



*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 Eric 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.

- Our patient intake forms are available to print and fill out by hand or to fill out electronically using [Adobe Reader](#). The choice is yours!
- To submit them electronically, please use the link found on this page for a secure way to upload them: www.lewisnaturalhealth.com/new-patient-forms/
- You may also fax (866-400-9118), mail, or personally deliver these forms to our office.
- Please note some sections require a signature that cannot be done electronically.

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 look forward to providing you with excellence in naturopathic healthcare!

INSTRUCTIONS FOR FILLING OUT OUR FORMS

Tips for Success

Our patient intake forms are available to fill out either electronically or manually by hand. The choice is yours!

If you are comfortable using your computer and prefer typing to handwriting, then read below for instructions on how to download and fill out the forms on your computer.

If you aren't comfortable filling the forms out on the computer, or if you just prefer to write by hand, that's fine too! We want you to choose the option that is easiest and best for you.

To fill out the forms by hand:

1. Download the PDF file to your computer
2. Open the PDF and send to your printer
3. Fill it out by hand (please print)
4. Mail, fax, or scan and upload it to us (using the link to the secure upload service found [here](#)). You can even just bring the paperwork by our office in person if you wish.

To fill out the forms electronically: **Even if you're computer savvy, we recommend you read these instructions including the tips at the end to help ensure success and prevent frustration and lost information!

1. Download the PDF file to your computer
2. Open the PDF in [Adobe Reader](#) or another Adobe program if you have it.
3. Fill out all editable sections by typing in the highlighted box or clicking the correct checkbox.
4. Please note that not all sections are fully available to fill out electronically. Examples include the homeopathic form and the sections that require signatures. You will still need to print these sections and fill them out by hand.
5. Once you're done, you'll want to "save as" and include your name or initials in the title, then upload the file to our secure system [here](#). This ensures that your private health information is transmitted with encryption and extra layers of security.

A few extra tips for success:

- **IMPORTANT:** While many programs will open a PDF, including within your browser or programs like "Preview" in Mac, we find the most positive and consistent experience comes from using the free Adobe Reader program. Other programs may not let you fill out all the fields, may act glitchy, and worst of all may not let you save your work! If you don't have Adobe Reader on your computer, you may download it for free [here](#).
- We recommend using a real computer and not a tablet or phone when filling out these forms.
- Before you shut down the program where you have the filled out information, DOUBLE CHECK that the saved version includes your information. The last thing we want to have happen is for you to have spent time filling out the form only to find out later that it was not saved correctly and all the information has been accidentally lost!
 - One way to test that everything is working correctly is to fill out just a few fields, like your name, then do a test "save as" version of the file to your computer. Then open up that new file and make sure you see your answers before you take the time to fill out everything else. Once you're confident that it's working, you can fill out the rest of the form.
- Finally, if this seems confusing or overwhelming, then please don't feel stressed out to do it the technically-fancy way. Old-fashioned handwritten printed forms are still a great option and we really don't mind receiving them that way!

Any questions? Contact us 828-298-4800



Confidential New Patient Information

PLEASE PRINT OR TYPE

Today's Date _____

Patient's Name: _____

Gender: _____ Birthdate: ____/____/____ Age: _____

Mailing Address: _____
Street City State Zip

Primary Phone: _____ Alternate Phone: _____

Email address: _____ Alternate Email: _____

Relationship Status (i.e. single, married, divorced): _____

Spouse/Partner's Name and Occupation _____

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: (name?) _____

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

(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 [] Other (please specify): _____

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

Four horizontal lines for text entry.

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>

Please list your current health care professionals:

<u>Doctor/Practitioner</u>	<u>Specialty</u>	<u>Office Name</u>	<u>Office Phone Number</u>

Please write down a general timeline of your health history. Starting from childhood, 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>

Have you had any recent lab tests or blood work? What kind, when, and what were the results?

Family History: Has anyone in your immediate family (parents, siblings, children) ever had heart disease, cancer, autoimmune disease, thyroid problems, or any other notable medical conditions? If so, please describe.

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

Review of Systems: Please indicate if you have had problems with any of the following:

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

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

Others/Details: _____

MEN ONLY:

Have you experienced any of the following?

Frequent urination (Day/Night)	<input type="checkbox"/>
Incomplete urination	<input type="checkbox"/>
Trouble starting urination	<input type="checkbox"/>
Discharge from urethra	<input type="checkbox"/>

Testicular pain/swelling	<input type="checkbox"/>
Hernia	<input type="checkbox"/>
Change in sex drive	<input type="checkbox"/>
Erectile difficulty	<input type="checkbox"/>
Rectal burning/itching	<input type="checkbox"/>
BPH	<input type="checkbox"/>

Prostate Cancer	<input type="checkbox"/>
Testicular Cancer	<input type="checkbox"/>
Infertility	<input type="checkbox"/>
Sexually Transmitted Disease	<input type="checkbox"/>

Do you have a history of sexual/mental/emotional/physical abuse? _____

When was your last:

Rectal/Prostate Exam: _____ PSA blood test: _____ Stool check for blood: _____

Any irregular results from any of these tests?: _____

WOMEN ONLY: Gynecological and Obstetrical 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?

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? _____ Do you have your ovaries? _____

Have you experienced any of the following?

Menstrual Irregularities	<input type="checkbox"/>
Prolonged bleeding	<input type="checkbox"/>
Painful periods	<input type="checkbox"/>
Heavy flow	<input type="checkbox"/>
Light flow	<input type="checkbox"/>
Change in menses (duration, regularity, flow, pain)	<input type="checkbox"/>
Pelvic pain	<input type="checkbox"/>
Discharge	<input type="checkbox"/>
Yeast infections	<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>
Hormone use	<input type="checkbox"/>
Breast pain (with cycle/constantly)	<input type="checkbox"/>
Fibrocystic breasts	<input type="checkbox"/>

Difficulty conceiving/carrying pregnancy to term	<input type="checkbox"/>
Hair growth on face	<input type="checkbox"/>
Pain with intercourse	<input type="checkbox"/>
Change in sex drive	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>
Uterine fibroids	<input type="checkbox"/>
Ovarian cysts	<input type="checkbox"/>
Female Cancer	<input type="checkbox"/>
Pelvic inflammatory disease	<input type="checkbox"/>
Sexually transmitted disease	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>
Osteopenia	<input type="checkbox"/>

Obstetrical History

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

Birth control pill, patch, or ring	P	C
	<input type="checkbox"/>	<input type="checkbox"/>
Injectable or implanted hormone	P	C
	<input type="checkbox"/>	<input type="checkbox"/>
Condoms	P	C
	<input type="checkbox"/>	<input type="checkbox"/>
Diaphragm, cervical cap, foam/gel	P	C
	<input type="checkbox"/>	<input type="checkbox"/>
Sterilization ("Tubes tied")	P	C
	<input type="checkbox"/>	<input type="checkbox"/>

Male partner had vasectomy	P	C
	<input type="checkbox"/>	<input type="checkbox"/>
IUD	P	C
	<input type="checkbox"/>	<input type="checkbox"/>
Natural family planning/rhythm method	P	C
	<input type="checkbox"/>	<input type="checkbox"/>
Other	P	C
	<input type="checkbox"/>	<input type="checkbox"/>

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? _____

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

Are you currently in a mutually monogamous relationship? _____

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.)? _____

Do you have a history of sexual, mental, emotional, and/or physical abuse? _____

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, Paleo, Gluten Free, 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

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): _____

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

Stress:

Stress level (1=low, 10=high): _____

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, etc.)?: _____

How may we best be of service to you? Do you have any specific wishes or requests regarding your treatment that you would like us to know about? Are there religious, spiritual, or cultural considerations you would like to share with us?



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Diet Diary for: _____ Beginning Date: _____

The purpose of this diary is to provide us 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

_____ Complete Medical Records

I authorize the release of photocopies of the following medical records. 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: _____

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, and all major credit cards. 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.

New Patient Series (Adult):	\$275 Part I (90 min), \$145 Part II (60 min)*
New Patient Series (Child 12 and under):	\$250 Part I (90 min), \$145 Part II (60 min)*
Established Patient Follow-up/Acute Visits:	\$145 (60 min)

*Payment of both Part I and Part II visits at the first visit receives a \$25 discount. We also have options for 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 90 minutes for all Part I visits, 60 minutes for all Part II visits, and 60 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. 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 4:00 on the Thursday before your appointment.
- To cancel an appointment, please call 828-298-4800. Our regular office hours are Monday-Thursday, 9:30-4:00. 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, 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, or treatment plans 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 or tax advisor 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:

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. 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!

SUMMARY OF POLICIES:

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: _____