Whole Family Wellness
Thauna Abrin, N.D.

Office: 132 S Main St Hardwick, VT 05843
Mailing: PO Box 28 Hardwick, VT 05843
(802) 472-9355 office (855) 823-0800 fax wellness@drthauna.com

Name____Date________________
Age_________Date of Birth_____________________________Gender______________
Address____
City______________________________State_______________Zip_______________
Home Phone________________________Work Phone ___________________________
Cell Phone_______________________
Number where it's ok to leave a message about your care_________________________
E mail address ____
Occupation______________________________Employer________________________
Employment status: □ Full-time □ Part-time □ Student □ Retired
Name of insurance company _________________________________ HMO or PPO
Policy number _________________________ group number ______________________

Please mark:
Are you: □ married □ divorced □ single □ significant partnership
Live with: □ spouse □ partner □ relatives □ parents □ friends □ alone □ pets □ children
Ages of children _____________
Emergency contact person______________________________Relation______________
Address____Phone home________________
cell ________________________

How did you hear about Dr. Abrin? ____________ Friend name?__________________

What **health concerns or health goals would you like to discuss today**?
1.____
2.____
3.____
And long term? ____
List any **allergies** to drugs, foods, supplements, pollens: _________________________
____
____

Please list **all prescription medications** you are taking

MEDICATION DOSE REASON
1.____
2.____
3.____
4.____
5. ____

Please list **all supplements and products** you are taking

BRAND & PRODUCT DOSE REASON
1.____
2.____

3.____
4.____
5.____
6.____
7.____
8.____
9.____
10.____

Current/Recent Health Care Providers & Primary Care Physician

Name & Date   Care Provided   Phone

____
____
____
____

Hospitalizations/Operations/ Accidents

Dates   Hospital   Diagnosis   Doctor

____
____
____
____

Family History

Member   Living?   Age?   Important Diseases   Cause of Death & Age

Important Diseases: Alcoholism, high blood pressure, cancer, diabetes, heart disease, osteoporosis, stroke, thyroid, allergies

Mother____
Father____Sister(s)____________
____
Brother(s)____
Maternal Grandmother____
Paternal Grandmother____
Maternal Grandfather____
Paternal Grandfather____
Maternal Aunt/Uncle(s)____
Paternal Aunt/Uncle(s)____

General

Current weight __________   Height __________

Personal History   Y=Yes, N= No

General Health: □Excellent   □Good   □Fair   □Poor
Have you had your cholesterol checked? __ Y / N__ Date___________Results________
Have you had a colonoscopy? _____ __   Y / N__ Date___________Results________
Have you had a mammogram? _________   Y / N _ Date___________Results________
Have you had a bone density test?_______   Y / N __Date___________Results________
Have you had a heavy metal test? ______   Y / N __Date___________Results________
Childhood diseases: □German measles   □Chicken pox   other_____________
Have you received vaccinations? Y / N   Known vaccination reaction?   Y / N

Past Medical Conditions: (list present conditions in the section below)
□Heart trouble__________________ □Stroke □Varicose veins □Phlebitis
□High blood pressure □Diabetes □Clotting defects □Bleeding tendencies
□Kidney trouble □Rheumatic fever □Jaundice/hepatitis □Epilepsy
□Fractures__________________________ □Cancer_____________________________
□Arthritis □Colitis □Asthma □Eating disorder □Anxiety
□Sexually transmitted infections □Anemia □Thyroid problem______________

Review of Systems
Check any symptom of present significance (If any past problems please note above)

General:
□Fevers or chills □Hot flashes □Unusual hair growth □Weight change
□Skin eruptions □Joint pain/changes □Numbness/tingling □ Cancer

Abdomen:
□Bloating □Heart burn □Cramps/pain □Diarrhea □Change in bowels
□Bloody stools □Nausea/vomiting □Constipation □Hemorrhoids □Other________
Number of bowel movements daily ________

Head:
□Headache □Dizziness □Visual defects □Hearing defects □Sinus trouble □Fainting

Bladder:
□Frequent urination □Painful urination □Blood in urine □Incontinence

Chest:
□Chest pain □Shortness of breath □Heart murmur □Palpitations □Cough
□Wheezing □Coughing up blood □Mitral valve prolapsed

Breasts:
□Lumps □Bleeding □Discharge □Tenderness □Swelling

Males:
□ Trouble urinating? □ Frequent urination? □ Hernia? □ Discharge?

Females:
Last period began________________________ Last pelvic exam_____________
Date Prior period began___________________ Last PAP smear______________
Have you ever had an abnormal pap?________ When________ Results________
□Abnormal menstrual bleeding (explain)_______________________________________
□Painful period □Pain with intercourse □Vaginal discharge or itching
□Sexually transmitted infection □DES exposure □Sexually active
□ PMS- please list symptoms ____

Females:
Birth control method___________________________
Trying to get pregnant? _________________________
Trouble conceiving? ____
Past pregnancy complications? ____

Habits

Dietary preferences/restrictions ____
____
Breakfast____
Lunch____
Dinner____
Drink____
Snacks ____
Alcohol use (how much)?_____________________________How often?_______________
Caffeine use (how much)?____________________________How often?_______________
Tobacco use (how much)?_____________________________How often?_______________
Physical exercise: Type?______________________________How often?_______________

Attitude, Energy & Sleep

□ Depression □ Anxiety
□ Fatigue □ Fatigue that affects daily activities
□ Trouble sleeping

Environment

□Water filter □Air filter □Organic produce □Free- range poultry/meat
□Non-toxic cleaning and personal care products
Do you have silver fillings?____________How many?_____________________________
When did you last see the dentist?_______________What for?______________________
How often do you eat fish?___________________type_____________________________
Is there mold where you live?__________________________
Any known long-term exposure to chemicals? ___________________________________

Stressors

Please list stressors in your life
____
____
____
____
How do you handle stress?____

What coping techniques to you have to handle stress? ____

Anything else you would like to tell me about your health? ____
____
____
____
____

Whole Family Wellness, Inc.

Dr Thauna Abrin, ND • PO Box 28• Hardwick VT 05843
Phone (802) 472-9355 Fax (855) 823-0800

Office and Financial Policies

Dear New Patient,

Welcome to Whole Family Wellness. We look forward to facilitating your health journey. We encourage your questions and participation in all aspects of your health care.

Please note our office and financial policies below and sign/initial to signify your acceptance. Feel free to ask any questions about this information.

Appointments and availability

_____ Office hours are Mon 9:30-12:30, 2-5, Tues & Thurs 10-12:30, 2-5:30, Fri 9:30-12:30, 2-3 .
Office visits are by appointment only. Please call 24 hours in advance to arrange to pick up your supplements.

For questions or concerns, Dr. Abrin is available via telephone from 1-2 pm or 5-5:30 pm Monday & Thursday. The first visit includes a complementary telephone consultation. For current patients, there is no charge for brief consultations (<6 minutes).

Longer consultations > 10 min will be billed to your insurance plan. Patients without insurance will be billed at the rate of $3.00/minute. The fee is due via credit card at completion of the phone appointment (for calls longer than 7 minutes).

Dr. Abrin is available for urgent calls after hours (6 pm Monday-Friday) or weekends at her home number. In the case of an emergency at any time, please go to the nearest emergency room.

For new patients, a copy of your current insurance card must be available for the first visit. If your card is not available, your visit will be rescheduled.

Patients who do not show-up to their appointment cannot be rescheduled for 1 month.

Patients who no-show or cancel (at the last minute) 2 confirmed appointments within a 12-month period will be referred to another medical provider.

FEE SCHEDULE

WHOLE FAMILY WELLNESS, INC. FEE SCHEDULE

	NEW PAT VISIT COMPRE-HENSIVE	FOLLOW UP VISIT EXTENDED	FOLLOW UP VISIT INTERMED	FOLLOW UP VISIT LIMITED	FOLLO W UP VISIT BRIEF	PHYS &/OR GYN EXAM	ADMIN-ISTER INJECTION
INSURANCE	287.50	218.50	195	161	138	230	50
TIME OF SERVICE DISCOUNT	225	150	130	100	85	130	25

Payment

_____ **For any missed appointments or late cancellations (less than 24 hours), you will be charged a $65 missed appointment fee**. The exception to this is illness or bad weather. PLEASE CALL THE OFFICE (NOT EMAIL) to communicate any last minute cancellations.

A reminder call will be made to your home phone number two days in advance of your appointment. During the call, you can confirm or cancel your appointment or request rescheduling. **Please call back or email us at wellness@drthauna.com if you are unable to keep the appt.**

If you have insurance coverage, Whole Family Wellness will bill your insurance company (for patients with Blue Cross/Blue Shield VT, BCBS Federal, Cigna, MVP, Green Mountain Care, Dr Dynasaur and You First).

Charges for visits, medicinary items, and co-payments are due at the time of the visit (check, cash, MC/VISA) unless specific arrangements have been made prior to your scheduled appointment. The patient is responsible for co-payment and co-insurance, both for visits and for injections.

For patients with insurance coverage, Whole Family Wellness with submit a claim for office visits at a rate of 219.00/hour. For those patients responsible for coinsurance, Whole Family Wellness will send you a bill for the coinsurance amount after a "RA" remittance advice is received.

For patients with a high deductible insurance plan, there is a choice of either:
1) Paying Whole Family Wellness at the time of service at a discounted rate or
2) Whole Family Wellness will submit a claim to your insurance company at a rate of 219.00/ extended visit. The patient will then receive a bill for the amount that is applied to your deductible after a "RA" remittance advice has been received by Whole Family Wellness. Please note that is total amount due is higher than the time of service discount rate.

For insurance companies in which Dr Thauna Abrin is not an enrolled provider, you are responsible for payment, and we will provide you with a bill to submit directly to your insurance carrier or to transfer onto a claim form provided by your insurance carrier. We do not accept work comp or bill for claims for automobile accidents.

For patients with Medicaid as secondary insurance, we cannot bill Green Mountain Care for co-payments. The patient is responsible for the primary insurance co-payment at the time of service.

Communication

Email communication:
Please contact Dr Abrin via email for:
●Brief treatment protocal questions & supplement refills
●Prescription refills

Please call the office for:
●Appointment changes, especially appointments cancelled in less than 24 hours
●Urgent medical concerns – 5-6 min phone appt is no charge, ask for " free phone consult"
●Scheduling follow-up appointments, both acute and chronic
●Prescription refills if you have not received a response from Dr Abrin via email

Medicinary items

_____ Insurance companies do not cover the medicinary items that we prescribe and dispense.

Nutritional supplements, including herbal tinctures and homeopathic remedies, are non-refundable.

Vitamin injections are billed at the rate of $10. This out-of-pocket expense covers the vitamin itself and your co-payment. We bill insurance for administering the injection. For self-pay patients, a vitamin b12 injection is $30.

In the event that a medicinary item needs to be special ordered, it will be shipped to you directly from the supplement company, with a $5 flat rat shipping charge (for supplement orders under $50). You will receive the item via UPS within 3-6 working days.

For supplements sent from our office, there is a shipping rate of $4 for shipping and handling, with additional charges for heavier packages. We send packages out once per week (Fridays).

If you have a Health Savings Account, we can provide a list of your supplements on prescription pad to submit to your employer.

For laboratory tests performed either at a local hospital or at home and sent to a specialized lab, the patient is responsible for any laboratory test-related fees. Be sure to call both your insurance plan and/or the billing office at the local hospital to verify coverage. Whole Family Wellness can provide the CPT (test codes) and ICD-9 (diagnostic codes) you will need to make these inquiries.

____

I have read and understand the above-stated policies of Whole Family Wellness, Inc. and will comply with them in all respects.

____________________________________ ________________

Signature (parent signature if minor) Date

____

Print (your/parent name)

Whole Family Wellness
Office of Dr Thauna Abrin

Informed Consent Form

I, __________________________ hereby request and consent to receive naturopathic medical care by the above named Vermont naturopathic doctor and/or other licensed naturopathic doctors who now or in the future may treat me while working at or associated with or serving as back-up for the above named doctor, whether signatories to this form or not. I have read and understand the attached NOTICE OF PRIVACY PRACTICES, which discusses my rights under the Health Insurance Portability and Accountability Act of 1996.

I understand that the methods of treatment are permitted under the Vermont Naturopathic Physician Act, which may include but are not limited to: nutritional counseling, herbal medicine, homeopathy, nutritional supplements, hydrotherapy, IV/injectable nutrients and certain prescription medications (according to Naturopathic Physician Formulary Rules).

I have had the opportunity to discuss with the naturopathic doctor named above the nature and purpose of naturopathic treatments and procedures. I am aware that all existing methods of diagnosis and treatment, including naturopathic healthcare, pose some level of risk. Within the general healthcare setting, the possible outcomes of these practices by a naturopathic doctor range from minor to fatal.

The herbs, homeopathic medicines and nutritional supplements (which are from plant, animal, mineral and other sources) that have been recommended, are considered safe when taken as instructed in the practice of naturopathic medicine. It is extremely important that you follow the prescribed recommendations when taking herbs, homeopathic medicines and nutritional supplements because they may be toxic when taken in large doses. I understand that herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I understand that some herbs and supplements may be inappropriate during pregnancy, and I will immediately notify the doctor if I become aware that I am pregnant.

I will immediately inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reaction (hives, rash, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with the treatment or the herbs or other supplements prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. In order to properly treat your medical condition, the doctor must be contacted promptly if an adverse reaction or condition occurs. In any event, if an emergency medical condition arises (such as trouble breathing, seizure, chest pain, fever above 103.5, anaphylaxis, or injury), please seek treatment immediately from a trauma center or call 9-1-1.

I have read, or have had read to me, the above information and consent. I have also had an opportunity to ask questions about its content, and by voluntarily signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

PATIENT NAME (printed) ____

PATIENT SIGNATURE ____ Date: __________