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 _____
Policy number _____ group number _____
Copayment _____ High deductible yes/no yearly deductible _____

Please mark:
Are you: □ married □ divorced □ widowed □ 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 Alcoholism, high blood pressure, cancer, diabetes, heart disease, osteoporosis, stroke, thyroid, allergies	Cause of Death & Age

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 type _____

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 prolapse

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

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,cannabis or other substance use (how much)?_____How often?_____
Physical exercise: Type?_____How often?_____

Attitude, Energy & Sleep

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

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 posted on our website www.drthauna.com.
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 by appt only. 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	FOLLOW UP VISIT BRIEF	PHYS &/OR GYN EXAM	ADMIN-ISTER INJECTION
INSURANCE	287.50	218.50	195	161	138	230	50
TIME OF SERVICE DISCOUNT	275 -350 depending on complexity of visit	160	130	100	85	160	30

Payment

_____ **For any missed appointments or late cancellations (less than 24 hours), you will be charged a $75 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, Harvard Pilgrim, 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 $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 $8 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 $6 for shipping and handling, with additional charges for heavier packages. We send packages out once per week.

If you have a Health Savings Account, we can provide a list of your supplements 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: _____