**Dr. Buffy Shawn Binder ND, Naturopathic Doctor**
**209 E. Swallow Rd.**
**Fort Collins, CO 80525**
**office (970) 223-7425 fax(866) 225-2126**
**www.thehealthyplace.com**

---

Dr. Binder is a Naturopathic Doctor. She received her B.A. in Psychology from the University of Montana. Dr. Binder then completed her Doctorate of Naturopathic Medicine from Southwest College of Naturopathic Medicine in Tempe, Arizona in March, 2000. This school is an accredited four year medical program (4500 hours) including basic sciences and clinical training. Dr. Binder is a licensed Naturopathic Physician in the state of Montana (as Colorado is not yet a licensing state) and has practiced in the state of Colorado and Montana since the spring of 2000. Dr. Binder is continually expanding her education with seminars and workshops several times a year, completing much more than the required continuing education hours. Dr. Binder is a member of the Colorado Association of Naturopathic Physicians, the American Association of Naturopathic Physicians, and the American College for Advancement in Medicine. As a second generation naturopath, Dr. Binder brings a unique understanding of natural health to her practice. Dr. Binder was drawn to the practice of naturopathic medicine by a desire to assist people in living more fulfilling lives through better health, and supporting future generations by encouraging healthful global practices. Dr. Binder works with preventative wellness, chronic health situations, and acute non- emergency health situations. Although Dr. Binder is a general practitioner and works with many health issues, she has a particular interest with hormone, neurotransmitter, and endocrine health; as well as working with nutrition, detoxification, herbal medicine, and physical therapies. The practice of Naturopathy includes: western diagnostics, botanical medicine, homeopathy, lifestyle counseling, nutrition, physical medicine, and Chinese Medicine. Dr. Binder may utilize one or a combination of the listed therapies.

**Fee Schedule:**
Rates based on -------------------------------------$180/hour
Return visit intermediate (45 minutes)-----------------$135
Return visit limited (30 minutes)-------------------------$90
Return visit brief (15 minutes)----------------------------$45
Annual female exam -------------------------------------$180
PAP (thin prep)----------------------------------------------$72
Constitutional Hydrotherapy-----------------------------$55
FCT (allergy elimination)---------------------------------$75
Naturopathic spinal manipulation------------------------$65
BIA (body composition analysis)-------------------------$45
EAV (Bodyscan 2000)-----------------------------$180/hour
Chelation----------------------------------------------------$115
Telephone consult -----------------------------$3.00/minute

All clients are asked to pay in full at the time of the visit. Supplements, labs, intravenous therapies, herbs, and homeopathic medicines are an additional fee to the cost of the treatment. I take great care, and am able with my education, to discern quality and potency. I use physician-only lines of supplements that are what they say they are, and that are designed to be very potent and therefore only used by physicians. These companies were created by doctors like me for doctors like me that “know the difference” and they cater to my particular, critical and demanding standards. Further, they often make available substances that only doctors like me know to use, and that the lay market does not know, understand and therefore demand so that they are not found in the lay market. I am able to use quality, potent materials that produce dramatic results for people working to improve their health. This is vital to the success of my patients.

As a client you are entitled to receive information about the methods of therapy, the treatment modalities used, and the duration of therapy if known. As a patient you may seek a second opinion from another health care professional, or may terminate or change therapy at any time. I have read the above information and my signature endorses my understanding of these conditions.

Printed Name________________________________________________________________

Signature________________________________Date_______________________________
(signed by guardian if under-age)

***Very Important Information ***

Please Read Carefully and Sign After Reading

We at the Three Rivers Natural Medicine PC are here to help you take care of your health in the best way that we know how. We realize you came in about health and not finances. The following is to assist you in understanding the clinics financial policies. Payment Requirements: Appointments must be paid for at time of service. We accept Visa, Master Card, check, cash, or Travelers checks. Please contact our desk for more details. You will be charged a $25 fee for returned checks. Appointments: We require 24 hours notice if you need to change or cancel your appointment. You will be charged a fee of 50% of the total cost of any missed appointment if the 24 hour advance cancellation policy was not met. Records: We keep a record of your health care. We charge a small fee for copies of your medical records. We will not disclose your record to others unless you direct us to do so or unless the law authorizes us to. Insurance and Medicare: This clinic does not bill insurance companies. Our doctors are not preferred providers for any insurance company. You may submit your paid invoice to your insurance for reimbursement. Please request this upon checkout if you wish to do this. We are not a Medicare provider. Medicare will not reimburse you for services rendered at this Clinic and you should not seek reimbursement from Medicare. I understand that I will have asked a practitioner of the Three Rivers Natural Medicine clinic for help and that he/she will help to the best of his/her ability.

I have read and understand the above statements.

Printed Name________________________________________________________________

Signature___________________________________Date_____________________________
(signed by guardian if under-age)

Printed Name of Doctor_______________________Date______________________________

Signature of Doctor__________________________Date______________________________

**THREE RIVERS NATURAL MEDICINE PC - A NATURAL HEALTH CLINIC**
**Dr. Buffy Binder, ND**
**Dr. Mark Kelley, ND, LAc**
**Members Colorado Association of Naturopathic Physicians www.coanp.org**
**American Association of Naturopathic Physicians www.naturopathic.org**
**American College for Advancement in Medicine www.acam.org**

Welcome to the Three Rivers Natural Medicine! We are honored that you have chosen us to help in your search for optimum health. This is your New Patient Information Packet. Please read, fill out and sign the attached forms and fax, mail or drop off to reach us at least 24 hours prior to your appointment. This allows our doctors and staff to use your appointment time most efficiently. Bring any prior lab work and your supplements with you to your appointment. If you wish to cancel or reschedule your appointment, please notify our office 24 hours or more before your appoint-ment. We charge a fee of one-half of the cost of the visit for missed appointments if less than 24 hours notice is given. It is our office policy to confirm appointments by phone one to two business days before your appointment. If you have an answering machine or voice mail, a message will be left. Many of our patients are sensitive to environmental substances, therefore we ask all patients to refrain from wearing strongly scented hair sprays, colognes, perfumes, aftershaves, etc. on the days you are here. If you have any questions please call our office at (970) 223-7425. We look forward to meeting you!

Date____________________________________________________
Full Name ______________________________________________
Birthdate_______________________________________________
Address( Number, Street, City, State, Zip)
________________________________________________________
________________________________________________________
Telephone: Home(____)_____________________________________
Work________________________ Email________________________
Employed by_____________________________________________
Occupation______________________________________________
Referred by (or how did you find us?)___________________________
Emergency contact (Name, Telephone)
________________________________________________________
Are you currently under the care of a medical practitioners? (write names)
____________________________________________________________
____________________________________________________________
Have you ever worked with an alternative health care provider?
(naturopathic doctor, acupuncturist, chiropractor, herbalist, nutritionist)
____________________________________________________________
List the main problems that you are having, or reason for this appointment: Please attach additional page if necessary
____________________________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________

**Past Medical History/Major Illnesses and Year:**
(IE. arthritis, asthma, autoimmune disease, blood clots or disorders, cancer, diabetes, edema or swellings, heart disease, joint or spine issues, liver disorders, osteoporosis, major infections, seizures)

______________________________
______________________________
______________________________
______________________________
______________________________

**Accidents/Major Trauma (scars - please give location):**

______________________________
______________________________
______________________________

**Hospitalizations/Surgeries (please give month/year if possible):**

______________________________
______________________________
______________________________
______________________________
______________________________

**Dental Procedures (root canals, approximate #, type of fillings, etc.):**

______________________________
______________________________
______________________________

**Past Medications, any adverse reactions?: (current meds list on last page)**

______________________________
______________________________
______________________________

**Allergies and Sensitivities (medication, foods, environmental, ever tested?):**

______________________________
______________________________
______________________________

**Occupational and/or Exposures (chemicals, sprays, residence near industry):**

______________________________
______________________________
______________________________

**Vaccinations:**

( ) DPT (Diphtheria, Pertussis, Tetanus) Year(s)______________________
( ) Booster (Usually DT) Year(s)______________________
( ) Polio injection ( ) Polio oral Year(s)______________________
( ) MMR (Measles, Mumps, Rubella)Year(s)______________________
( ) HBV (Hepatitis B Vaccine) Year(s)______________________
( ) Other (Flu shots, etc.) Year(s)______________________

**Lifestyle factors (Please fill in approximate amounts and frequency):**

Never -Occasionally- Weekly -Daily
Coffee/Decaf______________________
Alcohol______________________
Sodas/Soft drinks______________________
Fried foods (french fries, fried chicken)______________________
Black/Green Tea______________________

Recreational Drugs______________________________________________
Sleep Hours a night_______sleeping and waking time______________________
wake refreshed__________wake tired or groggy ________________________
trouble falling asleep________trouble staying asleep______________________
recurrent or troublesome dreams_________________________________

**Exercise Activities and Common Physical Activity (length of time and frequency)**
Never- Minutes- Hours- Weekly -Daily-Any aggravations or pain from activity?
Swim_____________________Run______________________Walk___________________
Dance___________________Bike______________________Garden_________________
Golf______________________Tennis____________________Ski____________________
Stretching_________________Yoga/Pilates_______________Martial Arts_____________
Weights___________________Horseback Riding_______________________________
Computer Work_____________Desk sitting_________________________________
Bending/Lifting______________________________________________________
Other___________________________________________________________

**Review of Systems** - Please circle if experienced and write location
Energy: overall - High(time of day)___________ Low (time of day)________________
Stress: level - low______________ moderate__________ high_____________________
Circulation: do you have feelings of hot/cold and where?__________________________
Sweating: excess in day____ night sweats_________ never sweat_________________
Skin: dry_____ clammy_______ itchy_____ burning_____ frequent rashes________
acne_______ dry scalp________ boils________ bruises easy________ hives__________
moles changing_______ warts________ lumps_______ hair loss____________________
Headaches: how often_____________ where ___________________________________
Vision: do you wear contacts, prescription glasses or have had corrective surgery?
________________________________________________________________________

**Respiratory & Chest:**
chronic sinusitis_____________ nasal polyps or septum issues________________________
any shortness of breath________ trouble breathing at night_____ palpitations_________
wheezing_________ chronic cough__________ coughing blood or phlegm____________
pain in chest__________________ color of sputum___________________________________
Blood pressure: if known_______________________blood type_______________________

**Musculoskeletal:**
pain in toes________ ankles_______ knees________ hips___________
low back_______ mid back________ upper back________ neck____________________
fingers_______ hands________ wrists__________ elbows_____ shoulders____________
loss of grip____________ loss of feeling in hands/feet_________ stiff all over__________
deep bone pain_______________ leg cramps_____________________________________
muscle cramps___________ herniated disc________ scoliosis_______________________

**Digestion:**
problems before or after eating_________ how long________________________________
hungry all the time_______ rarely hungry___________ appetite changes_______________
thirsty a lot________ rarely thirsty____ how many ounces of water daily______________
feel weak and shaky when miss a meal_______ can easily skip meals__________________
heartburn____ frequent burping/belching________ bad taste in mouth______________
bad breath________ sores in mouth____________ cold sores on lips__________________

stomach cramps______ nausea________ vomiting_____ bloating________________
weight change, how much in what length of time________________________________
Favorite foods:_____________________________Disliked foods__________________
Crave: salt______ sweets______ spicy______ sour_____ bitter__________________
Bowel Movements: # a day _____________ thin or thick__________color__________
constipation_______ diarrhea________ hemorrhoids___________________________
bleeding or mucous in stool________ lower bowel gas_________ bloating________
frequent gas/flatus_____ extreme foul odor of stool or gas_______________________

**Urination:**
frequent at night_________ pain or burning on urination________________________
dribbling or intermittent______________ loss of control________________________
strong smelling urine________________ frequent infections_____________________

**Mental/emotional:**
loss of concentration_____ memory loss_______ depression_____________________
mood swings______ anxiety_______ nervousness________ easily angered________
irritability________ frequent crying_________ suicidal________________________

**Neurological:**
dizziness______ poor coordination_______ loss of touch sensation____
numbness or tingling in limbs______ tremors______ muscle weakness____________
toes catch when walking_______ feel weak/shaky overall________________________

**Women:**
Currently pregnant (Y/N)______Birth control use _______________________________
Last Pap___________History of Abnormal Pap (year)____________________________
First day of last menstrual period__________age started menses_____stopped_______
# of children______Ages_____________miscarriage or abortion_________________
do you perform self breast exam?_______any breast tenderness or swelling__________
vaginal discharge (normal, thick, whitish, yellow, itchy, odor)_____________________
issues with period? (irregular, painful, heavy, clotting)__________________________
other hormone issues? (change in sex drive, food cravings, hot flashes, ovarian cyst, extreme mood changes)_______________________________________________
sexually transmitted diseases (past, present)____________________________________

**Men:**
Last Prostate Exam______________PSA Lab________________________________
Sex drive high, low, or problems with erection or ejaculation_____________________
Urinary dribbling, pain, or burning_________________________________________
urethral discharge_____________________penile warts or lesions________________
sexually transmitted diseases (past, present)____________________________________

**Other:**
Please use this space to write down anything else you would like to inform us about and give your typical breakfast, lunch, dinner and snacks.

FILL IN THIS FORM WITH ANY VITAMIN, MINERAL, AMINO ACID, SUPPLEMENTS OR MEDICATIONS THAT YOU MAY BE TAKING.

NAME:_______________________________________ DATE:_________________

| SUPPLEMENTS | MANUFACTURER | START DATE | DOSAGE | FREQUENCY |
| --- | --- | --- | --- | --- |
| EXAMPLE:<br>VITAMIN C | BRONSON | 1/1/08 | 500 MG | 2 PER DAY |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |