**Dr. Buffy Binder, ND**
Naturopathic Physician
1201 West Main Street
Hamilton, MT 59840
office (406) 375-0167 ● fax (866) 225-2126
www.thehealthyplace.com

**Welcome!** I am honored that you have chosen me to help you in your search for optimum health. This is your New Patient Information Packet. Please read, fill it out, sign the attached forms, then fax, email, mail or drop off this packet at the office at least 24 hours prior to your appointment. This will allow us to use your appointment time efficiently. We offer a $25 discount at your first appointment if we receive your paperwork at least 24 hours prior.

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 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 Montana Association of Naturopathic Physicians and the American Association of Naturopathic Physicians. 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 energized 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.

In order to best serve you, please bring any prior lab work and your supplements and medications with you 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 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 (406) 375-0167. Please no clinical emails as phone is the best way to communicate with us. We look forward to meeting you!

**Member Montana Association of Naturopathic Physicians www.mtnd.org**
**American Association of Naturopathic Physicians www.naturopathic.org**

**Fee Schedule:**

| Service | Fee |
|---|---|
| New Patient Initial (60 minutes) | $300 |
| New Patient Initial (90 minutes) | $400 |
| Return visit intermediate (30 minutes) | $100 |
| Return visit limited (15 minutes) | $50 |
| Return visit brief (5 minutes) | $17 |
| Annual female exam | $180 |
| PAP, basic (thin prep) | $42 |
| Naturopathic spinal manipulation | $65 |
| Telephone consult | $3.33/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 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.

***Very Important Information***
Please Read Carefully and Sign After Reading
Dr. Binder and here staff 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, MasterCard, 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. Dr. Binder is not a preferred provider 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. Dr. Binder is 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 have asked Dr. Binder for medical help and that she will help to the best of her ability.

I have read and understand the above statements.

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)

_________________________________________________________________________

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)

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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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_________________________________________________________________________

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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)**

______________________________________________________________________

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**Vaccinations**

( ) COVID ________________________________
( ) 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: _____________________________________________________

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**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: _________________________________________________________________

________________________________________________________________________