jealousy
Never Sometimes Always

Mood swings
Never Sometimes Always

Anger
Never Sometimes Always

Sadness
Never Sometimes Always

Anxiety/Worry
Never Sometimes Always

When you are sad, do you prefer company or do you prefer being alone?

Company Being Alone
1 2 3 4 5 6 7 8 9 10

How often and easily do you cry?

Never Often
1 2 3 4 5 6 7 8 9 10

How is your level of self-confidence?

Lack of confidence Pride/Haughty
1 2 3 4 5 6 7 8 9 10

How impulsive are you?

Never Often
1 2 3 4 5 6 7 8 9 10

Are you Capricious? (Willfulness, changeable and erratic desires that are difficult to satisfy)

1 2 3 4 5 6 7 8 9 10

How often do you forget the following:

Dates
Never Sometimes Always

Names
Never Sometimes Always

Numbers
Never Sometimes Always

Words
Never Sometimes Always

What someone just said to you
Never Sometimes Always

What you just said
Never Sometimes Always

How often do you make mistakes with the following?

Numbers
Never Sometimes Always

Words (when reading)
Never Sometimes Always

Words (when speaking)
Never Sometimes Always

Words (when writing)
Never Sometimes Always

How sensitive are you to any of the following?

Beauty
Never Sometimes Always

Criticism
Never Sometimes Always

Cruel stories
Never Sometimes Always

Frightening things
Never Sometimes Always

Being made fun of
Never Sometimes Always

Music
Never Sometimes Always

Reprimand
Never Sometimes Always

Rudeness
Never Sometimes Always

The suffering of others
Never Sometimes Always

How critical are you of others?

Not at All All the Time
1 2 3 4 5 6 7 8 9 10

How critical are you of yourself?

Not at All All the Time
1 2 3 4 5 6 7 8 9 10

How honest are you?

Always Lie Always honest
1 2 3 4 5 6 7 8 9 10

Do you have any of the following behaviors?

- Abusiveness
- Biting
- Breaking things
- Cursing
- Contrary behavior (acting opposite of what is expected)
- Disobedient
- Insulting
- Rageful
- Rudeness
- Hitting others
- Hitting yourself
- Violence in general



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Diet Diary for: _____ Beginning Date: _____

The purpose of this diary is to provide me with an unbiased record of your normal eating habits. Simply eat your typical diet for 5 days in succession and record it. Under breakfast, lunch, dinner and snack columns, list what you ate and drank. Under Notes, list anything you noticed during the day such as mood swings, bowel movements, indigestion, headaches, fatigue, etc. and after which meal they occurred.

BREAKFAST	LUNCH	DINNER	SNACKS	NOTES
Day 1				
Day 2				



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BREAKFAST	LUNCH	DINNER	SNACKS	NOTES
Day 3				
Day 4				
Day 5				



Records Release Authorization

To: _____
(Doctor/Hospital)

Address: _____

Phone: _____ Fax: _____

I hereby authorize and request you to release to:
Lewis Family Natural Health
16 Sterling Street
Asheville, NC 28803
Phone: 828-298-4800 Fax: 866-400-9118

The following information:

- _____ Lab only
- _____ X-ray only
- _____ Complete Medical Records

I authorize the release of photocopies of the following medical records and/or x-ray files. Records or files shall include all confidential communicable disease-related information, confidential alcohol or drug abuse-related information and confidential mental health diagnosis/treatment information.

Concerning my illness and/or treatment from _____ to _____.

Name: _____

Address: _____

SS# or DOB: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Dear Patient: Please read the following office policies and let us know if you have any questions.
YOUR SIGNATURE IS NEEDED ON THE LAST PAGE. THANK YOU!

FINANCIAL POLICIES:

Lewis Family Natural Health, Inc., is a fee-for-service office and does not accept or submit health insurance claims for payment. Therefore, payment for services and nutritional supplements is due in full at the time of service. Please let us know if you need to discuss other payment options. We accept cash, personal checks, Visa, and MasterCard. There is a minimum \$25 fee for returned checks and no further personal checks will be accepted.

Every effort has been made to ensure an easy-to-understand schedule of fees. For a more detailed description of our fees for services, please ask us for additional information. Fees as listed below are for office visits only, and do not include the cost, if any, of nutritional supplements or lab work. The exception is the UltraLite program, which *does* include all supplies.

New Patient Series (Adult):	\$225 Part I, \$145 Part II*
New Patient Series (Child 12 and under):	\$175 Part I, \$145 Part II*
Established Patient Follow-up/Acute Visits:	\$85 (regular), \$145 (extensive)
New Patient Acute Illness Visits:	\$175
One-Hour Wellness Consultations:	\$145
One-Hour Detoxification Consultations:	\$145
UltraLite Weight Loss Program:	\$155 initial visit (includes supplies) \$85 each week (includes supplies)

*Discounts are available to Students (college/university) and to our Senior patients (65 and older). Payment of both Part I and Part II visits at the first visit receives a \$20 discount. We also have extended payment plans. Please ask for more details.

We also wish to make every effort to answer your questions. Any brief phone or e-mail conversation that serves to **clarify instructions** from a previous visit is free of charge. A phone call or e-mail that **covers new material, requires new information, or takes an extensive amount of time, or results in a change in the naturopathic plan** is considered to be a substitute for an office visit, and will be billed according to the schedule above.

CANCELLATION, RESCHEDULING, AND MISSED APPOINTMENT POLICIES:

- Our doctors only see one patient at a time to give each patient their full attention, and only see a limited number of patients per day. Each doctor reserves 1 ½ to 2 hours for all Part I visits, 1 full hour for all Part II visits, and 45 minutes for future follow up visits. When you make an appointment, that scheduled time is reserved for your exclusive use.
- Our doctors also meticulously prepare for each appointment by reviewing your paperwork and treatment plan prior to your appointment to help provide you with the best care possible.
- For these reasons, if you are not able to make your appointment as scheduled, we need to know in advance so that we can contact other patients who are waiting for an appointment.

Appointment and Cancellation Policies:

- We have a **48-hour (2 business days) cancellation policy**.
- Our office will confirm your appointment at least two business days in advance by phone. If you are unable to keep your appointment as scheduled, please let us know 48-hours in advance in order to avoid a missed appointment charge.
- If you have a Monday appointment, we need to hear from you by 4:30 on the Thursday before your appointment.
- To cancel an appointment, please call 828-298-4800. Our regular office hours are Monday-Thursday, 9:30-4:30, and Friday 9:30-12:30. If you cannot reach us in person by phone, you may leave a detailed voicemail message with your name, date and time of your scheduled appointment, and your request to cancel or reschedule.

Policies for a New Patient Visit:

- A **\$100 deposit** is required to reserve your first 90-minute appointment. You may use a credit card (Visa or MasterCard), cash, or personal check (local address only). Please note that we cannot reserve your appointment until we receive this deposit.
- This deposit will be applied to the charge for your first appointment.
- This deposit is fully refundable (minus a \$15 processing fee) if you cancel or reschedule 48-hours (2 business days) before your scheduled appointment time.
- If you need to reschedule your appointment to a later date, this deposit can be used to secure this next appointment as long as we have had 48-hours notice.
- Cancellations made with less than 48-hours notice forfeit the \$100 deposit.

Policies for a Follow up Visit:

- We do not require a deposit for follow up visits.
- However, the same 48-hour cancellation policy does still apply. For cancellations made less than 48-hours (2 business days) before your scheduled follow up appointment, we reserve the right to charge a \$50 fee.

PLEASE NOTE: ***Missed appointments with no notice given in person or by phone are subject to a charge for the full amount of the scheduled visit.***

In the case of a true emergency, this cancellation policy does not apply. Please let us know as soon as possible if this is the case. However, we ask that this only be used in the case of a real emergency and that you otherwise make every attempt to keep your appointment.

HEALTH INSURANCE POLICIES:

We have many questions from patients about insurance coverage for naturopathic care. The following describes our office policy based on our understanding of the laws in North Carolina.

Traditional Health Insurance:

- At this time, there is no license for naturopathic physicians available in the state of North Carolina.
- This means that by law we are not able to diagnose and treat disease, and by extension, our services are not covered by traditional health insurance plans.
- If we were to file a claim for insurance reimbursement, this could be considered insurance fraud.
- Because of this, we are not able to provide documentation, diagnosis codes, treatment plans, etc. to your insurance company. Any form that asks for this information is, unfortunately, not a form our office is able to fill out.
- In the future, when our profession is fully recognized by the state of NC, we will be able to amend this policy as appropriate.

Health Savings Accounts (HSA) and Flex Spending Plans:

- Naturopathic services and supplements are sometimes covered under HSA and Flex plans. Not all plans cover all naturopathic care. The specifics of what is and is not covered depends on the rules of each specific plan.
- We recommend that you contact your plan administrator before using your HSA or Flex card at our office to determine what is covered and how it should be used.
- We are able to provide documentation to your HSA or Flex plan with the following information: Patient's name and birth date, date(s) of visit(s) to our office, supplements and other recommendations by our naturopathic doctors, and medical diagnosis that another doctor has given you. We are not able to diagnose disease in the state of NC, and therefore cannot list conditions or diagnoses that are not coming to us second-hand through another practitioner.

EMAIL POLICY AND PROCEDURES:

Many people now use email as a primary way to communicate with others. We appreciate that email can be a great way to ask a quick question or clarify something from your last visit, or share with us how you are doing. We have found through experience, however, that email is often not the best way to deal with more

treatment-oriented questions and decisions such as questions regarding your medical issues, changes in your symptoms, or complex requests. Instead, in these cases please schedule an appointment so your naturopathic doctor will have time set aside to directly hear and address your concerns.

When using email, please keep the following in mind:

- Never use email for an urgent or emergency problem. The telephone is a much better way to reach us quickly. Typical turn around time for an email sent to our office is 1-2 days.
- If you have sent us an email and have not heard back from us after several days, please follow up with a phone call. Spam and other filters may have caused your email or our reply email to be lost in cyberspace.
- Please know that email is not confidential and is inherently not secure. Do not use email to communicate anything that you wouldn't want someone else to read. If you send an email from your work email address, your employer has a legal right to read what has been written. Likewise, we may forward your email to a member of our staff if appropriate (i.e. for requests to reschedule an appointment or for a supplement refill order). Reserve more confidential requests for a telephone or in-person visit with your naturopathic doctor.
- All electronic communication with LFNH becomes a part of your medical record. We print a copy and file it in your chart. This means if you request that we send your records to another healthcare provider, they will receive copies of your email as well as our appointment notes.
- Email is never a substitute for seeing your naturopathic doctor. If you think that you need to be seen, please call and schedule an appointment!

By signing below, I agree that I have read and understand these policies. I have been given the opportunity to ask questions and clarify the information listed above. I guarantee payment of all charges incurred as a patient of Dr. Eric Lewis, ND, Dr. Kristina Lewis, ND and Lewis Family Natural Health, Inc. I understand that insurance does not routinely cover naturopathic services in the state of North Carolina. I also understand that there is a 48-hour cancellation policy for all appointments. I understand the inherent risks in electronic communication and may choose whether or not I wish to use email to communicate with Lewis Family Natural Health.

Patient or Responsible Party's Signature: _____

Printed name: _____ Date: _____

INFORMED CONSENT:

Drs. Eric and Kristina Lewis are Naturopathic Doctors. They are co-owners of Lewis Family Natural Health, Inc.

Both doctors graduated from the Southwest College of Naturopathic Medicine in Tempe, Arizona, a 4-year post-graduate medical school accredited by the US Department of Education. They carry licenses to practice medicine in the state of Vermont. In the state of Vermont, Naturopathic Medicine is regulated by the Vermont Secretary of State's Office of Professional Regulation of Naturopathic Physicians under Vermont Statutes, Title 21, Chapter 81, Section 4121 through 4132.

Dr. Eric Lewis and Dr. Kristina Lewis are licensable in all states licensing Naturopathic Physicians. At this time, there is no such license available in the state of North Carolina. They are therefore not licensed to diagnose or treat disease in North Carolina. As a result, they do not intend to nor imply to diagnose and treat disease. The advice provided by the doctors is educational and intended to complement, not replace, any treatment prescribed by a licensed physician.

I understand the above statement. I further understand that Lewis Family Natural Health, Inc., and its associates, Dr. Eric Lewis and Dr. Kristina Lewis, are not medical doctors and are not attempting to conduct the activities of medical doctors.

Patient or Responsible Party's Signature: _____

Printed name: _____ Date: _____