

## **Itasca Naturopathic Clinic** **Client's Bill of Rights**

Welcome to Itasca Naturopathic Clinic. If this is your first time visiting a naturopath, you probably have a lot of questions. Your questions are important to us and we are happy to answer them. The philosophy of naturopathic medicine makes this field of health care unique. Naturopaths work with the healing power of nature to improve your quality of life. The goal is to build health and wellness. We do not treat disease and pathogens; we strengthen the body's vital force and stimulate healing of the body. Symptoms are an external expression that the body has some type of dysfunction occurring within, and instead of palliating these symptoms, we look for the cause of the problem.

Naturopaths are trained as primary care physicians and receive a doctorate degree at a four year accredited naturopathic medical school. Currently there are five institutions in the country; a four-year bachelor's degree is required to enter the program. Specific pre-medical courses in the basic sciences are required such as biology, chemistry, physics, etc. The basic courses taken in the first two years of naturopathic medical school are similar to those taken in conventional medical school including anatomy, physiology, biochemistry, histology, psychology, pathology, neuro-anatomy, microbiology, immunology, research and statistics, clinical and physical diagnosis, lab diagnosis, pharmacology, and public health. There are also courses in cardiology, gynecology, obstetrics, diagnostic imaging, minor surgery, pediatrics, geriatrics, environmental medicine, EENT, endocrinology, dermatology, neurology, proctology, oncology, urology, medical genetics, counseling, and stress management.

Naturopathic training is unique in that it teaches pharmacology and the role of conventional medicine, but the focus is on natural alternatives that can be used to improve health and wellness. There are a plethora of natural therapeutics taught at naturopathic medical schools including clinical nutrition, botanical (herbal) medicine, homeopathy, hydrotherapy, massage, naturopathic manipulative therapies, physiotherapy, and classical Chinese medicine. Clinical training occurs over the last three years of medical school under the supervision of a licensed naturopathic doctor. During this three-year period, clinical rotations are performed in hydrotherapy and massage, naturopathic medicine, laboratory services, minor surgery, and women's health care. This curriculum provides the students with a vast exposure to a variety of conditions and treatment modalities in naturopathic patient care.

At Itasca Naturopathic Clinic, our naturopaths are graduates from the National College of Natural Medicine in Portland, Oregon. If you have more questions regarding the medical training of our naturopaths, we will provide you with direct contact information for the schools and the national organization. If you are looking for graduates in other locations, we would be happy to provide you with direct access to the American Association of Naturopathic Physicians, which is the nationwide professional organization for the field of naturopathic medicine. [www.naturopathic.org](http://www.naturopathic.org)

**AS OF JULY 1, 2009, MINNESOTA STATUTE CHAPTER 147E RECOGNIZES NATUROPATHIC DOCTORS WHO MEET ALL QUALIFICATIONS AS OUTLINED BY THAT LAW.**

All information provided during office visits, such as chart notes and lab reports are confidential. Information will not be released without the patient's written and signed request. All patients have the right to access this information. It is our policy to provide copies of laboratory reports to patients during follow-up appointments. All patients have the right to be seen by other practitioners; at the written request of the patient, we will transfer the information from our clinic to the new provider to ensure continuity of care. Patients have the right to refuse any recommended services or treatments, and Itasca Naturopathic Clinic has the right to refuse service to anyone. All facilities are guaranteed to be free of sexual abuse. Patients may assert their rights without retaliation.

### Clinic Location

*Main Contact Dr. Rachel Oppitz. If complaints arise for any reason for any of our employees, please submit a written statement to Itasca Naturopathic Clinic, attention Dr. Oppitz, ND*

Itasca Naturopathic Clinic  
110 E. First Street  
Park Rapids, MN 56470  
218-237-2312  
218-237-2499 (fax)  
ccroppitz@msn.com

522 Beltrami Avenue Suite 101  
Bemidji, MN 56601  
218-444-5868

If you are unable to resolve your complaints, please contact the Minnesota Department of Health at 651-215-5800.

### Policy Statement

**Appointments:** Initial office visits with the naturopaths will be scheduled for 60 to 90 minutes and follow-ups will vary depending on patient needs, but the average is 30 to 45 minutes. All patients are seen on an appointment basis and appointments should be made as far in advance as possible. On rare occasions emergencies may prevent us from keeping an appointment; in this event you will be notified as soon as possible and your appointment rescheduled, *If you miss an appointment or fail to cancel the appointment at least 24 hours before your scheduled time, you will be charged at the ½ hour rate*

**Telephone Consultations:** If you have questions that require speaking with a naturopath, you will be asked to set up a telephone consultation. Any call over 5 minutes will be billed per the naturopathic fee schedule.

**Payments:** *Payment is due in full at the time of the visit.* No laboratory tests can be issued without payment in full at the time of the service. Credit card services are available for Visa, Master Card and Discover.

**Insurance:** Naturopathic care is not covered by insurance in the state of Minnesota or North Dakota. Occasionally chart notes, progress reports, and case analysis are requested: there will be a copy fee of \$1.13 per page and the time spent by the naturopath in generating reports will be billed at the rate of \$165 per hour. If the insurance company does not pay for processing fees, the patient is responsible.

**Past-Due Accounts:** A monthly finance charge of 1.5% is added to all accounts not paid in full at the time of service. If past accounts are shown to have no activity for more than 90 days, they will be turned over to a collection agency.

**Change of Address and Telephone Number:** We request that you keep your file current by informing us of any changes of address and/or telephone number.

**Mail Order Service:** Mail orders are available for patients who need refills and are unable to pick up medicinal items at either clinic location. The policy for mail orders is that full payment must be made prior to the order being shipped, either by credit card or check.

### Naturopathic Consultation Fee Schedule

Initial office visit with ND (30-120 minutes)	\$82.50-330
Return office visit with ND (15-60 minutes)	\$41.25-165
Phone visit with ND (5-60 minutes)	\$13.75-165
Medicinary	By item
Laboratory Services	By item
Shipping and handling	Per weight & items
NSF Check fee	\$25

### Declaration and Consent to Treatment

Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_ E-mail address \_\_\_\_\_

The undersigned understands that any treatment or advice provided by INC is not mutually exclusive from any treatment or advice that the undersigned may now be receiving or may receive in the future from another health care provider. The undersigned is at liberty to seek or continue medical care from a medical doctor, surgeon, or any other health care provider. No person has suggested or recommended that the undersigned refrain from seeking or following the advice from another health care provider.

The undersigned understands that the treatment and therapies rendered or recommended by INC may differ from those usually offered by a conventional medical doctor or health care provider. The undersigned is aware that the practice of naturopathic medicine is not an exact science and acknowledges that no guarantees have been made pertaining to the result of treatment.

The undersigned also understands that the treatments and/or procedures used by INC are of a naturopathic (alternative) medical practice and can be used as integrative health care along with allopathic (conventional) medicine.

I have received a copy of the Client's Bill of Rights for INC; I have read and fully understand the contents of the document.

\_\_\_\_\_  
Patient Signature or Guardian's signature (if under 18)

\_\_\_\_\_  
Date

**Itasca Naturopathic Clinic**  
110 E. 1<sup>st</sup> Street  
Park Rapids, MN 56470  
(218) 237-2312 FAX (218) 237-2499

**PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), Public law 104-191, published December 29, 2000, by the U.S. Department of Health and Human services, we are required to notify you of your Protected Health Information (PHI).

This law allows the clinic to collect and use your PHI for the use of health care purposes only. **“Health care purposes only” refers to normal release of practitioner’s notes and/or examination findings to insurance companies authorized to reimburse this clinic for incurred charges by the patient named below or signed by their representative as stated below.** This clinic will ensure that health information is not used for non-health purposes. PHI will be disclosed only for the purpose of health care treatment, payment and operations as allowed by HIPPA. Any non-routine disclosure of the PHI will be prohibited without signed, informed consent by the patient agreeing to such disclosure.

Itasca Naturopathic Clinic (INC) reserves the right to change privacy policies that are described in its Privacy Notice, in accordance with applicable law.

I understand and consent to the following appointment reminders that may be used by INC: a) mailing a postcard to me at the address provided; and b) a telephone call to my home with a message on my answering machine or with the individual answering the phone.

I understand that I have the right to request that INC restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, INC is not required to agree to any restrictions that I have requested. If INC agrees to a requested restriction, then the restriction is binding on INC.

I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent in writing at any time. I understand that if I revoke this Consent at any time, INC has the right to refuse treatment.

By signing below, I understand these rights and authorize the release of my PHI for routine health care treatment, payment, and operations. I understand I have the right to inspect, receive copies of, and request amendments to my file at any time. I also have the right to receive information from this clinic by alternative means. Any non-routine disclosures must be authorized by me via a signed consent. I understand that I have the right to complain to this clinic’s Privacy Officer or to file a formal complaint to the Secretary of the Department of Health and Human Services if I feel my PHI rights have been violated. I understand that these privacy policies may change in the future.

(I understand that if I do not sign this document as evidence of my consent of the disclosures described to me and contained in the Privacy Notice, then INC will not treat me).

**I have read and understand the foregoing notice, and all my questions have been answered to my satisfaction in an understandable manner.**

\_\_\_\_\_  
Printed Name of Individual

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Signature of Legal Representative  
(E.g., Attorney-in-Fact, Guardian, Parent if minor)

\_\_\_\_\_  
Relationship

Date signed \_\_\_ / \_\_\_ / \_\_\_

\_\_\_\_\_  
Witness

# Itasca Naturopathic Clinic

110 E. 1st STREET  
 PARK RAPIDS, MN 56470  
 PHONE: 218.237.2312  
 FAX: 218.237.2499  
 E-MAIL: [chris@itascainegrative.com](mailto:chris@itascainegrative.com)  
[www.itascainegrative.com](http://www.itascainegrative.com)

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone (Home) \_\_\_\_\_  
 (Work) \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Full Time or Part Time or Seasonal \_\_\_\_\_  
 Education \_\_\_\_\_  
 Referred by \_\_\_\_\_  
 Who is your primary care physician? \_\_\_\_\_  
 Would you like a Naturopath from Itasca Naturopathic  
 Clinic to be your primary care practitioner? Yes No

Today's Date \_\_\_\_\_  
 Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 SS # \_\_\_\_\_  
**Are You (please circle)**  
 Married Separated Divorced Single Cohabiting  
**Live With (please circle)**  
 Spouse Partner Parents Relatives Friends Pets Alone  
**Who to call in case of emergency**  
 Name \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone (Home) \_\_\_\_\_  
 (Work) \_\_\_\_\_

*A NOTE TO OUR PATIENTS: Naturopathic and preventive health care require the physician to have a complete picture of the patient physically, mentally and emotionally. Please take your time as you complete this health questionnaire to ensure thorough answers and a complete history.*

## Current Health Information

When, where and from whom did you last receive medical or health care? \_\_\_\_\_

Do you have any contagious diseases at this time?  
 \_\_\_ Yes \_\_\_ No

If yes, what? \_\_\_\_\_

What are your most important health concerns?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

Which of the above problems are of most immediate concern? \_\_\_\_\_

## Current Medications

Do you take or use:

- \_\_\_ Laxatives \_\_\_\_\_
- \_\_\_ Tranquilizers \_\_\_\_\_
- \_\_\_ Appetite Suppressants \_\_\_\_\_
- \_\_\_ Pain relievers \_\_\_\_\_
- \_\_\_ Thyroid medication \_\_\_\_\_
- \_\_\_ Nasal decongestants \_\_\_\_\_
- \_\_\_ Antacids \_\_\_\_\_
- \_\_\_ Sleeping pills \_\_\_\_\_
- \_\_\_ Birth Control Pills \_\_\_\_\_
- \_\_\_ Cortisone \_\_\_\_\_
- \_\_\_ Antibiotics \_\_\_\_\_
- \_\_\_ Hormones \_\_\_\_\_

Please list any prescription and/or over-the-counter medications, vitamins, herbs, or other supplements you are taking and dosages:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## FAMILY HISTORY

	Father	Mother	Brothers	Sisters	Children
Ages (if living)	_____	_____	_____	_____	_____
Health	_____	_____	_____	_____	_____
Age at death	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____

**Check those applicable:**

Anemia	_____	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____	_____
Asthma/Hayfever/Hives	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____
Gout	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Seizures/Epilepsy	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Thyroid Problems	_____	_____	_____	_____	_____

### FOR THE FOLLOWING, PLEASE MARK:

YES - a condition you currently have    NEVER - a condition you've never had    PAST - a condition you've had before

	YES	NEVER	PAST		YES	NEVER	PAST
<b><u>HEAD</u></b>							
Headaches	_____	_____	_____	Head Injury	_____	_____	_____
Migraines	_____	_____	_____	Jaw/TMJ problems	_____	_____	_____
Double Vision	_____	_____	_____	Fainting Spells	_____	_____	_____
Dizziness	_____	_____	_____	other	_____	_____	_____
<b><u>EYES</u></b>							
Glasses/contacts	_____	_____	_____	Impaired vision	_____	_____	_____
Spots in eyes	_____	_____	_____	Cataracts	_____	_____	_____
Blurriness	_____	_____	_____	Eye pain/strain	_____	_____	_____
Color blindness	_____	_____	_____	Tearing or Dryness	_____	_____	_____
Sensitivity to light	_____	_____	_____	Glaucoma	_____	_____	_____
<b><u>EARS</u></b>							
Discharge from ears	_____	_____	_____	Pain in ears	_____	_____	_____
Hearing problems	_____	_____	_____	Ringing in ears	_____	_____	_____
Sensitivity to noise	_____	_____	_____	Many ear infections	_____	_____	_____
<b><u>NOSE &amp; SINUSES</u></b>							
Frequent colds	_____	_____	_____	Nose bleeds	_____	_____	_____
Stuffiness	_____	_____	_____	Hayfever	_____	_____	_____
Sinus problems	_____	_____	_____	Loss of smell	_____	_____	_____
<b><u>MOUTH &amp; THROAT</u></b>							
Frequent sore throat	_____	_____	_____	Copious saliva	_____	_____	_____
Teeth grinding	_____	_____	_____	Mouth ulcers	_____	_____	_____
Bleeding gums	_____	_____	_____	Hoarseness	_____	_____	_____
Speech difficulties	_____	_____	_____	Loss of voice	_____	_____	_____
<b><u>NECK</u></b>							
Lumps	_____	_____	_____	Swollen glands	_____	_____	_____
Goiter	_____	_____	_____	Pain or stiffness	_____	_____	_____

	YES	NEVER	PAST		YES	NEVER	PAST
<b><u>CARDIOVASCULAR</u></b>							
Heart Disease	___	___	___	Angina	___	___	___
High blood pressure	___	___	___	Low blood pressure	___	___	___
Blood clots	___	___	___	Fainting	___	___	___
Phlebitis	___	___	___	Palpitations	___	___	___
Rheumatic fever	___	___	___	Chest pain	___	___	___
Swelling in ankles	___	___	___	Heart murmurs	___	___	___

<b><u>RESPIRATORY</u></b>							
Cough	___	___	___	Sputum production	___	___	___
Spitting up blood	___	___	___	Wheezing	___	___	___
Asthma	___	___	___	Bronchitis	___	___	___
Pneumonia	___	___	___	Pleurisy	___	___	___
Emphysema	___	___	___	Difficulty breathing	___	___	___
Pain upon breathing	___	___	___	Shortness of breath (SOB)	___	___	___
Tuberculosis	___	___	___	SOB lying down	___	___	___
Night sweats	___	___	___	SOB at night	___	___	___

<b><u>GASTROINTESTINAL</u></b>							
Trouble swallowing	___	___	___	Heartburn	___	___	___
Bad breath	___	___	___	Bad taste in mouth	___	___	___
Change in thirst	___	___	___	Change in appetite	___	___	___
Nausea	___	___	___	Vomiting	___	___	___
Vomiting blood	___	___	___	Constipation	___	___	___
Blood in stool	___	___	___	Diarrhea	___	___	___
Pain or cramps	___	___	___	Gall bladder disease	___	___	___
Belching	___	___	___	Ulcers	___	___	___
Passing gas	___	___	___	Hemorrhoids	___	___	___
Eating disorder	___	___	___	Distress from eating fats	___	___	___
Black stools	___	___	___	Jaundice	___	___	___
Liver disease	___	___	___	Bad body order	___	___	___
Bowel movements? How often	_____			Is this a change? ___Yes ___No			

<b><u>URINARY</u></b>							
Pain on urination	___	___	___	Increased frequency	___	___	___
Frequency at night	___	___	___	Inability to hold urine	___	___	___
Many urinary infections	___	___	___	Problems starting urination	___	___	___
Blood in urine	___	___	___	Kidney stones	___	___	___

<b><u>MALE REPRODUCTION</u></b>							
Hernias	___	___	___	Testicular mass	___	___	___
Testicular pain	___	___	___	Prostate disease	___	___	___
Discharge or sores	___	___	___	Herpes	___	___	___
Syphillis	___	___	___	Chlamydia	___	___	___
Gonorrhea	___	___	___	Condyloma	___	___	___
Premature ejaculation	___	___	___	Impotence	___	___	___
Vasectomy	___	___	___	Painful erections	___	___	___
Sexually active	___	___	___				
Sexual orientation: ___Heterosexual ___Bisexual ___Homosexual							

<b><u>MUSCULOSKELETAL</u></b>							
Joint pain or stiffness	___	___	___	Arthritis	___	___	___
Broken bones	___	___	___	Weakness	___	___	___
Muscle spasms/cramps	___	___	___	Back pain	___	___	___

	YES	NEVER	PAST		YES	NEVER	PAST
<b><u>BLOOD/PERIPHERAL VASCULAR</u></b>							
Easy bleeding/bruising	___	___	___	Anemia	___	___	___
Deep leg pain	___	___	___	Cold hands/feet	___	___	___
Varicose veins	___	___	___	Thrombophlebitis	___	___	___
Bleeding from unusual places	___	___	___	Fluid retention	___	___	___
<b><u>EMOTIONAL</u></b>							
Anxiety/nervousness	___	___	___	Excessive worry	___	___	___
Mood swings	___	___	___	Depression	___	___	___
Treated for emotional problems	___	___	___	Panic Attacks	___	___	___
Considered/attempted suicide	___	___	___	Tension	___	___	___
<b><u>NEUROLOGIC</u></b>							
Seizures/epilepsy	___	___	___	Paralysis	___	___	___
Muscle weakness	___	___	___	Numbness or tingling	___	___	___
Loss of memory	___	___	___	Easily stressed	___	___	___
Vertigo or dizziness	___	___	___	Loss of balance	___	___	___
<b><u>ENDOCRINE</u></b>							
Hypothyroid	___	___	___	Heat/cold intolerance	___	___	___
Hypoglycemia	___	___	___	Diabetes	___	___	___
Excessive thirst	___	___	___	Excessive hunger	___	___	___
Change in sexual desire	___	___	___	Seasonal depression	___	___	___
Unexplained weight loss	___	___	___	Fatigue	___	___	___
Unexplained weight gain	___	___	___				
<b><u>IMMUNE</u></b>							
Vaccinations	___	___	___	Reactions to vaccinations	___	___	___
Chronic fatigue syndrome	___	___	___	Chronic infections	___	___	___
Chronically swollen glands	___	___	___	Slow wound healing	___	___	___
<b><u>SKIN</u></b>							
Rashes	___	___	___	Eczema/hives	___	___	___
Acne/boils	___	___	___	Itching	___	___	___
Color changes	___	___	___	Hair loss	___	___	___
Lumps	___	___	___	Warts	___	___	___
<b><u>HABITS</u></b>							
Use alcoholic beverages	___	___	___	Treated for alcoholism	___	___	___
If yes, list types and amounts: _____				If Yes When _____			
Use recreational drugs	___	___	___	Treated for drug dependency	___	___	___
If yes, list types and amounts: _____				If Yes When _____			
Smoke tobacco products	___	___	___	Chew tobacco products	___	___	___
If yes, list types and amounts: _____				If Yes list types and amounts _____			
Drink coffee	___	___	___	Drink cola	___	___	___
If yes, amounts: _____				Diet often	___	___	___
Drink black tea	___	___	___	Eat excessive salt	___	___	___
If yes, amounts: _____							
Eat out often	___	___	___				
Eat excessive sugar	___	___	___				

**ALLERGIES**

Are you hypersensitive or allergic to any:

Drugs \_\_\_\_\_

\_\_\_\_\_

Foods \_\_\_\_\_

\_\_\_\_\_

Chemicals or environmental toxins \_\_\_\_\_

\_\_\_\_\_

What happens when you have an "allergy attack?"

\_\_\_\_\_

\_\_\_\_\_

What prior types of allergy testing have you had?

None \_\_\_\_\_

Scratch \_\_\_\_\_

Blood IgG food \_\_\_\_\_

Blood IgE inhalant/food \_\_\_\_\_

Intradermal \_\_\_\_\_

Kinesiology \_\_\_\_\_

Cytotoxic \_\_\_\_\_

Food Intolerance \_\_\_\_\_

Electroacupuncture \_\_\_\_\_

**GENERAL INFORMATION**

Weight \_\_\_\_\_ lbs

Weight 1 year ago \_\_\_\_\_ lbs

Maximum weight \_\_\_\_\_ lbs When \_\_\_\_\_

Height \_\_\_\_\_ ft \_\_\_\_\_ in

When is your energy the best during the day? \_\_\_\_\_

When is your energy the worst during the day? \_\_\_\_\_

**CHILDHOOD ILLNESSES**

Rubella (German 3-day measles) \_\_\_\_\_

Measles (2 weeks) \_\_\_\_\_

Mumps \_\_\_\_\_

Chickenpox \_\_\_\_\_

Whooping cough \_\_\_\_\_

Rheumatic fever \_\_\_\_\_

Polio \_\_\_\_\_

Scarlet fever \_\_\_\_\_

Roseola \_\_\_\_\_

Asthma \_\_\_\_\_

Others \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**LIFE STYLE**

The information you provide below will be helpful in allowing the doctor to make the right choices specific to you and your case. All information is confidential and if you don't feel comfortable putting it all down on paper, we can discuss these issues in person within your boundaries.

Main interests and hobbies: \_\_\_\_\_

\_\_\_\_\_

Do you exercise? Yes \_\_\_ No \_\_\_

If yes, explain? \_\_\_\_\_

\_\_\_\_\_

Do you have a religious or spiritual practice? Yes \_\_\_ No \_\_\_

If yes, explain? \_\_\_\_\_

\_\_\_\_\_

Do you eat 3 meals a day? Yes \_\_\_ No \_\_\_

If no, how many? \_\_\_\_\_

\_\_\_\_\_

Do you average 6-8 hours of sleep? Yes \_\_\_ No \_\_\_

If no, how many? \_\_\_\_\_

\_\_\_\_\_

Do you sleep well? Yes \_\_\_ No \_\_\_

If no, why? \_\_\_\_\_

\_\_\_\_\_

Do you awaken rested? Yes \_\_\_ No \_\_\_

If no, why? \_\_\_\_\_

\_\_\_\_\_

Do you enjoy your work? Yes \_\_\_ No \_\_\_

If no, why? \_\_\_\_\_

\_\_\_\_\_

Do you spend time outside? Yes \_\_\_ No \_\_\_

If yes, how much and in what form? \_\_\_\_\_

\_\_\_\_\_

Do you watch television? Yes \_\_\_ No \_\_\_

If yes, how much? \_\_\_\_\_

\_\_\_\_\_

Do you read? Yes \_\_\_ No \_\_\_

If yes, what & how much? \_\_\_\_\_

\_\_\_\_\_

Do you take vacations? Yes \_\_\_ No \_\_\_

If yes, how long and what kind? \_\_\_\_\_

\_\_\_\_\_

Do you have a supportive relationship? Yes \_\_\_ No \_\_\_

If no, what would you change? \_\_\_\_\_

\_\_\_\_\_

Do you have a history of abuse or trauma? Yes \_\_\_ No \_\_\_

If yes, explain? \_\_\_\_\_

\_\_\_\_\_

**IMMUNIZATIONS**

Pertussis \_\_\_\_\_  
Tetanus \_\_\_\_\_  
Polio \_\_\_\_\_  
Diphtheria \_\_\_\_\_  
Measles/Mumps/Rubella (MMR) \_\_\_\_\_  
Hepatitis \_\_\_\_\_  
Others \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**X-RAYS & SPECIAL STUDIES**

Electrocardiogram (EKG) \_\_\_\_\_  
Electroencephalogram (EEG) \_\_\_\_\_  
Intravenous Pyelogram (IVP) \_\_\_\_\_  
What x-rays, CAT scans, or other studies have you had?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HOSPITALIZATION & SURGERY**

What hospitalizations or surgeries have you had?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**TYPICAL FOOD INTAKE**

Breakfast: \_\_\_\_\_  
\_\_\_\_\_  
Lunch: \_\_\_\_\_  
\_\_\_\_\_  
Dinner: \_\_\_\_\_  
\_\_\_\_\_  
Snacks: \_\_\_\_\_  
\_\_\_\_\_  
Fluids: \_\_\_\_\_  
\_\_\_\_\_

**CURRENT ILLNESS OR CONDITIONS**

How does your condition affect you? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you think is happening? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Why? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you feel needs to happen for you to get better?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you enjoy most in life? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How much change are you willing to make at this time for improving your health? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## WOMEN'S HEALTH SCREEN

### GENERAL HEALTH

Chronic Fatigue \_\_\_\_\_  
 Irritability \_\_\_\_\_  
 Shortness of Breath \_\_\_\_\_  
 Headaches \_\_\_\_\_  
 Bone Pain \_\_\_\_\_  
 Memory Fails \_\_\_\_\_  
 Unintentional weight loss or gain of 10lbs or more in the last three months? Gain\_\_\_\_ Loss\_\_\_\_ None\_\_\_\_

### GYNECOLOGICAL HISTORY

Date of last gynecological exam: \_\_\_\_\_  
 PAP \_\_\_\_\_  
 Mammogram \_\_\_\_\_  
 Results \_\_\_\_\_  
 Date of last menstrual cycle \_\_\_\_\_  
 Length of cycle \_\_\_\_\_  
 Interval of time between cycle \_\_\_\_\_  
 Any recent changes in normal menstrual flow \_\_\_\_\_  
 \_\_\_\_\_  
 Age of first period \_\_\_\_\_  
 Form of birth control \_\_\_\_\_  
 Number of children \_\_\_\_\_  
 Number of pregnancies \_\_\_\_\_  
 C-Section \_\_\_\_\_  
 Surgical menopause date \_\_\_\_\_  
 Describe surgery \_\_\_\_\_  
 \_\_\_\_\_  
 Endometriosis \_\_\_\_\_  
 Infertility \_\_\_\_\_  
 Fibrocystic Breast \_\_\_\_\_  
 Fibroids/Ovarian Cysts \_\_\_\_\_  
 Reproductive Cancer \_\_\_\_\_  
 Pelvic Inflammatory Disease \_\_\_\_\_  
 Vaginal Infections \_\_\_\_\_  
 Vaginal Candidiasis \_\_\_\_\_  
 STDs \_\_\_\_\_

### LIFESTYLE & DIET

What is the current level of stress you are experiencing on a scale of 1 to 10 ( 1 being the lowest ) \_\_\_\_\_  
 Identify the major causes of this stress  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Check the symptoms you experience regularly one to two weeks before your period:

\_\_\_\_\_ Anxiety  
 \_\_\_\_\_ Irritability  
 \_\_\_\_\_ Nervous tension  
 \_\_\_\_\_ Aggressive or hostile toward family/friends  
 \_\_\_\_\_ Engage in self destructive behavior  
 \_\_\_\_\_ Weight gain  
 \_\_\_\_\_ Water retention  
 \_\_\_\_\_ Abdominal bloating  
 \_\_\_\_\_ Tender, swollen and/or painful breasts  
 \_\_\_\_\_ Breast lumps increase in size and tenderness  
 \_\_\_\_\_ Discharge from nipples  
 \_\_\_\_\_ Craving for sweets  
 \_\_\_\_\_ Increased appetite  
 \_\_\_\_\_ Heart palpitations  
 \_\_\_\_\_ Fatigue  
 \_\_\_\_\_ Headaches  
 \_\_\_\_\_ Shaky or clumsy  
 \_\_\_\_\_ Depressed  
 \_\_\_\_\_ Withdrawn  
 \_\_\_\_\_ Confused  
 \_\_\_\_\_ Forgetful  
 \_\_\_\_\_ Insomnia/difficulty sleeping

Check the symptoms and/or behaviors that occur during your period with a frequency or intensity that affects your daily activities:

\_\_\_\_\_ Cramping in lower abdomen or pelvic area  
 \_\_\_\_\_ Sharp intermittent pain  
 \_\_\_\_\_ Dull aching pain  
 \_\_\_\_\_ Upset stomach  
 \_\_\_\_\_ Diarrhea  
 \_\_\_\_\_ Nausea or vomiting  
 \_\_\_\_\_ Low back aches  
 \_\_\_\_\_ Headaches  
 \_\_\_\_\_ Difficulty concentrating  
 \_\_\_\_\_ Accident prone  
 \_\_\_\_\_ Unusual fatigue (take naps)  
 \_\_\_\_\_ Decreased productivity  
 \_\_\_\_\_ Weight gain  
 \_\_\_\_\_ Painful and/or swollen breasts  
 \_\_\_\_\_ Irritability  
 \_\_\_\_\_ Mood swings  
 \_\_\_\_\_ Depression  
 \_\_\_\_\_ Painful Intercourse





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218-237-2312

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218-444-5868

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### Welcome Patient:

We would like to introduce you to **The Itasca Plan**; a way to make naturopathic healthcare expenses easier to manage. Under the plan, patients receive lower, fixed rates for office visits and BIA (Bio Impedance Analysis) tests. The details of the plan are as follows:

- The cost of the six-month program is \$150 (payment plan available)
- Office visits are \$35 for thirty minutes or less, \$70 for visits between thirty and sixty minutes, \$105 for visits between sixty and ninety minutes, and \$140 for visits over ninety minutes.
- BIAs, optional, are \$15 (normally \$25).

### As such:

- A 75-minute office visit with optional BIA for a new patient is typically \$120 (normally \$231.25)
- A 20-45 minute follow-up visit with optional BIA is either \$50 or \$85 (normally \$80.00-\$148.75)

### Our goals in designing this program:

- Make it easy to join.
- Make the terms of the commitment both reasonable and fair.
- Structure it so that anybody can see a real benefit.

### FAQs

#### When can I join?

You may join at any time. Most people join at the time of an office visit. Individual family members can join at different times.

#### What happens at the end of the six month period?

Your plan terminates, and you can start up again at your next appointment.

#### How does the payment plan option work?

The first \$25 will be added to your bill the day you join; the remaining five payments of \$25 are charged to a credit or debit account on your choice of the fifth, fifteenth or twenty-fifth of each month.

#### Are there discounts for supplements or labwork?

No. Supplements and labwork are not affected by this program.

#### Are phone visits included?

Yes. As always, brief questions (less than five minutes) are not charged. Anything between five and twelve minutes will be billed the regular rate (\$2.75/minute) while anything over twelve minutes will follow the guidelines of the plan as outlined above.

#### Will I benefit by signing up for this program?

While new patients and those requiring frequent visits are going to see the biggest impact financially, everyone can benefit by the predictability offered by this program. Ultimately, it is up to each patient to determine if it is right for him or her.

Additional questions can be addressed to Dr. Oppitz or by INC's clinic administrator Chris Oppitz.

# The Itasca Plan Agreement

By signing this form you are stating that you understand and agree to the following:

- The six-month program is \$150.
- If I choose the payment plan, the first installment of \$25 is paid the day I join; the remaining five installments of \$25 will be charged to the credit or debit card I have listed below.
- Under this plan, office and phone visits will be billed as follows:
  - Phone visits five minutes or less are not charged
  - All visits between six and twelve minutes will be billed at \$2.75/minute (max \$33.00)
  - All visits between thirteen and thirty minutes will be \$35
  - All visits between thirty and sixty minutes will be \$70
  - All visits between sixty and ninety minutes will be \$105
  - All visits over ninety minutes will be \$140
- In addition to this, BIAs are \$15.
- Supplements, labwork, and services performed by practitioners other than Rachel Oppitz or Lee Aberle are not affected by this plan.
- This plan may be used only for the patient listed below and is non-transferable.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed: \_\_\_\_\_

Phone #: \_\_\_\_\_

Patient Name (if different than above): \_\_\_\_\_

-----Information below necessary only for those choosing the payment plan-----

Credit/Debit Card: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Exp. Date: \_\_\_\_\_ - \_\_\_\_\_

Please circle:    Visa    MC    Discover

Monthly draw/charge date (choose one):    5<sup>th</sup>    15<sup>th</sup>    25<sup>th</sup>

Billing Address: \_\_\_\_\_  
\_\_\_\_\_

-----Office Use Only Below This Line-----

Date Drawn: \_\_\_\_\_

Initials: \_\_\_\_\_

Plan Expires: \_\_\_\_\_ . Expiration letter sent: \_\_\_\_\_ by \_\_\_\_\_.