# 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 □ 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 _____ email address _____

How did you hear about Dr. Abrin? _____ Friends 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._____ | | |

ANY LONG-TERM MEDICATION USE? □ Y □ N

WHICH MEDICATIONS? _____

Patient Name

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

BRAND & PRODUCT DOSE REASON

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____

**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<br>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 _____ □ low BP □ high BP

**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_____

Patient Name

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 (Type)_____
□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

**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 □Scar from biopsy?

**Males:**
□ BPH □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 _____

| Patient Name |
|---|

**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 that you would like to tell me about your health?
_____
_____
_____
_____
_____

Patient Name

# *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 review our office and financial policies and sign below. Feel free to ask any questions about these policies.

## Appointments and availability

- **OFFICE HOURS**:

Mon: 9:30-12:30, 1:30-5:00 pm
Tues: (telemedicine only) 9:30-12:30, 1:30-5:00 pm
Wed: By Appt Only
Thurs: 9:30-12:30, 1:30-5:00 pm
Fri 9:30-2:00 pm.

- **Please call 24 hours in advance to arrange a time to pick-up your supplements.**

- **Phone appointments**: For current patients, there is no charge for brief phone consultations (<6 minutes). **Longer consultations > 6 min must be conducted via telemedicine in order to bill your insurance plan. Phone or telemedicine appointments for self-pay patients will be billed at the rate of $4.00/minute. The fee is due via credit card at completion of the appointment.**

- Dr. Abrin is available for urgent calls after hours (after 6pm Monday-Friday) or weekends on her cell number**. In the case of a true emergency, please go to the nearest emergency room**.

- **For new patients, a copy of your current insurance card must be available for the first visit.**

- **Email messages**: The best way to reach Dr. Abrin during the day is via email ( ideally through the OPTIMANTRA patient portal confidential website). Dr. Abrin will respond to brief email messages at no charge. **Lengthy email messages with more than one question will be charged $20-60**.

- If you don't hear back from Dr. Abrin, please leave a message at the office and your call will be returned within 24-48 hours. If you have a urgent medical question, please call the office to schedule a phone, telehealth or in-office consultation.

- **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 6-month period will be referred to another medical provider.

## Fees & Payment

- **Please contact our office for office visit fees.**

** For seniors > 65, we offer a 15% discount off visit fees and a 10% discount off supplements.*

- Fees are due at the time of service, including co-pays for telemedicine appointments.

| Patient Name |
|---|

## Fees & Payment

- We accept the following forms of payment : cash, check and credit card (MC and VISA).
- A reminder call will be made to your home phone number two days in advance of your appointment.
- **In the event that your appointment needs to be cancelled in less than 24 hours, please CALL the office and EMAIL erin@drthauna.com ASAP.**
- **Missed appointment fee is $75.00 unless there is a medical emergency or inclement weather**.
- For self-pay patients, telephone consults are no charge for the first 6 minutes**. Phone or telemedicine appointments for self-pay patients will be billed at the rate of $4.00/minute.**
- **Lengthy email messages with more than one question will be charged $20-60**
- **Bodywork such as Bowen technique and craniosacral therapy are not covered by insurance**
- **Returned check fee is $40.00**
- **Special paperwork fee - Reasonable accommodations or Disability form $30 & HSA form $10**
- **Medical records**- There is no fee to transfer your medical records to another provider, however there is a fee of **$10-30 for us to send you a copy of your medical records**. All of your laboratory and imaging results are located the documents section of Optimantra patient portal, where you can download them at no charge.

**Insurance Coverage**

We are in network providers for these Vermont insurance plans :

- **Blue Cross Blue Shield of Vermont, Federal BCBS, Cigna, CBA Blue, Dr Dynasaur/Green Mt Care/Medicaid, Harvard Pilgrim (certain plans only), MVP, and You First (formerly Ladies First)**
- We do not accept insurance for patients located in Maine or New Hampshire; however we will provide a superbill to submit to your insurance for possible reimbursement.
- Unfortunately, Medicare does not accept naturopathic medicine.
- Telemedicine through zoom.us or optimantra video chat is offered by Whole Family Wellness and covered by all insurance plans listed above.
- For patients with Blue Cross Blue Shield of Vermont and Medicaid, you can choose Dr. Abrin to be your designated PCP (primary care physician).
- 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.

- For patients with insurance coverage, Whole Family Wellness with submit a claim for office visits at a rate of 218.50 for an extended visit. For patients responsible for coinsurance, Whole Family Wellness will send you a bill for the coinsurance amount after a "RA" remittance advice is received by our office.

- **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 $218.50 for an extended visit. If you want the billed amount for the visit to go towards your deductible, Whole Family Wellness will send you a bill for the visit after a "RA" remittance advice is received by our office.

- For insurance companies in which Dr. Abrin is not an enrolled provider, you are responsible for payment at the time of service. However, we can provide a superbill to submit to your insurance for possible reimbursement.

- We do not accept work comp or bill for claims for automobile accidents.

| Patient Name |
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## Medicinary items

- Insurance companies do not cover any 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 $20. This out-of-pocket expense covers the vitamin syringe . In some cases, we can bill insurance for administering the injection. For self-pay patients, a vitamin b12 injection is $30.

- **We have an online dispensary called FULLSCRIPT. Medicinary item will be shipped to you directly from FULLSCRIPT, with a $8.75 UPS shipping charge (4-7 days) or $11.95 (1-3 days) for supplement orders under $50**. For supplements sent from our office, the shipping rate varies.

- If you have a Health Savings Account, please ask your employer for a form that we complete listing your a supplements and diagnostic codes. HSA accounts can be used to pay supplements , nebulizers, and/or air purifiers.

- **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-10 (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)

| Patient Name |
|---|

**Whole Family Wellness, Inc.**
**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: _____
_

PARENT OR GUARDIAN'S SIGNATURE _____ Date: _____

| Patient Name |
|---|