

Glenn Ingram, Jr, ND
Marty Ingram, ND

www.throughwoods.com



2861 Asheville Highway
Pisgah Forest, NC 28768

Phone: 828-553-6705

Name _____ Today's Date _____

Parent/Guardian Name(s): _____ Relationship _____

Age _____ Date of Birth ____/____/____ Gender: Female Male Social Security # _____

Address _____ City/State/Zip _____

Guardian Phone # (Home) _____ (Work) _____ (Cell) _____

At which phone number(s) may we leave voice mail messages? _____

E-mail _____

Guardian Occupation _____ Employer _____

Emergency Contact _____ Emergency Contact Phone _____

Primary Care Physician _____ PCP Phone _____

How did you hear about us? _____

Referred by a doctor? Yes No Who? _____

May we contact you via e-mail for feedback, updates, and newsletters? Yes No

What are your goals for your child's health care? _____

Briefly describe your child's current health concern. _____

What are your most important health concerns? List in order of importance?

1. _____
2. _____
3. _____
4. _____
5. _____

When was the last visit to a doctor? _____ For? _____

CURRENT MEDICATIONS

Please list any prescription medications, over the counter medications, homeopathic remedies, herbs, vitamins, or other supplements you are taking along with dosage amounts?

ALLERGIES

Are you hypersensitive or allergic to...

No Known Allergies

Any drugs? _____

Any foods? _____

Anything in the environment? _____

Tape/Adhesives

Latex

GENERAL

Weight _____ lbs.

Height/Length _____ Head Circumference (if applicable) _____

PAST MEDICAL HISTORY

Surgeries or Hospitalizations: _____

Major Illnesses: _____

Have a history of abuse? Y N

Head injuries? Y N

FAMILY HISTORY

Do you have a family history of any of the following? Check all that apply.

Diabetes

Heart Disease

Cancer

Autoimmune Disease

Allergies

Mental Illness

Other: _____

Is there a family history of your current complaints? Y N

Which ones? _____

REVIEW OF SYSTEMS

Check all that apply. Y = Yes, I have this now P = In the past N = Never had

MENTAL/EMOTIONAL

Mood Swings? Y P N

Anxiety or nervousness? Y P N

Depression? Y P N

Poor concentration? Y P N

Memory problems? Y P N

Fatigue? Y P N

HEAD

Headaches? Y P N

Hair Loss? Y P N

EARS

Earaches? Y P N

Impaired hearing? Y P N

Dizziness? Y P N

Ringings? Y P N

EYES

Loss of vision? Y P N

Pain/irritation? Y P N

Redness? Y P N

NOSE AND SINUSES

Nose Bleeds? Y P N

Stiffness? Y P N

Hayfever? Y P N

Loss of smell? Y P N

MOUTH AND THROAT

Frequent sore throat? Y P N

Sore tongue/lips? Y P N

CARDIOVASCULAR

Heart disease? Y P N

High/Low Blood Pressure? Y P N

Palpitations/Fluttering? Y P N

Bleed easily? Y P N

RESPIRATORY

Cough? Y P N

Wheezing? Y P N

Asthma? Y P N

Bronchitis? Y P N

GASTROINTESTINAL

- Heartburn? Y P N
- Belching or passing gas? Y P N
- Change in thirst? Y P N
- Change in appetite? Y P N
- Constipation? Y P N
- Diarrhea? Y P N
- Bowel Movements
How often? _____

URINARY

- Increased frequency? Y P N
- Frequent infections? Y P N
- Difficulty starting? Y P N
- Pain? Y P N

MUSCULOSKELETAL

- Joint pain or stiffness? Y P N
- Arthritis? Y P N
- Muscle spasms or cramps? Y P N
- Injuries? Y P N

SKIN

- Rashes, Acne, Boils? Y P N
- Itching? Y P N

IMMUNE

- Vaccinations? Y P N
Any problems with vaccines? Y N
- Chronic infections? Y P N
- Chronically swollen glands? Y P N
- Slow wound healing? Y P N

ENDOCRINE

- Thyroid problems? Y P N
- Heat or cold intolerance? Y P N
- Hypoglycemia? Y P N
- Diabetes? Y P N

LIFESTYLE AND HABITS

- Get plenty of exercise? Y P N
- Participate in sports? Y P N
If yes, what kind? _____
How often? _____
- Sleep well? Y P N
- Spend time outside? Y P N
- How many hours of television? _____
- How many hours do you read? _____
- Attend School? Y P N
How often? _____
What grade? _____
- Do you eat 3 meals a day? Y P N
- Family have a spiritual practice? Y P N
Describe _____
- Does anyone smoke tobacco? Y P N
How much? _____
- Use recreational drugs? Y P N
Which ones? _____
How much? _____
- Does anyone drink alcohol? Y P N
How much? _____
- Hobbies? _____
- Other interests _____

Is there anything you would like to add? _____

Welcome! I'm happy to help you; if you have any questions, just ask

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Financial Policy and Fee Schedule

(Effective November 2009)

It is our hope you will understand our financial policies are a necessary part of assuring the resources required to maintain our unique health care services for our patients and the community.

BILLING POLICY:

- **All payments are due in full at the time of service.** We are a fee-for-service office. If you are not prepared to pay, we will need to reschedule your appointment or make other arrangements.
- We accept Cash, Check, Debit, or Credit card.
- A \$25.00 fee will be charged to your account for all returned checks plus any bank fee charges.
- **We do not accept or submit health insurance claims for payment.** Naturopathic medicine is not covered by health insurance in the state of North Carolina at this time.

FEE SCHEDULE:

The following fees are for office visits only, and do not include the cost of any medicinal items or lab testing. Discounts are available for students and low income patients. The fees charged are standardized and based on a relative value scale that takes into account the time, skills and professional component required for each visit and procedure. They are comparable to fees charged in this and neighboring communities by other competent doctors.

- 15-minute informational interview free
- Extensive new patient visit \$180 (\$150 for children 12 and under)
- Return visits
 - Brief \$40
 - Intermediate \$60
 - Standard \$80
 - Extensive \$110

We welcome your questions, and any brief phone call or email clarifying your existing treatment plan is free of charge. Any phone call or email that covers new material or takes an extensive amount of time will be billed as an office visit.

Ask about our **Family Plan** if you have several people in your household who would like to come and see us.

DELINQUENT ACCOUNTS:

Accounts exceeding 60 days past due from the date of service are considered delinquent.

At the discretion of the office manager, all accounts 90 days are delinquent and will be referred to an outside collection agency. **A \$50.00 collection fee will be charged if the account is placed with an outside agency.** We will be unable to see you until the account is paid in full.

CANCELLATION POLICY:

You must notify the office 48 hours prior to canceling or rescheduling your appointment. We reserve the right to charge a \$35 fee for cancellations made less than 2 business days before your scheduled appointment.

I understand and agree that I am responsible for payments to Through the Woods Natural Health for charges to my account. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I agree to pay for all costs and expenses including reasonable attorney fees.

Signature

Date

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Disclosure and Informed Consent

I, _____ (client name) request, authorize and consent to a program of naturopathic services to be performed by Through the Woods Natural Health.

I understand that Glenn Ingram, Jr, ND and Marty Ingram, ND are not licensed medical doctors in the State of North Carolina, as the State of North Carolina does not presently recognize qualified, naturopathic physicians. It is therefore understood that Glenn Ingram, Jr, ND and Marty Ingram, ND do not diagnose and treat any disease and/or condition, but rather offer an alternative approach to the client for the condition(s) presented. The services to be provided by Through the Woods Natural Health are not meant to replace medical care by a licensed medical provider; it is the responsibility of the client to obtain all appropriate tests and evaluations by their primary care physician and/or specialist.

I have been notified of the Notice of Use of Private Health Information from Through the Woods Natural Health, posted on our website (<http://www.throughwoods.com/New%20Patient>) and in our office, in accordance with *The Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") established by The US Department of Health and Human Services to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have also been given the opportunity to have any questions regarding this notice answered by my health care provider or staff, as well as the appropriate contact information to the Office of Civil Rights.

Signature

Date