Dr. Mark Kelley ND, LAc
Naturopathic Physician and Acupuncturist
1201 West Main Street Hamilton, MT 59840
phone 406.375.0167 ● fax 866.225.2126
www.thehealthyplace.com

Welcome! I am honored that you have chosen me 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 this packet at least 24 hours prior to your appointment. This allows me and my staff to use your appointment time most efficiently. Bring any prior lab work, supplements and medications to your appointment. If you wish to cancel or reschedule your appointment, please notify our office 24 hours or more before your appointment. 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 my 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. I look forward to meeting you!

Dr. Kelley received his pre-medical training with a BA in Psychology from Ohio University. Dr. Kelley then completed his Doctorate of Naturopathic Medicine from Southwest College of Naturopathic Medicine in Tempe, AZ in 2000. This school is an accredited four-year medical program, (4500 hours), specializing in natural therapeutics including basic sciences and clinical training. Dr. Kelley then went on to complete a Masters Degree in Oriental Medicine (2001) from Southwest Acupuncture College, (2643 hours), in Boulder, CO. After passing the naturopathic licensing board exams, Dr. Kelley obtained a license as a Naturopathic Physician in the state of Montana (2001), Arizona (2000) (ret.) and Vermont (2000). Dr. Kelley is also a licensed acupuncturist in Colorado (2004) and Montana (2001). Dr. Kelley is certified through the National Certification Commission for Acupuncture and Oriental Medicine as a Diplomate in Acupuncture from 8/31/01 to 8/31/13. Dr. Kelley has never had a registration, certificate or license suspended or revoked. Dr. Kelley is continually expanding his education with seminars and workshops several times a year, completing much more than the required continuing education hours. Dr. Kelley is a member of the Montana and Colorado Association of Naturopathic Physicians, the American Association of Naturopathic Physicians, American College for Advancement in Medicine, and American Association of Orthopedic Medicine. The practice of Naturopathy includes: western diagnostics/labs, botanical medicine, homeopathy, lifestyle counseling, nutrition and physical medicine. The scope of Chinese Medicine includes: acupuncture, needling and injections, Chinese herbs, (bulk teas, fluid extracts and patent formulas), moxibustion, and guasha. Dr. Kelley may utilize one or a combination of the above listed therapies in working with clients and has trained extensively in combining therapies to meet the health needs of the client. This office complies with all rules and regulations promulgated by the Montana Department of Public Health, including those related to the proper cleaning used in the practice of acupuncture and the sanitation of acupuncture offices. This office uses one-time use disposable needles only. 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 therapy at any time. All clients are asked to pay in full at the time of the visit. All expenses for supplements, herbs, and homeopathic medicines are in addition 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.

Fee Schedule:

Initial Visit (60 minutes)	$200
Initial Visit (45 minutes)	$150
Return visit limited (30 minutes)	$100
Return visit brief (15 minutes)	$50
Return visit short (5 minutes)	$17
Regenerative Injection Therapies (prolotherapy, etc)	$200
New Patient Acupuncture	$135
Acupuncture follow up	$85
Telephone consult	$3.33/minute

Emails: Please no emails as phone calls are the preferred way for us to communicate.

***Very Important Information *** Please Read Carefully and Sign After Reading

I am here to help you take care of your health in the best way that I know how. I realize you came in about health and not finances. The following is to assist in understanding the financial policies.

Payment Requirements: Appointments must be paid for at time of service. I accept Visa, Master Card, Discover, check or cash. 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: I will keep a record of your health care. I will not disclose your record to others unless you direct us to.

Insurance and Medicare: I do not offer insurance billing as I do not contract with any insurance company. However, we can provide you with a superbill which you can then submit yourself for reimbursement. Remember, payment is expected at time of service and any insurance payments will go directly to you. I am unable to bill Medicare or Medicaid! Medicare will not reimburse you for services rendered with me and you should not seek reimbursement from Medicare.

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)

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)

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List the main problems that you are having, or reason for this appointment:
Please attach additional page if necessary

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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)

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Family History (parents, grandparents, siblings, history of diabetes, cancer, strokes, etc.)

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Accidents/Major Trauma (scars - please give location)

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

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____

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?)

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____
____

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
Tobacco ____
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 describe your typical breakfast, lunch, dinner and snacks and anything else you would like us to know about you.

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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
EX: VITAMIN C	BRONSON	1/1/08	500 MG	2 PER DAY

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Dr. Buffy Binder, ND
Dr. Mark Kelley, ND
1201 W Main Hamilton, MT 59840

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____

Relationship to Patient: ____
(if applicable)

Signature: ____

Date: ____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of this *Notice of Privacy Practices Acknowledgment*, but was unable to do so as documented below:

DATE: ___________________ INITIALS: ____________________

REASON: ____

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