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.

- 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

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NATURAL HEALTH

Confidential New Patient Information—Pediatric Form (12 and under)

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**: _____

Parent/Guardian Name(s) and Occupation(s): _____

_____

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

Siblings (Names/Ages)_____

School _____ **Grade:** _____

Hobbies/Interests: _____

Pediatrician: Name: _____ Office Phone: _____

Other health care professionals: _____

How did you hear about us? (select all that apply)

☐ 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? How may we best be of service to you? Do you have any specific wishes or requests (including religious, spiritual, or cultural considerations) that you would like us to know about?

_____

_____

_____

_____

List, in order of importance, your child's major health concerns/what you wish to discuss 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)

Medication	*Dose/Frequency*	*For how long?*	*For what reason?*

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)

Supplement	*Brand*	*Dose/Frequency*	*For how long?*	*For what reason?*

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.

Illness/Operation/Hospitalization/Injury/Diagnoses:	*Year*	*Details/Notes*

Pregnancy and Birth History

Mother's age at conception: _____ Is your child adopted?: _____

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? _____

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:

☐ Have given all vaccines according to the CDC schedule

☐ Have given some vaccines according to an alternative schedule

☐ Have declined all vaccines

☐ Other: _____

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

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

HEAD:	
Headache	☐
Migraine	☐
Head injury	☐
Dizziness/Vertigo	☐
Cradle Cap	☐
EYES/EARS/NOSE/THROAT:	
Seasonal allergies	☐
Chronic sniffles	☐
Blurry vision	☐
Double vision	☐
Other eye disorder	☐
Ear aches/infections	☐
Hearing disorder	☐
Tinnitus (ringing in ears)	☐
Sinus pain/infection	☐
Nasal congestion	☐
Nose bleeds	☐
Frequent colds	☐
Sore throat	☐
Voice hoarseness	☐
Strep Throat	☐
Poor teeth	☐
RESPIRATORY:	
Asthma	☐
Bronchitis	☐
Coughing	☐
Shortness of breath	☐
Wheezing	☐
CARDIOVASCULAR:	
Heart disease	☐
Palpitations	☐
Murmurs	☐
Edema (swelling)	☐
Rheumatic fever	☐
Anemia	☐
Heart disease	☐
Palpitations	☐
Murmurs	☐
Edema (swelling)	☐
URINARY TRACT:	
Frequent urinary infections	☐
Pain with urination	☐
Discharge/blood in urine	☐
Frequent urination/urgency	☐
Bed-Wetting	☐
GASTROINTESTINAL:	
Heartburn/Acid reflux/GERD	☐
Ulcer	☐
Bloating	☐
Excessive flatulence	☐
Nausea/Vomiting	☐
Constipation	☐
Diarrhea	☐
Colic	☐
Newborn Jaundice	☐
Stomach aches	☐
Hernia	☐

SKIN:	
Dry skin	☐
Acne	☐
Rash	☐
Hives	☐
Eczema	☐
Psoriasis	☐
Moles	☐
Warts	☐
Diaper Rash	☐
MUSCULOSKELETAL:	
Arthritis	☐
Joint pains, swelling, stiffness	☐
Muscle aches/pains	☐
Weakness	☐
Tremors	☐
Growing pains	☐
NERVOUS SYSTEM:	
Tingling/numbness	☐
Paralysis	☐
Seizures	☐
Insomnia	☐
ENDOCRINE:	
Diabetes (Type I or II)	☐
Thyroid disease	☐
Early puberty	☐
Late puberty	☐
Very sweaty baby/child	☐
Bad food odor	☐
Other hormonal problems	☐
MENTAL/EMOTIONAL/OTHER:	
Anxiety	☐
Depression	☐
Bipolar disorder	☐
Suicidal	☐
Anger	☐
Fearful/Phobias	☐
Panic attacks	☐
Mood swings	☐
Poor memory	☐
Nightmares/Night Terrors	☐
Tantrums	☐
Disobedient	☐
Hyperactivity	☐
ADD/ADHD	☐
Autism/Autism spectrum	☐
Learning disability	☐
Speech impediments	☐
Physical/Mental/Sexual abuse	☐
GIRLS ONLY:	
Have you started your period?	☐
Any problems with your period?	☐
BOYS ONLY:	
Undescended testicles	☐

Others/Details:_____

_____

_____

_____

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

What special diet do you follow, if any? (Vegetarian, Vegan, Gluten Free, Dairy Free, etc.)_____

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 you 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? _____

Allergies:
Please list any known allergies (Medication, Chemical, Food, Environmental):

_____

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Name: _____ **Date:** _____

Homeopathic Information Form

Please try to answer the questions on the following pages as **carefully, thoughtfully, and accurately as possible**. Many of the questions may not seem directly related to your problem or main complaint, and some may seem downright irrelevant or silly, but this information is critical in selecting the most appropriate homeopathic remedy for you as a whole person. **All information in this questionnaire is kept confidential.**

Do any of the following bother you? If so, please circle all that apply.

WEATHER CONDITIONS:

Cloudy	Snow
Clear	Storms
Wet	Wind
Dry	Fog
Damp	Hot Sun

SEASONS:

Spring
Summer
Fall
Winter

LOCATIONS:

The Mountains
The Beach

Are you generally sensitive to and/or troubled by:

Bright Light
Never *Sometimes* *Always*

Darkness
Never *Sometimes* *Always*

Open Air
Never *Sometimes* *Always*

Stuffy Rooms
Never *Sometimes* *Always*

Tight Clothing
Never *Sometimes* *Always*

Noise
Never *Sometimes* *Always*

Odors
Never *Sometimes* *Always*

Drafts
Never *Sometimes* *Always*

Are you generally a chilly or a warm person?

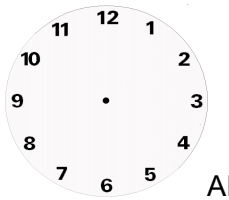
Chilly Warm
1 2 3 4 5 6 7 8 9 10

Which are you generally most sensitive to, being a little too warm or a little too cold?

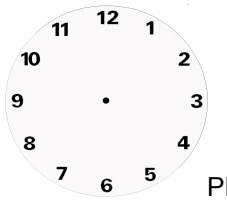
A little too cold A little too warm

Are there any times of day when you usually feel bad (low energy, poor mood, a worsening of your symptoms)? Are there certain times of day when you always feel better? If so, please indicate below. If not, please leave this section blank.

Worst

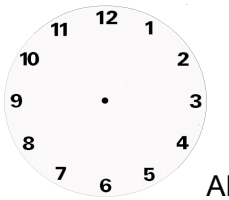


AM



PM

Best



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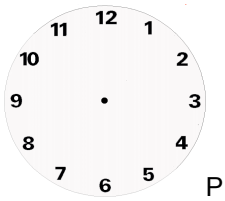

PM

Please circle which of the following sleep habits you experience: (you may choose more than one)

Tooth Grinding
Restlessness
Talking
Perspiration
Frequent Urination
Excess Heat or Cold
Laughing
Snoring
Nightmares
Recurring Dreams
Sleepwalking

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Do you sleep: (you may circle more than one)

Without Covers
Partly Covered
Fully Covered (Not including Head)
Fully Covered (Including Head)
With Arms or Legs Out of the Covers
Without Clothing
With a Fan or Air Blowing on You
With the Window open

What position do you sleep in most often?

Right Side On Back
Left Side On Abdomen

How much do you perspire?

Never All the Time
1 2 3 4 5 6 7 8 9 10

Food Desires and Aversions:

In the following questions you are asked how much you desire or are averse to a particular food or taste. Please answer from the point of view of your natural desires, not your knowledge of nutrition. For example, you may never eat fatty meat for health reasons, however you do love the taste of fat. In this case, you would answer the question that you like fat. If you strongly desire or crave a food or taste, "always." If you detest a food or taste, mark "never.'

If all foods were equally healthy and your food choices were made on cravings/desire alone, what foods would you crave the most?

Do you crave:

Sweet Foods
Never Sometimes Always

Salty Foods
Never Sometimes Always

Sour Foods
Never Sometimes Always

Bitter Foods
Never Sometimes Always

Spicy Hot Foods
Never Sometimes Always

What is your temperature preference:

Food:
Hot
Warm
Room temperature
Cold

Drinks:
Hot
Warm
Room temperature
Chilled
Cold with ice

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

Reckless Cautious
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

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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

Argumentative/Bossy Yielding/Mild
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*

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.

Feeling towards people close to you:

Loving
Affectionate
Indifferent
Resentment
Hatred

Feeling toward romantic partner:

Loving
Affectionate
Dissatisfaction
Disappointed
Indifferent
Resentment
Hatred

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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

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

How sensitive are you to any of the following?

Beauty
Never *Sometimes* *Always*

Criticism
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?
Breaking things
Cursing
Contrary behavior (acting opposite of what is expected)
Disobedient
Insulting
Rageful
Rudeness
Hitting

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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				

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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: _____

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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: _____