**LAVAGE- New Leaf Holistic Health**

31 Broadway, Kingston NY. 160 Benmont Ave. Suite 30, Bennington VT.

Tel 845.331.2235 Fax 845.943.4483

NewLeafHolisticHealth.com

Welcome to our practice.

We are pleased that you have chosen Naturopathic Medicine as an option to reach optimal health.

**OFFICE HOURS:**

Office hours below are by appointment only. A 24-hour notice for cancellation is appreciated.

Monday VERMONT ONLY

Tuesday CLOSED

Wednesday 12 pm to 6 pm

Thursday 12 pm to 6 pm

Friday 10 am to 2 pm

**CONTACT:**

To reach the doctors, please call the office. If we are unable to answer during regular business hours because we are with patients, please leave a voice message. We are diligent about returning every phone call we receive within the same day. **Please note that E-mails are not a secure way to communicate with us about your health.**

**MEDICINARY ITEMS:**

You may stop by the office during regular business hours to pick up your supplements, however it is always best to call before you do so. If we do not have the item you need, we are usually able to order it within a week. As a general rule please call one week before your supplement runs out, so we may make arrangements for you to pick it up. **We must have a credit card on file if you request out of stock products or special-order items.**

**LABORATORY WORK:**

**As a general rule we prefer to review laboratory results during office visits.** We do not feel it is professional to review results over the telephone, unless prior arrangements have been made. We often will give our patients "KITS" for private laboratory testing. We require payments for kits at the time of visit.

**If kits are not completed within 3 months, fees will be forfeited.**

**INSURANCE BILLING:**

Please see the Financial Form in the intake questionnaire for details. However, as a general rule the following apply:

1)NEW YORK

a) Insurance plan must cover out **of network acupuncture** benefits if you see Dr. Tecchio.

2) VERMONT

a) Dr. Finley is a preferred provider for BCBS and Cigna.

b) Dr. Tecchio is an out of network provider and may bill any insurance, however coverage may vary from plan to plan.

**OUR POLICY IS TO KEEP A CREDIT CARD ON FILE**

**IF YOU WANT US TO BILL YOUR INSURANCE**

Please complete the attached intake to the best of your knowledge and sign **all** forms.

We look forward to working with you. Patient's Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Glenn R Finley ND

Ileana Tecchio ND LAc Patient's Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Patient Health History Questionnaire**

**New Leaf Holistic Health**

160 Benmont Ave Suite 30, Bennington VT…31 Broadway, Kingston NY

Tel. 845.331.2235 Fax. 845.943.4483 NewLeafHolisticHealth@gmail.com

Today's Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Legal Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name Middle Initial

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street/PO Box City State Zip Code

Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Work Cell Phone

E-mail address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Telephone Relationship

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_ Female \_\_\_\_\_ Male \_\_\_\_\_

Single \_\_\_\_\_\_ Married\_\_\_\_\_\_ Other\_\_\_\_\_\_ Partner’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Full-time Part-time Student Retired

Is there a number you prefer us **NOT** to leave a message? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who can we thank for your referral? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your primary care physician?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Name Name of Practice Telephone if Known

For what concern did you last receive health or medical care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MAIN CONCERNS**

**What are the concerns for which you are seeking care?**

**1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of onset \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of onset \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of onset \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of onset \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NEW LEAF HOLISTIC HEALTH FINANCIAL POLICIES**

**Unless prior arrangement is made, full payment is appreciated at the time of service.**

* Your payment options are: cash, check, or credit/debit cards. We accept Visa, MasterCard, and Discover.
* Twenty-four-hour cancellation notice is appreciated.

**Insurance Billing**

* If you would like us to bill your insurance, we will contact your insurer(s) and bill them based upon the **non-guaranteed** information they provide to us.
* You are responsible for all co-payments, deductibles and other adjustments made by your insurer(s).
* Insurance companies may reimburse differently than the information they initially provide to us.
* You are responsible for and will be billed for any resulting unpaid balance.
* We may use your health care information and may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize the use of my signature an all insurance submission. I certify that I have read and understand the above information.
* IF WE HAVE NOT BILLED YOUR INSURANCE COMPANY BEFORE WE WILL ASK YOU TO LEAVE A CREDIT CARD ON FILE WITH US TO BE CHARGED IF NECESSARY, AS WE DO NOT COLLECT UNTIL INSURANCE CLAIMS ARE PROCESSED. \_\_\_\_\_Initials
* IF YOUR INSURANCE IS BILLED AND AN EXPLANATION OF BENEFITS (EOB) IS SENT DIRECTLY TO YOU, YOU HAVE 4 WEEKS TO FORWARD THE EOB AND ANY CHECK AMOUNTS YOU RECEIVED TO US. IF WE DO NOT RECEIVE THE EOB YOUR CREDIT CARD ON FILE WILL BE CHARGED FOR THE BALANCE DUE. \_\_\_\_\_Initials

**Laboratory Kits:**

If we provide you with laboratory "KITS" for private testing, we require payments for kits at the time of visit.

IF KITS ARE NOT COMPLETED WITHIN 3 MONTHS, FEES WILL BE FORFEITED. \_\_\_\_\_Initials

**Past Due Accounts**

* **Accounts greater than 30 days past due will be charged a $5.00/month administrative fee.**
* **Accounts greater than 90 days overdue will be sent to a collection agency.**

**Below is our Fee Schedule**

* **New Patient**

Initial Comprehensive Consultation 50 Min 210.00

* **Established Patient**

Acupuncture/Cupping 50 Min 86.00

Follow Up Visit 50 Min 86.00

Focused Follow Up 30 Min 71.00

* **Hydrotherapy**

Single Hydrotherapy 100.00

Series (3) Hydrotherapy 270.00

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I have read, understood and agree to the policies described above.

Patient Name (Please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVATE PRACTICES**

**PATIENT RIGHTS**

**Right to request restrictions on uses and disclosures:** To request a restriction, please write a request to New Leaf Holistic Health. Upon receiving your request, we will put the limits and terms in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required to make.

**Right to receive confidential communications:** This includes the right to direct where communications are sent. For example, you may request that information be sent to our work address rather than your home address or via Email than by regular mail. To verify or modify where or how you would like communication sent, contact New Leaf Holistic Health. Unless requested otherwise, we will direct mailings and telephone messages to the address/telephone number we have on record.

**Right to inspect and copy.** Includes the rights to see and get copies of your information that we maintain. Submit your request in writing to New Leaf Holistic Health and we will respond to you within 30 days of receipt of your written request.

**Right to amend:** If you believe there is a mistake or missing information, you have the right to request that we correct or add to your file. You must provide the request in writing to New Leaf Holistic Health. We will respond within 30 days of receipt of your written request. We may deny your request in writing if your information is 1) correct and complete, 2) not created by us, 3) not allowed to be disclosed, or 4) not part of our records. Upon approval, we will make the changes, inform you when the changes are complete, and inform others that need to know about the change in a timely manner. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. You also have the right to request that copies of your initial request and our denial be attached to all future disclosures of your information.

**Right to receive an accounting of disclosures.** This will not include uses or disclosures made for treatment, payment or health care operations, disclosures made directly to you, those you have already authorized, those made for national security reasons or to law enforcement that has lawful custody over you. We will respond within 30 days of receiving written request. Please include the time period for which you want the accounting (can be no longer than 6 years and may not include dates before April 14, 2003). The accounting will include the date of the disclosure, to whom information was sent, a brief description of the information disclosed, and a brief statement of the purpose for the disclosure. We will provide the first accounting at no charge. For additional accountings, we may charge you a fee but will inform you of that fee in advance.

**Right to get a paper copy of this Notice.** At any time even if you previously agreed to receive an electronic copy.

**Right to file a complaint.** If you believe your health information has been improperly used or disclosed, or that your privacy rights have been violated, you may file a privacy complaint with us. Contact New Leaf Holistic Health to file a complaint. You also have the right to file a complaint with the Secretary of the US Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint with us or the DHHS.

**I acknowledge having carefully read this copy of the Notice of Privacy Practices.**

Patient Name (Please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note: if this acknowledgement is being signed by a legal representative, you must provide a copy of the power of attorney or other relevant document(s) designating you as the legal representative.

**INFORMED CONSENT**

GLENN FINLEY N.D.

Glenn Finley N.D. is licensed to practice Naturopathic Medicine in the state of Vermont. Glenn Finley N.D. has a Doctorate degree in Naturopathic Medicine from the National College of Natural Medicine. He is a member of the American Association of Naturopathic Physicians. Glenn Finley N.D. does not provide after hour services and in case of an emergency I understand I should contact the appropriate licensed health care provider.

**Naturopathic Medicine in the state of New York**

A Naturopathic Doctor is trained as a primary care provider and is a board-certified physician in states where licensure is applicable. **Currently licensure for Naturopathic Doctors is not available in the state of New York**. Therefore, Glenn Finley N.D. does not practice medicine, and does not diagnose or treat diseases, or medical conditions in the state of New York. In the state of New York, Glenn Finley N.D. focuses his practice on the enhancement of health. The services he provides are not meant to substitute or replace those of a licensed physician. Patients seeking his consultation are advised to also be under the care of a licensed New York state physician.

**Naturopathic Medicine in the State of Vermont**

As a Naturopathic Doctor in the state of Vermont, Glenn Finley N.D. is licensed to practice as a primary health care provider and is a board-certified physician.

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I hereby request and consent to a naturopathic consultation, herbal and nutritional supplement suggestions for me (or for the patient named below, for which I am legally responsible) by Glenn Finley N.D.

**I understand that all my records will be kept confidential and will not be released without my written consent.**

I understand it may be necessary for Glenn Finley N.D. to contact another one of my health care providers in order to discuss any emergency situation. My signature gives Glenn Finely N.D. permission to release my medical records for the reason listed above.

I have been informed that I have the right to refuse any suggestions given by Glenn Finley N.D. I have read, or have had read to me, the above consent. I intend this consent form to cover all the suggestions Glenn Finley N.D. will provide me for my present condition and for any future condition(s) for which I seek assistance with. I have also had an opportunity to ask questions about this consent, and by signing below I agree to the above.

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_