Simmonds McMurrer Naturopathic Medicine

Dr.Kali Simmonds,N.D. Dr.Lana McMurrer,N.D. Dr.Nara Simmonds,N.D.

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ACUTE INTAKE FORM

Name: ______________________________ Date of Birth: ______________________

Address: ____

____

Home Phone: ________________Work Phone: _______________ Email:_______________

Occupation: ______________________ Employer: _________________________________

Sex: M / F Marital Status: ____________ # of Children: ______________________

Contact Person in case of Emergency: ______________________ Phone #: _______________

Does your extended health care plan cover naturopathic services? Y / N

Date of last medical visit: _________________ Reason: ______________________

Family physician: ________________________ Phone #: _____________________

Past injuries: _________________________ When? ______________________

_________________________ When? ______________________

Past surgeries: _________________________ When? ______________________

_________________________ When? ______________________

Allergies (please list):

____

____

What is your primary reason for visiting the doctor today?

____

____

Please list food supplements, vitamins, minerals, homeopathics, and herbs you currently take and indicate dosage:

___________________ ___________________ ___________________

___________________ ___________________ ___________________

Please list prescription and non-prescription medicines you currently take and indicate dosage:

___________________ ___________________ ___________________

___________________ ___________________ ___________________

AGREEMENT AND CONSENT TO TREATMENT•

It is our pleasure to provide you with effective and quality health care. In order to do this, please understand the following policies and procedures:

Fee Schedule	
15 minute consultation	$40.00
30 minute consultation	$75.00

THIS IS TO ACKNOWLEDGE that I have been informed and understand:

1. Any treatment or advice provided to me as a patient of the Clinic is not mutually exclusive from any treatment or advice that I may now be receiving or may receive in the future from another licensed health care provider
2. I understand that Naturopathic Medicine is a comprehensive approach to health and illness and focuses on prevention and the use of natural substances and treatments including: Clinical Nutrition, Lifestyle Counselling, Homeopathy, Chinese Medicine & Acupuncture Botanical Medicine, Physical Medicine & Hydrotherapy
3. I am at liberty to seek and/or continue medical care from a medical doctor or other qualified health care provider
4. I am aware that no part of my treatment or testing is covered by P.E.I. Medicare and that I am solely responsible for payment
5. Payment is to be made at the time of treatment

I HEREBY AUTHORIZE AND CONSENT TO NATUROPATHIC TREATMENT BY:

DR. KALI SIMMONDS, N.D. ___
DR. LANA MCMURRER, N.D. ___
DR. NARA SIMMONDS, N.D. ___

I understand and agree to the above policies and procedures:

Patient's Full Name (please print): ______________________________
First Middle Last

Date of Consent: ______________________________
Day Month Year

Signature: ______________________________
Patient or legal guardian

How did you hear about us?

Advertisement / Word of Mouth / Walk-by / Referral / Other: ____________________

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