

Dr. Mark Kelley ND, LAc
Naturopathic Physician and Acupuncturist
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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. We offer a \$25 discount at your first appointment if we receive your paperwork at least 24 hours prior. 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)	\$300
Initial Visit (45 minutes)	\$225
Return visit limited (30 minutes)	\$150
Return visit brief (15 minutes)	\$75
Return visit short (5 minutes)	\$25
Regenerative Injection Therapies (prolotherapy, etc)	\$200
New Patient Acupuncture	\$135
Acupuncture follow up	\$85

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.

Also, my malpractice insurance requires me to inform you that treatment results are not guaranteed and naturopathic medicine is not a substitute for conventional medical treatment.

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)

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 _____
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.

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: _____
