Dear Patient,

Thank you for the opportunity to be a partner with you in your health care.

We have included several important forms that we will review at your first appointment. Your detailed and thoughtful responses will help us to utilize our time more effectively. Please bring these forms to your first office visit. Your first visit will be a thorough assessment of your health and you will need to allow an hour and a half.

If you are unable to keep your scheduled appointment time, please let us know at least 48 hours prior to the scheduled time so that we may allow other patients to have your appointment. We will be glad to reschedule your visit. Please help us to serve you better by keeping scheduled appointments.

Please remember to bring in copies of any recent lab work or medical records as well as all the bottles of supplements and/or medications you are currently taking.

We look forward to seeing you. Our goal is to become a trusted partner in assisting you with your health care needs.

Yours in health,

Dr. Peter V. Swanz
Vital Force Naturopathy
Inspiring Your Unique Vitality

812-716-HEAL (4325)
The Horizon Business Center ~ 3012 Eastpoint Pkwy ~ Louisville, KY 40223
info@drswanz.com ~ www.DrSwanz.com

FINANCIAL RESPONSIBILITY AND POLICY STATEMENT

Thank you for choosing Vital Force Naturopathy (VFN) for your healthcare needs. Our healthcare providers and staff are committed to enhancing the quality of your care and overall health. This policy statement is designed to inform you of our policies and answer questions regarding payment for services.

PAYMENT FOR SERVICES

VFN is a fee for service clinic. Patients are to assume all financial responsibility for the office visit and services rendered during the time of service.

For your convenience, we accept cash, personal checks, and can process credit cards online. Returned checks are subject to a $25 return fee and no further personal checks will be accepted.

PHONE SUPPORT

Phone support is to aid in answering any questions or concerns that may arise, or to clarify instructions. This is not intended to take the place of an office visit.

Phone consultations that *cover new material, require new information, take an extensive amount of time, or require a change in the treatment plan* are considered substitutes for an office visit. These will be billed for the same rate as the visit for which they substitute. For example, a phone consultation that substitutes for a regular follow up will be billed at $89.

CANCELLATION POLICY

If you are not able to keep your scheduled appointment, please notify us within 48 hours of the appointment. There is no charge if an appointment is cancelled within 48 hours. A cancellation with less than 48 hours notice does not allow enough time for other interested patients to be scheduled, and is a great inconvenience for our center. Thus, for naturopathic visits there is a $100 charge for new patient and a $50 charge for follow-up cancellations.

I agree to the above defined financial policies. In case of default of payment, I am responsible for full payment of the balance, interest accrued, and any collection costs and legal fees incurred to collect on this account. I the undersigned, have read, understand and accept the information and conditions specified in this document.

______________________________________	___________________________
Patient or Parent/Guardian Signature	Date

Naturopathic Medicine Legal Disclosure

As a valued patient of Vital Force Naturopathy, it is important to us that you are fully aware of the laws surrounding Naturopathic Medicine in Kentucky.

• The states of Kentucky and Indiana do not offer a Naturopathic License to Naturopathic Physicians, and our physicians do not hold a current medical licenses for either state.
_____ Initial

• As a result, our physicians cannot legally prescribe pharmaceutical drugs, perform minor surgeries, administer injections, or diagnose illnesses.
_____ Initial

• Our Naturopathic Physicians are trained as primary care physicians. However, we are unable to fill that role in the state of Kentucky and Indiana. Because of this, we ask you to maintain your relationship with a primary care physician. If you need a referral, we can provide a list of primary care physicians.
_____ Initial

_______________________________ ____

Patient or Parent Signature Printed Name Date

Patient-Provider E-Mail Agreement

E-mail offers an easy and convenient way for patients and doctors to communicate. In many circumstances, it has advantages over office visits or telephone calls. But remember, there are important differences. E-mail is not the same as calling the office; there is no person at the other end of the e-mail – just a computer. You can't tell for certain when your message will be read or if the doctor is in the office or on vacation.

Nonetheless, we believe that the ease of communication e-mail affords is a benefit to patient care. It will further assist us if you could identify the nature of your request in the subject line of your message. Below are our rules for contacting us via e-mail.

- E-mail is never appropriate for urgent or emergency problems! Please use the telephone or go to the Emergency Room for emergencies.
- E-mail is great for asking those little questions that don't require a lot of discussion.
- E-mail should not be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- **E-mail is not confidential!** It is like sending a postcard through the mail. Our staff may read your e-mails to handle routine, non-clinical matters. You should also know that if sending e-mails from work, your employer has a legal right to read your e-mail if he or she chooses.
- E-mail may become part of the medical record when we use it; a copy may be printed and placed in your chart.
- **E-mail is not a substitute for seeing your physician**. If you think that you need to be seen, please call and schedule an appointment!
- E-mails may be forwarded to our staff for handling, if appropriate.

Finally either party can revoke permission to use the e-mail system at any time.

I **DO** want to communicate with my doctor electronically. I have read the above information and understand the limitations of security on information transmitted.

Patient Name: ___________________________ Patient Signature: ________________________
E-mail Address: ____ Date: ___________

CONFIDENTIAL PATIENT REGISTRATION FORM

Date: ____________________

New Patient Information

Name: *(Last)* ______________________ *(First)*_____________________
Sex*:* ___ *DOB*: ___/___ /___ Age: ____
Address: __________________________________
City: _______________________ St: ___________ Zip: _________
Home Phone: (__) Cell Phone: (__) Work Phone: (__) ____________
Email Address: ___________________ Would you like to receive our email newsletter? Y N

Additional Patient Information

Primary Care Physician: __________________________ Physician's Phone: (__)_____________
Address: ________________________City: _________________
State: _________ Zip: ______
Employer: _____________________________ Occupation: ______________________
Highest level of Education: Some high school Graduated high school Some college Bachelor's degree Master's degree Graduate degree
Household Income: < $50,000 $50,000 - $100,000 $100,000 - $200,000 > $200,000
Marital Status (circle): Single Married Separated Divorced With Partner Widow(er)
Number of Children: _____
Name of Spouse/Partner: ____________________________
Emergency Contact: ________________________ Relationship to you: ______________________
Emergency Contact #: (__)________________________