



*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!***

List, in order of importance, your child's 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)

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

What other medication has your child taken in the past? _____

How many times has the child taken antibiotics? _____

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

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

Please write down a general timeline of your child's health history. Starting from birth, include all major illnesses, injuries, operations, hospitalizations, and other medical diagnoses.

<u>Illness/Operation/Hospitalization/Injury/Diagnoses:</u>	<u>Year</u>	<u>Details/Notes</u>

Pregnancy and Birth History

Mother's age at conception: _____ Did she have other children already? Yes No

Mother's Health and Habits During Pregnancy:

- Smoking Coffee Recreational Drugs Alcohol
 Diabetes Nausea/Vomiting Emotional Stress Preeclampsia/Eclampsia
 Length of Labor Vaginal Birth C-Section

If the birth was difficult, please explain: _____

Health of baby at birth: _____

Child's Weight at birth: _____ Child's Height at birth: _____ Premature? Y N

Was/is the child breast-fed? If so, for how long? _____

Was/is the child on formula? Which brand? _____

When was solid food introduced? _____ When did child first: Walk? _____ Talk? _____

Vaccination History (YES, has had; NO, has not; SOME, did not finish all shots):

- MMR: Y N S DPT: Y N S Hep B: Y N S Hib: Y N S
 Chicken Pox: Y N Polio: Y N S Others: _____

Any reactions to vaccinations? If so, please explain: _____

Medical History—Please list date of test and results:

Physical Exam: _____ Dental Exam: _____

Bloodwork: _____ Eye Exam: _____

Hearing Test: _____

Any other diagnostic tests? (i.e. X-ray, Ultrasound, MRI, CT Scan, etc.)

Family History: Please circle "Y" for Yes:

	Child	Father	Mother	Siblings	Grandparents
Cancer	Y	Y	Y	Y	Y
High blood pressure	Y	Y	Y	Y	Y
Heart disease	Y	Y	Y	Y	Y
Heart attack	Y	Y	Y	Y	Y
Stroke	Y	Y	Y	Y	Y
Diabetes	Y	Y	Y	Y	Y
Autoimmune disease	Y	Y	Y	Y	Y
Thyroid disease	Y	Y	Y	Y	Y
Obesity	Y	Y	Y	Y	Y
Osteoporosis	Y	Y	Y	Y	Y
Arthritis	Y	Y	Y	Y	Y
Alcoholism	Y	Y	Y	Y	Y
Drug addiction	Y	Y	Y	Y	Y
Eating disorder	Y	Y	Y	Y	Y
Anxiety	Y	Y	Y	Y	Y
Depression	Y	Y	Y	Y	Y
Suicide/Suicidal	Y	Y	Y	Y	Y
Allergies	Y	Y	Y	Y	Y
Asthma	Y	Y	Y	Y	Y
Skin disease	Y	Y	Y	Y	Y

Other (please describe): _____

Describe cancer (if any): _____

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

**Review of Systems: Please indicate if your child has 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
Cradle Cap	P	C
EYES/EARS/NOSE/THROAT:		
Seasonal allergies	P	C
Chronic sniffles	P	C
Blurry vision	P	C
Double vision	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
Strep Throat	P	C
Poor teeth	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
Palpitations	P	C
Murmurs	P	C
Edema (swelling)	P	C
Rheumatic fever	P	C
Anemia	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
Bed-Wetting	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
Colic	P	C
Jaundice (as a baby)	P	C
Stomach aches	P	C
Hernia	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
Warts	P	C
Diaper Rash	P	C
MUSCULOSKELETAL:		
Arthritis	P	C
Joint pains, swelling, stiffness	P	C
Muscle aches/pains	P	C
Weakness	P	C
Tremors	P	C
Growing pains	P	C
NERVOUS SYSTEM:		
Tingling/numbness	P	C
Paralysis	P	C
Seizures	P	C
Insomnia	P	C
ENDOCRINE:		
Diabetes (Type I or II)	P	C
Thyroid disease	P	C
Early puberty	P	C
Late puberty	P	C
Very sweaty baby/child	P	C
Bad food odor	P	C
Other hormonal problems	P	C
MENTAL/EMOTIONAL/OTHER		
Anxiety	P	C
Depression	P	C
Bipolar disorder	P	C
Suicidal	P	C
Anger	P	C
Fearful/Phobias	P	C
Panic attacks	P	C
Mood swings	P	C
Poor memory	P	C
Nightmares/Night Terrors	P	C
Tantrums	P	C
Disobedient	P	C
Hyperactivity	P	C
ADD/ADHD	P	C
Autism/Autism spectrum	P	C
Learning disability	P	C
Speech impediments	P	C
Physical/Mental/Sexual abuse	P	C
GIRLS ONLY		
Have you started your period?	Y	N
Any problems with your period?	P	C
BOYS ONLY		
Undescended testicles	P	C

Diet:

Is your child a finicky eater? If so, describe: _____

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

Eating Habits: (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Breast-fed exclusively | <input type="checkbox"/> 3 meals a day | <input type="checkbox"/> Eat constantly whether hungry or not |
| <input type="checkbox"/> Formula-fed exclusively | <input type="checkbox"/> 2 meals a day | <input type="checkbox"/> Generally eat on the run |
| <input type="checkbox"/> Breast-fed and Formula | <input type="checkbox"/> Graze (small, frequent meals) | <input type="checkbox"/> Crave sweets |
| <input type="checkbox"/> Solid foods | <input type="checkbox"/> Food rotation | |
| <input type="checkbox"/> Skip breakfast | | |
| <input type="checkbox"/> Crave salt | | |

What does your child drink during the day and how much? (Soda, water, juice, milk, etc.)

Exercise:

Does your child exercise? _____ What type of exercise does he/she do? _____

Weight:

Child's weight today: _____ Child's height: _____ Have you been told where he/she falls on a Pediatric Growth Chart? _____

Sleep:

How long does your child sleep each night? _____ Does he/she have difficulty sleeping? _____
Does your child nap? _____ Does your child have frequent bad dreams? _____

Stress:

Are there any particular stressors that your child has witnessed or gone through (home, school, etc.)? Please describe: _____

Social:

- How does your child enjoy school? _____
- Describe your child's friendships: _____
- What activities does your child enjoy? _____
- How would you describe your child's personality? _____

Toxin Exposure:

- Does anyone smoke in your household? _____
- Has your child ever lived near a refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were they exposed to? _____
- Has your child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health at all? _____
- Does the child seem particularly sensitive to perfumes, gasoline or other vapors? _____
- Do you spray pesticides, herbicides or other chemicals around your home? _____

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: _____