NEW CLIENT PACKET
Welcome To Our Clinic

First Visit Checklist

- Completed **intake forms**
  If forms are completed before the day of your appointment, please scan and send by email to drwilesgoss@gmail.com.
- Please bring all **supplements/medications** and recent **lab work.**
- Please plan to arrive **5 minutes early**. We have a "no wait" policy. Every effort will be made to be respectful of your time by keeping on schedule.
- Upon entering the office, a receptionist will be there to greet you, please **check in** and **wait in the seating area** and I will be with you shortly.
- All payments are expected at the **time of service**. We accept cash, check, Visa, and MasterCard.
- If we accept your insurance, please bring your insurance information so that we can provide you with all the necessary information to submit to your insurance provider. If possible, please e-mail or fax a copy of both sides of your insurance card to drwilesgoss@gmail.com or 541-585-3727, prior to the visit, so we can have that information for you at the first visit.

DR. ABRIANNE GOSS, ND

Health With a Twist of Happiness

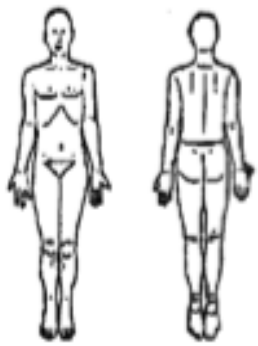
Name_____ **Date of Birth**_____

F / M Height _____ **Weight** _____ **Reason for Visit**_____

Phone_____ **Email**_____ **Emergency Contact**_____

Address_____ **State**_____ **Zip**_____ **Date**_____

Current Health Problems/Diagnoses/ Onset (list in order of importance)		**Family Disease History** Self, Parent, Grandparent	**S**	**P**	**G**	**Current Vitamins, Herbs or Supplements**		**Current Prescription Medications**	
1.		Asthma				1.		1.	
2.		Arthritis				2.		2.	
3.		Alcoholism				3.		3.	
4.		Diabetes				4.		See space at bottom of 2nd column	
5.		Epilepsy				5.		**Nutrition**	
		Thyroid				6.		**Estimate how often you use.**	
Surgery/Hospitalization/Imaging-Year		Obesity				7.		**Weekly (W)**	**#/ W**
1.		Heart Disease						Grains	
2.		High Blood Pressure				**Drug Allergies/ Type of Reaction?**		Dairy	
3.		Mental Disorder				1.		Vegetables	
4.		Cancer				2.		Fruit	
Complications with your birth?	**Y / N**	Other:				**Airborne Allergies?**	✓	Soda Pop	
Rate Current Wellbeing	**0-10**	**Personal Health History**				Type: _____		Coffee/Black Tea/Green Tea (circle)	
Poor 1-3 Good 4-6 Excellent 7-10		**Current , Past**	C	P		**Food Sensitivities?**	✓	Fruit Juice	
Job or School		Fatigue				Type: _____		Beer / Wine / Spirits	
Financial / Money		Low Blood Sugar				_____		# yrs / When quit?	
Primary relationship		Poor Sleep				**Lifestyle**	✓	Nutrasweet/Artif sweet	
Family, Parents, Children		Anxiety				TV: Hours/Day ____		Aspirin	
Freedom from Allergies		Depression				Read: Hours/Day ____		Tylenol	
Overall Freedom from Stress		Overweight				Regular Vacations		Tobacco / Cigarettes	
Overall Sleep/ Hours: ____		Headache				Date of last vacation:		# yrs / When quit?	
Overall Physical Energy		Neck Pain				Spiritual practice			
Overall Mental Energy		Back Pain				Toxic Exposure			
Other Challenges:		Joint Pain				Silver Dental Fillings			
		Allergies, Hayfever				Chemical Sensitivities			
General (10= most)	0-10	Sinusitis						**Current Medical**	
Stress Level		Recurrent Colds, Flu				**Exercise - Times Per Week**		**Provider**	
Energy Level		Other Recurrent Infections				Walk/Run:		M.D./ D.O.:	
Happiness		Ear/Eye Problems				Swim:		Chiropractor:	
		Poor Digestion, Gas,				Bike:		Naturopathic Dr.:	
		Recurrent Diarrhea				Aerobics:		OB/GYN:	
		Constipation				Other:		Psychologist:	
		Abdominal Pain / Bloating						Other:	
		High Blood Pressure							
List your Health Goals		Elevated Cholesterol or Fat				1.			
		Anemia				2.			
		Heart Flutters/ Palpitations				3.		**Mark Problem Areas below**	
		Swelling in ankles				4.			
		Premenstrual Symptoms							
		Menstrual Problems				What is your present level of			
		Menopause Symptoms				commitment to address any			
		Hair Loss				*underlying causes* of your			
How did you hear about us?	✓	Breast Problems				signs and symptoms?			
Doctor:		Alcoholism							
Friend:		Drug Addictions				Rate from 0-10, 10 being 100%			
Internet:		History of Abuse				committed. 0-10 ( )			
Article in Media:		Sexual Dysfunction							
Other:		Other, Please list on right→							



Abrianne Wiles Goss, ND

106 NW Greeley Avenue * Bend, Oregon 97701

www.doctorwilesgossnd.com * ph: 541.585.3726 * drwilesgoss@gmail.com

CONSENT TO TREATMENT

At our clinic we believe in treating people, not disease. Therefore, each individual patient will receive a treatment plan that is specifically developed for them. Dr. Wiles Goss will employ such therapeutic procedures as manual soft tissue work, and spinal/joint manipulation as needed on an individual patient basis. Other forms of treatment include clinical nutrition consultation and supplementation, herbal therapy, homeopathy, stress management and lifestyle changes. It is understood that while our practices and procedures are safe and effective, not everyone responds the same way to different treatments, and occasionally side effects or complications may arise.

While the risk of complications or side effects from any of the above treatments is rare, it is our policy to inform our patients about them. These complications may include, but are not limited to, soreness, bruising, inflammation, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications of specific treatments is available upon request.

The way in which we choose to treat people will often be different than the conventional care of your MD. It is our policy to always inform you of the procedure being performed and any risks and alternative treatments available to you. If your practitioner's explanation is not to your satisfaction, please ask for more information.

Please recognize, understand, and agree that your health care provider is a sole practitioner and is not a partner or otherwise affiliated with any other health care provider who may be providing similar services at our clinic. Your health care practitioner is solely responsible for and shall provide all professional services to you, and you are relying solely on your practitioner's skill for the professional services rendered at our clinic.

I have read and understand the above statements regarding treatments and side effects.

_____

Patient Signature or Guardian if patient is a minor Date

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YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that *you identify* who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds.
- Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please check all that apply:

___Please do not phone me at home. Use this alternate phone number: _____

___Please do not phone me at work. Use this alternate phone number: _____

___Please do not leave messages on my answering machine.

___Please do not contact me by email (Note: This is *not a secure* way to share personal or medical information.)

___Please send mail, including my bills, to this alternate address: _____

___Other request (please describe): _____

_____
Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ _____/_____/_____
Patient Signature (Parent/guardian signature if minor) Date

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PAYMENT AGREEMENT

Dear New Patient,

Welcome to Dr. Wiles Goss Natural Health. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care.

Please **read and initial** the following statements:

_____ Payment for all services, tests, and medicinary items is due at the time of service. We accept cash, checks, Visa and MasterCard. **Returned checks will be subject to a $35.00 NSF fee.**

_____ We use a variety of nutritional supplements, homeopathic remedies, and botanical medicines. Once these products leave our office, we cannot bear responsibility for their storage or their use. For the health and safety of our patients, we cannot accept returns on any medicinary products.

_____ We only accept certain insurance plans at this time. If your plan has out-of-network naturopathic coverage, we will happily provide all the appropriate coding and documentation to submit to the insurance provider.

_____Your health care provider may prescribe medication, which may be purchased at the clinic or elsewhere. Your insurance company may not cover the medicinary items that are prescribed.

_____ To provide you with the most comprehensive care, we must set aside large blocks of time for your treatments. Please understand that you will be charged a **missed appointment fee of $50.00 for any missed appointments or late cancellations (less then 24 hours notice)**.

I have read and understand the above-stated policies of Dr. Wiles Goss Natural Health, LLC and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

_____
Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ Date _____/_____/_____
Patient Signature (Parent/guardian signature if minor)

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