

Dear New Client,

Welcome to the SPAhT Homeopathic Medical Spa. We are pleased by your choice to come to the SPAhT to achieve your health and wellness goals. Our purpose is to help you look and feel your best. Our aim is to do this as naturally as possible by improving your overall health and vitality. We believe that by addressing your constitutional health we bring you a greater sense of well-being today, and it filters into all aspects of your physical, mental and emotional life. We believe that you deserve that youthful, rejuvenated "fresh from the spa" feeling all day long, every day.

How much do you know about naturopathic medicine and homeopathy? As a Naturopathic Physician, I look for holistic complements or alternatives to a medical doctor's drugs and surgery, and whenever possible use homeopathy and natural therapies that support and stimulate the body's own healing power. I work with you to investigate the root cause of the problem, so our treatments are effective and long-lasting. I use interview, physical exam, and available lab tests to help in determining the focus of your treatment: how you can optimize your health to look and feel radiant!

We try to make your appointments as convenient to your schedule as possible. If you need to reschedule an appointment, we ask that you give at least 24 hours' notice. A cancellation fee of \$50 will be charged for all missed appointments and all cancellations within 24 hours of your scheduled appointment.

Our policy is to collect full account payment at the time of each visit. We do not contract directly with insurance companies, but you may find that your insurance provider may reimburse you based on your out-of-network benefits. We are happy to provide you with a copy of your fee slip if you would like to bill your insurance company.

At times you may find it necessary to speak to the doctor on the phone. If the doctor has asked you to call, or if you have any questions regarding your treatment plan, there is no fee. All other phone consultations will be charged as an office visit according to the doctor's fee schedule.

Most of our new patients come from other satisfied clients. Your referral of someone in need of our service is the best compliment you can ever give a doctor. Thank you.

Dr. Tolle B. Murphy
Licensed Naturopathic Physician
SPAHT Homeopathic Medical Spa

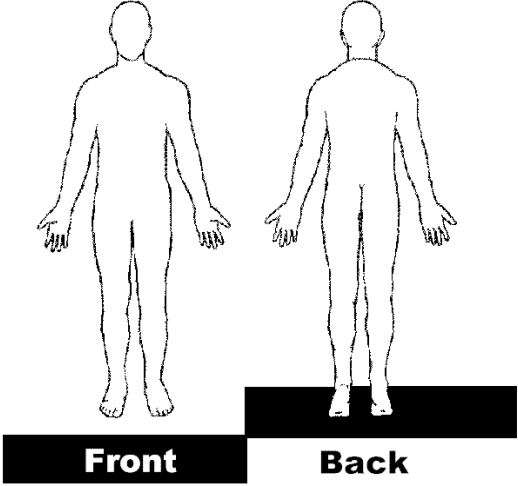
PATIENT PROFILE

Last Name: _____ First Name: _____

Birth date: _____ Sex: _____ Date: _____

A note to our patients: This is a confidential record of your medical treatment and only be released when you have provided us with written authorization to do so. Thank you.

PRESENT HEALTH CONCERNS

Please list most important health concerns in their order of significance.	Prior diagnosis of this problem? If so, what?	Indicate painful or distressed areas:
1.		
2.		
3.		
4.		
5.		

What goals/expectations/questions do you have for your visit at the clinic today? _____

Have you previously consulted a (please circle) Naturopathic Physician, an Acupuncturist, a Nutritionist or a Counselor? Names if current _____

Please list name/specialty of physicians you see _____

Please list prescription medications that you are currently taking, with dosages:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

List vitamins, minerals, herbs, homeopathic remedies you are currently taking with dosage.

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Please list any severe or life-threatening allergies: _____

If you have no known drug allergies, please circle NONE

Personal Habits:

Please circle any of the following substances that you use regularly, indicate frequency:
 Tobacco _____ Coffee/black tea/cola _____ Alcohol _____ Recreational drugs _____
 Do you follow any particular diet regimens or restrictions? If yes, please describe: _____

Do you exercise regularly? Yes No What type? _____
 How long? _____ How often? _____

Past History:

Hospitalizations: _____

Serious Illnesses and Injuries: _____

Date of last physical/annual exam _____ Date of last blood tests: _____

Personal and Family History:

Please check the "yes" box next to each condition that applies to you or one of your family members. Please note whether condition applied to family member in the past or currently by denoting a "P" for past or "C" for current. Indicate the relationship or the word "self" in the "Relationship" column.

	YES	RELATION	DATES RESOLVED Past(P)/Current(C)		YES	RELATION	DATES RESOLVED Past(P)/Current(C)
Alcohol/Drug Addiction				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema				Other			
Epilepsy							

Social History:

Please circle those that apply: Single Married Partnered Children: Age(s) _____

CONSENT FOR TREATMENT

I hereby authorize Dr. Tolle Murphy to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

General Diagnostic Procedures (including but not limited to venipuncture, pap smears, radiography, and blood and urine labwork, general physical exams, neurological and musculoskeletal assessments)

Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions

Herbs/Natural Medicines (prescribing of various therapeutic substance including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical cremes, pastes, plasters washes; suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.)

Dietary Advice and Therapeutic Nutrition (use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.)

Soft Tissue and Osseous Manipulation (use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy)

Electromagnetic and Thermal Therapies (includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and infrared and ultraviolet therapies or moxa—warming or indirect burning of an acupuncture point and hydrotherapies.)

Potential Risks: Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Tolle Murphy. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

Guardian/Personal Representative's Name (PRINT)

Patient's Name (PRINT)

Guardian/Personal Representative's Signature

Patient's Signature

Relationship/Representative's Authority

Date



Patient Information

Last Name: _____ First Name: _____ Middle Name _____

Address: _____ City: _____ State: _____ Zip Code: _____

SS#: _____ Home Ph:(_____) _____ Work Ph:(_____) _____ Cell Ph:(_____) _____

May we leave confidential voice-mail messages for you? No Yes (specify): Home Work Cell

Mother's Name (minors only): _____ Father's Name (minors only): _____

Emergency Contact: _____ Relationship of Contact _____ Phone: (_____) _____

What expectations do you have of Dr. Murphy? 1) _____ 2) _____ 3) _____

Specify if you have special needs: _____ What do you love? _____

How did you hear about us? _____

Subscribe to our free bi-monthly e-newsletter, ink SPAHT, by providing your email address _____@_____._____

Guarantor Information

Complete this section if someone other than the patient is financially responsible for the patient's account.

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: (_____) _____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X _____

Guarantor's Signature

Date

Terms of Admission

Financial Terms: I understand that full account payment is due at the time of each visit, and that if I am providing insurance billing information that I am responsible for all charges whether or not they are covered by my insurance. I understand that finance charges will begin accruing on accounts that are 30 days past due for payment at a rate of 5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if that guarantor is someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.

Privacy Terms: We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so. The SPAHT Homeopathic Medical Spa is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at the SPAHT, wish to inquire about your rights or if you wish schedule an appointment to view your medical record, please call our office at (206)632.2030. Medical record copy fee is \$19.00 + \$0.83/p for first 30 pages, and \$0.63 for additional pages. Thank you.

I hereby acknowledge that I have received a copy of the SPAHT Homeopathic Medical Spa's Notice of Privacy Practices. Should I refuse or fail to sign this form, I acknowledge that the SPAHT has made a good faith effort to obtain my acknowledgement.

X _____

Patient's Signature

Date

X _____

Guardian/Representative's Signature AND Relationship

Date