

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:

New Patient Initial (60 minutes)	\$300
New Patient Initial (90 minutes)	\$400
Return visit intermediate (30 minutes)	\$150
Return visit limited (15 minutes)	\$75
Return visit brief (5 minutes)	\$25
Annual female exam	\$180
PAP, basic (thin prep)	\$42
Naturopathic spinal manipulation	\$65

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)

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

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

- () Covid-19 Year(s) _____
- () 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 _____

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: _____
