Riverbirch Holistic Health

Dear Client,

We want to thank you for choosing us as your naturopathic healthcare provider. In order to give you the best possible care, please review the following information before your first appointment.

Your First Appointment(s) with Michelle Drains, ND

- **Client name:** _____
- **Initial appointment:** _____
- **Wellness Plan appointment:** _____

Please fill out the following forms and provide them to our office at least 2 days *BEFORE* your first appointment. You may mail, email or personally deliver these forms to our office.

- A completed New Client Information Form
- A completed Homeopathic Information Form

Please bring to your first appointment:

- Any forms not yet completed
- All current medications, supplements, and/or vitamins (in their original bottles, if possible)
- Copies of any previous medical records (including lab work). To request records from another physician, please use the "Records Release" form included in this packet. If you do not have records to share, you can leave this form blank.

To change your appointment, please contact us **24-hours in advance**, and we will be happy to reschedule you to a more convenient time. In order to reserve your first appointment, we require a **$100 deposit**. This deposit is refundable minus a $15 processing fee with a 24-hour cancellation notice. ***Missed appointments with no notice given in person or by phone are subject to a charge for the full amount of the scheduled visit.*** Please review our office policies and the end of this packet for more details.

If you have any questions before your appointment, please do not hesitate to call us at **877-825-8740 Ext #701**. Thank you!

We are looking forward to providing you with excellence in naturopathic healthcare!

Confidential New Client Information—Pediatric Form (12 and under)

PLEASE PRINT

Today's Date _____

Client's Name: _____

Gender: M F **Birthdate**: ____/____/____ **Age**: _____

Mailing Address:_____
Street City State Zip

Primary Phone: _____ **Alternate Phone**: _____

Email address: _____ **Alternate Email**: _____

Parent/Guardian Name(s) and Occupation(s): _____

_____

Parents are: Single Married Partnership Separated Divorced Widow(er)

Siblings (Names and ages): _____

Child's School _____ **Grade in School:** _____

Hobbies/Interests: _____

Pediatrician: Name: _____ Office Phone: _____

Other health care professionals: _____

How did you hear about us? (select all that apply)

☐ Referral from an existing client: (who?) _____

☐ Referral from another health care provider: (who?) _____

(If you were referred, may we have your permission to thank the individual?)
Yes, please! *Yes, but please keep my name anonymous* *No*

☐ Internet search ☐ Yellow Pages ☐ Newspaper/Magazine: _____

☐ Television ☐ Speaking Event (which one?): _____

☐ Other (please specify): _____

What made you decide to make an appointment with Riverbirch Holistic Health? How can we best be of service to you? What are you hoping to gain from this relationship? Do you have any specific wishes or requests regarding your treatment that you would like us to know about?

_____

_____

List, in order of importance, your child's major health concerns/what you wish us to address today:

1. _____
2. _____
3. _____
4. _____
5. _____

What treatments have you already tried?

☐ Conventional Medicines ☐ Surgery ☐ Diet/Nutrition ☐ Chiropractic ☐ Massage

☐ Herbal Medicines ☐ Homeopathy ☐ Acupuncture ☐ Vitamins ☐ Fasting/Detoxification

☐ Other: _____

Current Medications: (include all prescription and over-the-counter medications)

Medication	*Dose/Frequency*	*For how long?*	*For what reason?*

What other medication has your child taken in the past? _____

How many times has the child taken antibiotics? _____

Current Supplements: (include all vitamins, herbs, homeopathy, or other supplements)

Supplement	*Brand*	*Dose/Frequency*	*For how long?*	*For what reason?*

Please write down a general timeline of your child's health history. Starting from birth, include all major illnesses, injuries, operations, hospitalizations, and other medical diagnoses.

Illness/Operation/Hospitalization/Injury/Diagnoses:	*Year*	*Details/Notes*

Pregnancy and Birth History

Mother's age at conception: _____ Did she have other children already? Yes No

Mother's Health and Habits During Pregnancy:

☐ Smoking ☐ Coffee ☐ Recreational Drugs ☐ Alcohol

☐ Diabetes ☐ Nausea/Vomiting ☐ Emotional Stress ☐ Preeclampsia/Eclampsia

☐ Length of Labor ☐ Vaginal Birth ☐ C-Section

If the birth was difficult, please explain: _____

Health of baby at birth: _____

Child's Weight at birth: _____ Child's Height at birth: _____ Premature? Y N

Was/is the child breast-fed? If so, for how long? _____

Was/is the child on formula? Which brand? _____

When was solid food introduced? _____ When did child first: Walk? _____ Talk? _____

Vaccination History (YES, has had; NO, has not; SOME, did not finish all shots):

☐MMR: Y N S ☐DPT: Y N S ☐Hep B: Y N S ☐Hib: Y N S

☐Chicken Pox: Y N ☐ Polio: Y N S ☐ Others: _____

Any reactions to vaccinations? If so, please explain: _____

Medical History—Please list date of test and results:

Physical Exam: _____ Dental Exam: _____

Bloodwork: _____ Eye Exam: _____

Hearing Test: _____

Any other diagnostic tests? (i.e. X-ray, Ultrasound, MRI, CT Scan, etc.)

_____

Family History: Please circle "Y" for Yes:

	Child	Father	Mother	Siblings	Grandparents
Cancer	Y	Y	Y	Y	Y
High blood pressure	Y	Y	Y	Y	Y
Heart disease	Y	Y	Y	Y	Y
Heart attack	Y	Y	Y	Y	Y
Stroke	Y	Y	Y	Y	Y
Diabetes	Y	Y	Y	Y	Y
Autoimmune disease	Y	Y	Y	Y	Y
Thyroid disease	Y	Y	Y	Y	Y
Obesity	Y	Y	Y	Y	Y
Osteoporosis	Y	Y	Y	Y	Y
Arthritis	Y	Y	Y	Y	Y
Alcoholism	Y	Y	Y	Y	Y
Drug addiction	Y	Y	Y	Y	Y
Eating disorder	Y	Y	Y	Y	Y
Anxiety	Y	Y	Y	Y	Y
Depression	Y	Y	Y	Y	Y
Suicide/Suicidal	Y	Y	Y	Y	Y
Allergies	Y	Y	Y	Y	Y
Asthma	Y	Y	Y	Y	Y
Skin disease	Y	Y	Y	Y	Y

Other (please describe): _____

Describe cancer (if any): _____

Please list any known allergies (Medications, Foods, Environmental, Chemical):

_____

Review of Systems: Please indicate if your child has had problems with any of the following:
Circle P for Past or C for Current

HEAD:		
Headache	P	C
Migraine	P	C
Head injury	P	C
Dizziness/Vertigo	P	C
Cradle Cap	P	C
EYES/EARS/NOSE/THROAT:		
Seasonal allergies	P	C
Chronic sniffles	P	C
Blurry vision	P	C
Double vision	P	C
Other eye disorder	P	C
Ear aches/infections	P	C
Hearing disorder	P	C
Tinnitus (ringing in ears)	P	C
Sinus pain/infection	P	C
Nasal congestion	P	C
Nose bleeds	P	C
Frequent colds	P	C
Sore throat	P	C
Voice hoarseness	P	C
Strep Throat	P	C
Poor teeth	P	C
RESPIRATORY:		
Asthma	P	C
Bronchitis	P	C
Coughing	P	C
Shortness of breath	P	C
Wheezing	P	C
CARDIOVASCULAR:		
Heart disease	P	C
Palpitations	P	C
Murmurs	P	C
Edema (swelling)	P	C
Rheumatic fever	P	C
Anemia	P	C
URINARY TRACT:		
Frequent urinary infections	P	C
Pain with urination	P	C
Discharge/blood in urine	P	C
Frequent urination/urgency	P	C
Bed-Wetting	P	C
GASTROINTESTINAL:		
Heartburn/Acid reflux/GERD	P	C
Ulcer	P	C
Bloating	P	C
Excessive flatulence	P	C
Nausea/Vomiting	P	C
Constipation	P	C
Diarrhea	P	C
Colic	P	C
Jaundice (as a baby)	P	C
Stomach aches	P	C
Hernia	P	C
SKIN:		
Dry skin	P	C
Acne	P	C
Rash	P	C

Hives	P	C
Eczema	P	C
Psoriasis	P	C
Moles	P	C
Warts	P	C
Diaper Rash	P	C
MUSCULOSKELETAL:		
Arthritis	P	C
Joint pains, swelling, stiffness	P	C
Muscle aches/pains	P	C
Weakness	P	C
Tremors	P	C
Growing pains	P	C
NERVOUS SYSTEM:		
Tingling/numbness	P	C
Paralysis	P	C
Seizures	P	C
Insomnia	P	C
ENDOCRINE:		
Diabetes (Type I or II)	P	C
Thyroid disease	P	C
Early puberty	P	C
Late puberty	P	C
Very sweaty baby/child	P	C
Bad food odor	P	C
Other hormonal problems	P	C
MENTAL/EMOTIONAL/OTHER		
Anxiety	P	C
Depression	P	C
Bipolar disorder	P	C
Suicidal	P	C
Anger	P	C
Fearful/Phobias	P	C
Panic attacks	P	C
Mood swings	P	C
Poor memory	P	C
Nightmares/Night Terrors	P	C
Tantrums	P	C
Disobedient	P	C
Hyperactivity	P	C
ADD/ADHD	P	C
Autism/Autism spectrum	P	C
Learning disability	P	C
Speech impediments	P	C
Physical/Mental/Sexual abuse	P	C
GIRLS ONLY		
Have you started your period?	Y	N
Any problems with your period?	P	C
BOYS ONLY		
Undescended testicles	P	C

Diet:
Is your child a finicky eater? If so, describe: _____

What special diet do you follow, if any? (Vegetarian, Vegan, Food allergy, etc.)_____

Eating Habits: (check all that apply):

☐ Breast-fed exclusively
☐ Formula-fed exclusively
☐ Breast-fed and Formula
☐ Solid foods
☐ Skip breakfast
☐ Crave salt
☐ 3 meals a day
☐ 2 meals a day
☐ Graze (small, frequent meals)
☐ Food rotation
☐ Eat constantly whether hungry or not
☐ Generally eat on the run
☐ Crave sweets

What does your child drink during the day and how much? (Soda, water, juice, milk, etc.)
_____

Exercise:
Does your child exercise? _____ What type of exercise does he/she do? _____

Weight:
Child's weight today: _____ Child's height: _____ Have you been told where he/she falls on a Pediatric Growth Chart? _____

Sleep:
How long does your child sleep each night? _____ Does he/she have difficulty sleeping? _____
Does your child nap? _____ Does you child have frequent bad dreams? _____

Stress:
Are there any particular stressors that your child has witnessed or gone through (home, school, etc.)?
Please describe: _____
_____

Social:

- How does your child enjoy school? _____
- Describe your child's friendships: _____
- What activities does your child enjoy? _____
- How would you describe your child's personality? _____

Toxin Exposure:

- Does anyone smoke in your household?_____
- Has your child ever lived near a refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were they exposed to? _____
- Has your child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health at all? _____
- Does the child seem particularly sensitive to perfumes, gasoline or other vapors? _____
- Do you spray pesticides, herbicides or other chemicals around your home? _____

Name: _____ ***Date:*** _____

Homeopathic Information Form

Please try to answer the questions on the following pages as **carefully, thoughtfully, and accurately as possible**. Many of the questions may not seem directly related to your problem or main complaint, and some may seem downright irrelevant or silly, but this information is critical in selecting the most appropriate homeopathic remedy for you as a whole person. **All information in this questionnaire is kept confidential.**

Do any of the following bother you? If so, please circle all that apply.

WEATHER CONDITIONS:

Cloudy
Clear
Wet
Dry
Damp
Snow
Storms
Wind
Fog
Hot Sun

SEASONS:

Spring
Summer
Fall
Winter

LOCATIONS:

The Mountains
The Beach

Are you generally sensitive to and/or troubled by:

Bright Light
Never *Sometimes* *Always*

Darkness
Never *Sometimes* *Always*

Open Air
Never *Sometimes* *Always*

Stuffy Rooms
Never *Sometimes* *Always*

Tight Clothing
Never *Sometimes* *Always*

Noise
Never *Sometimes* *Always*

Odors
Never *Sometimes* *Always*

Drafts
Never *Sometimes* *Always*

Are you generally a chilly or a warm person?

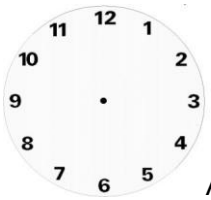
Chilly Warm 1 2 3 4 5 6 7 8 9 10

Which are you generally most sensitive to, being a little too warm or a little too cold?

A little too cold A little too warm

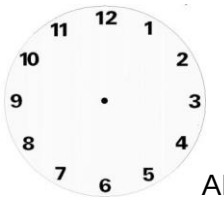
Are there any times of day when you usually feel bad (low energy, poor mood, a worsening of your symptoms)? Are there certain times of day when you always feel better? If so, please indicate below. If not, please leave this section blank.

Worst

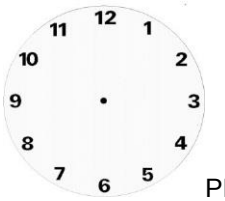


AM

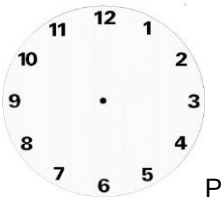
Best



AM



PM



PM

Please circle which of the following sleep habits you experience: (you may choose more than one)

Tooth Grinding
Restlessness
Talking
Perspiration
Frequent Urination
Excess Heat or Cold
Laughing
Snoring
Nightmares
Recurring Dreams
Sleepwalking

Do you sleep: (you may circle more than one)

Without Covers
Partly Covered
Fully Covered (Not including Head)
Fully Covered (Including Head)
With Arms or Legs Out of the Covers
Without Clothing
With a Fan or Air Blowing on You
With the Window open

What position do you sleep in most often?

Right Side On Back
Left Side On Abdomen

How much do you perspire?

Never All the Time
1 2 3 4 5 6 7 8 9 10

Do you have difficulty waking?

Never All the Time
1 2 3 4 5 6 7 8 9 10

Do you wake unrefreshed?

Never All the Time
1 2 3 4 5 6 7 8 9 10

Food Desires and Aversions:

In the following questions you are asked how much you desire or are averse to a particular food or taste. Please answer from the point of view of your natural desires, not your knowledge of nutrition. For example, you may never eat fatty meat because this is known to increase cholesterol, however you do love the taste of fat. In this case, you would answer the question that you like fat. If you strongly desire or crave a food or taste, "always." If you detest a food or taste, mark "never.'

If all foods were equally healthy and your food choices were made on cravings/desire alone, what foods would you crave the most?

Do you crave:

Sweet Foods
Never Sometimes Always

Salty Foods
Never Sometimes Always

Sour Foods
Never Sometimes Always

Bitter Foods
Never Sometimes Always

Spicy Hot Foods
Never Sometimes Always

Smoked Foods
Never Sometimes Always

Juicy Foods
Never Sometimes Always

If the following foods were all equally healthy, and you could eat as much of any of them as your heart desired, which of the following foods would you choose to eat?

Alcohol
Apples
Bacon
Bread
Butter
Candy
Cheese
Chocolate
Coffee
Eggs
Fat (on meat, chicken, pork, etc.) Fish
Fruit
Grain products (pasta, breads, cereal, etc.) Ham
Ice
Ice cream
Indigestible things (like chalk, clay, paper, etc.)
Lemonade
Meat
Milk
Nut butter (peanut, almond, etc.)
Oranges
Oysters
Pickles
Vegetables
Vinegar

What is your temperature preference:

Food:
Hot
Warm
Room temperature
Cold

Drinks:
Hot
Warm
Room temperature
Chilled
Cold with ice

How thirsty are you in general?

Not at all Very 1 2 3 4 5 6 7 8 9 10

Do you notice any specific tastes in your mouth (e.g., metallic, bitter, foul, etc.)?

Mental and Emotional State:

Where do you fall on the continuum of the following personality traits. Answer as honestly as you can.

Stingy — Overly generous
1 2 3 4 5 6 7 8 9 10

Hurried, impatient — Slow
1 2 3 4 5 6 7 8 9 10

Messy — Clean and organized
1 2 3 4 5 6 7 8 9 10

Calm — Restless
1 2 3 4 5 6 7 8 9 10

Lazy — Always busy
1 2 3 4 5 6 7 8 9 10

Shyness/Timid/Bashful — Outgoing
1 2 3 4 5 6 7 8 9 10

Mild — Angry/Temper
1 2 3 4 5 6 7 8 9 10

Never feels guilty — Always feels guilty
1 2 3 4 5 6 7 8 9 10

Not religious — Very religious
1 2 3 4 5 6 7 8 9 10

Stubborn — Yielding
1 2 3 4 5 6 7 8 9 10

Reckless — Cowardice
1 2 3 4 5 6 7 8 9 10

Aversion to company — Desire for company
1 2 3 4 5 6 7 8 9 10

Indecisive — Quick to decide
1 2 3 4 5 6 7 8 9 10

Unselfish — Selfish
1 2 3 4 5 6 7 8 9 10

Quarrelsome — Yielding
1 2 3 4 5 6 7 8 9 10

Bossy/Dictatorial — Yielding/Fawning
1 2 3 4 5 6 7 8 9 10

Not trusting — Trusting
1 2 3 4 5 6 7 8 9 10

Gullible — Suspicious
1 2 3 4 5 6 7 8 9 10

Quiet — Talkative
1 2 3 4 5 6 7 8 9 10

How much do you worry about the following things:

Your physical health
Never *Sometimes* *Always*

Your mental health
Never *Sometimes* *Always*

Your emotional health
Never *Sometimes* *Always*

The health of your loved ones (family and close friends)
Never *Sometimes* *Always*

Financial security
Never *Sometimes* *Always*

Morals/Past indiscretions
Never *Sometimes* *Always*

Religion
Never *Sometimes* *Always*

Social life
Never *Sometimes* *Always*

Social position
Never *Sometimes* *Always*

The future
Never *Sometimes* *Always*

Work
Never *Sometimes* *Always*

List any other worries that you have:

_____

Fears:

How fearful in general are you?

Frightened Easily Never Afraid
1 2 3 4 5 6 7 8 9 10

Are you afraid/fearful of any of the following? Please circle all that apply:

Animals
Being alone
Death (your own)
Death of a loved one
Impending disease
Downward motion
Evil
Failure
Falling
Ghosts
Heights
Insanity
Misfortune/Bad Luck
Crowds
People
Robbers/Intruders
Snakes
Spiders
Strangers
Having a stroke/heart attack
That something will happen
Darkness
Thunderstorms
Water
Wind

Circle the expression that best describes your feelings about the following issues.

Circle which best expresses your general mood.

Morose
Sad
Apathy/Indifferent
Excitement
Exhilaration

Feeling towards people close to you:

Loving
Affectionate
Indifferent
Resentment
Hatred

Feeling toward spouse/lover:

Loving
Affectionate
Dissatisfaction
Disappointed
Indifferent
Resentment
Hatred

Feeling towards significant past emotionally traumatic events:

Resolved Grief
Dwells on Past
Inconsolable
Remorse
Guilt

Feeling toward disease/condition:

Optimistic
Doubtful of recovery
Discouraged
Fearful
Despair of recovery

Feeling toward life

Love life
Indifferent
Bored
Weary of life
Loathing of life
Suicidal

Emotional State:

How often to you experience the following emotions:

Irritability
Never *Sometimes* *Always*

Jealousy
Never *Sometimes* *Always*

Mood swings
Never *Sometimes* *Always*

Anger
Never *Sometimes* *Always*

Sadness
Never *Sometimes* *Always*

Anxiety/Worry
Never *Sometimes* *Always*

When you are sad, do you prefer company or do you prefer being alone?

Company Being Alone
1 2 3 4 5 6 7 8 9 10

How often and easily do you cry?

Never Often
1 2 3 4 5 6 7 8 9 10

How is your level of self-confidence?

Lack of confidence Pride/Haughty 1 2 3 4 5 6 7 8 9 10

How impulsive are you?

Never Often
1 2 3 4 5 6 7 8 9 10

Are you Capricious? (Willfulness, changeable and erratic desires that are difficult to satisfy)

1 2 3 4 5 6 7 8 9 10

How often do you forget the following:

Dates
Never *Sometimes* *Always*

Names
Never *Sometimes* *Always*

Numbers
Never *Sometimes* *Always*

Words
Never *Sometimes* *Always*

What someone just said to you
Never *Sometimes* *Always*

What you just said
Never *Sometimes* *Always*

How often do you make mistakes with the following?

Numbers
Never *Sometimes* *Always*

Words (when reading)
Never *Sometimes* *Always*

Words (when speaking)
Never *Sometimes* *Always*

Words (when writing)
Never *Sometimes* *Always*

How sensitive are you to any of the following?

Beauty
Never *Sometimes* *Always*

Criticism
Never *Sometimes* *Always*

Cruel stories
Never *Sometimes* *Always*

Frightening things
Never *Sometimes* *Always*

Being made fun of
Never *Sometimes* *Always*

Music
Never *Sometimes* *Always*

Reprimand
Never *Sometimes* *Always*

Rudeness
Never *Sometimes* *Always*

The suffering of others
Never *Sometimes* *Always*

How critical are you of others?

Not at All All the Time
1 2 3 4 5 6 7 8 9 10

How critical are you of yourself?

Not at All All the Time
1 2 3 4 5 6 7 8 9 10

How honest are you?

Always Lie Always honest
1 2 3 4 5 6 7 8 9 10

Do you have any of the following behaviors?

Abusiveness
Biting Breaking things Cursing

Contrary behavior (acting opposite of what is expected) Disobedient
Insulting
Rageful
Rudeness
Hitting others
Hitting yourself
Violence in general

*151 Church Street N. * Concord, NC 28025 * 877-825-8740 * RiverBirchHolistic.com*

Dear client: Please read the following office policies and let us know if you have any questions.
YOUR SIGNATURE IS NEEDED ON THE LAST PAGE. THANK YOU!

Riverbirch Holistic Health, LLC., is a fee-for-service office and does not accept or submit health insurance claims for payment. Therefore, payment for services and nutritional supplements is due in full at the time of service. Please let us know if you need to discuss other payment options. We accept cash, personal checks, Visa, and MasterCard. There is a minimum $25 fee for returned checks and no further personal checks will be accepted.

Every effort has been made to ensure an easy-to-understand schedule of fees. For a more detailed description of our fees for services, please ask us for additional information. Fees as listed below are for office visits **only**, and do not include the cost, if any, of nutritional supplements or lab work. The exception is the 21 Day Purification program which *does* include all supplies.

New Client Initial Visit :	$ 325 Part I, $210 Part II
Follow-up/ Acute Visits:	$ 210 1 hour $ 100 ½ hour
21 Day Purification Program	$ 380 (*Pricing includes products and visits*)
Cold Laser Therapy	$ 45
AuriculoTherapy (Ear Seeds)	$ 20
Phone Consultations	$50-75

** *(Phone consults over 30 minutes will be priced according to full visits)*

We also wish to make every effort to answer your questions. Any brief phone or e-mail conversation that serves to **clarify instructions** from a previous visit is free of charge. A phone call or e-mail that **covers new material, requires new information, or takes an extensive amount of time, or results in a change in the naturopathic plan** is considered to be a substitute for an office visit, and will be billed according to the schedule above.

CANCELLATION, RESCHEDULING, AND MISSED APPOINTMENT POLICIES:

- We at Riverbirch Holistic Health only see one client at a time to give each client their full attention, and only see a limited number of clients per day. We reserve 1 ½ to 2 hours for all initial visits, and 30- 60 minutes for future follow up visits. When you make an appointment, that scheduled time is reserved for your exclusive use.
- We also meticulously prepare for each appointment by reviewing your paperwork and treatment plan prior to your appointment to help provide you with the best care possible.
- For these reasons, if you are not able to make your appointment as scheduled, we need to know in advance so that we can contact other clients who are waiting for an appointment.

Appointment and Cancellation Policies:

- We have a **24-hour cancellation policy**.
- Our office will confirm your appointment at least 24 hours in advance by phone. If you are unable to keep your appointment as scheduled, please let us know 24-hours in advance in order to avoid a missed appointment charge.
- To cancel an appointment, please call 877-825-8740 Ext 701. If you cannot reach us in person by phone, you may leave a detailed voicemail message with your name, date and time of your scheduled appointment, and your request to cancel or reschedule.

Policies for a New Client Visit:

- A **$100 deposit** is required to reserve your first appointment. You may use a credit card (Visa or MasterCard), cash, or personal check. Please note that we cannot reserve your appointment until we receive this deposit.
- This deposit will be applied to the charge for your first appointment.
- This deposit is fully refundable (minus a $15 processing fee) if you cancel or reschedule 24 hours before your scheduled appointment time.
- If you need to reschedule your appointment to a later date, this deposit can be used to secure this next appointment as long as we have had 24-hours' notice.
- Cancellations made with less than 24-hours' notice forfeit the $100 deposit.

Policies for a Follow up Visit:

- We do not require a deposit for follow up visits.
- However, the same 24-hour cancellation policy does still apply. For cancellations made less than 24 hours (2 business days) before your scheduled follow up appointment, we reserve the right to charge a $50 fee.

PLEASE NOTE: ***Missed appointments with no notice given in person or by phone are subject to a charge for the full amount of the scheduled visit.***

In the case of a true emergency, this cancellation policy does not apply. Please let us know as soon as possible if this is the case. However, we ask that this only be used in the case of a real emergency and that you otherwise make every attempt to keep your appointment.

HEALTH INSURANCE POLICIES:

We have many questions from clients about insurance coverage for naturopathic care. The following describes our office policy based on our understanding of the laws in North Carolina.

Traditional Health Insurance:

- At this time, there is no license for naturopathic physicians available in the state of North Carolina.
- This means that by law we are not able to diagnose and treat disease, and by extension, our services are not covered by traditional health insurance plans.
- If we were to file a claim for insurance reimbursement, this could be considered insurance fraud.
- Because of this, we are not able to provide documentation, diagnosis codes, treatment plans, etc. to your insurance company. Any form that asks for this information is, unfortunately, not a form our office is able to fill out.
- In the future, when our profession is fully recognized by the state of NC, we will be able to amend this policy as appropriate.

Health Savings Accounts (HSA) and Flex Spending Plans:

- Naturopathic services and supplements are sometimes covered under HSA and Flex plans. Not all plans cover all naturopathic care. The specifics of what is and is not covered depends on the rules of each specific plan.
- We recommend that you contact your plan administrator before using your HSA or Flex card at our office to determine what is covered and how it should be used.
- We are able to provide documentation to your HSA or Flex plan with the following information: client's name and birth date, date(s) of visit(s) to our office, supplements and other recommendations by our naturopathic doctors, and medical diagnosis that another doctor has given you. We are not able to diagnose disease in the state of NC, and therefore cannot list conditions or diagnoses that are not coming to us second-hand through another practitioner.

151 Church Street N. * Concord, NC 28025 * 877-825-8740 Ext 701 * RiverbirchHolistic.com

EMAIL POLICY AND PROCEDURES:

Many people now use email as a primary way to communicate with others. We appreciate that email can be a great way to ask a quick question or clarify something from your last visit, or share with us how you are doing.

We have found through experience, however, that email is often not the best way to deal with more treatment-oriented questions and decisions such as questions regarding your medical issues, changes in your symptoms, or complex requests. Instead, in these cases please schedule an appointment so your naturopathic doctor will have time set aside to directly hear and address your concerns.

When using email, please keep the following in mind:

- Never use email for an urgent or emergency problem. The telephone is a much better way to reach us quickly. Typical turnaround time for an email sent to our office is 1-2 days.
- If you have sent us an email and have not heard back from us after several days, please follow up with a phone call. Spam and other filters may have caused your email or our reply email to be lost in cyberspace.
- Please know that email is not confidential and is inherently not secure. Do not use email to communicate anything that you wouldn't want someone else to read. If you send an email from your work email address, your employer has a legal right to read what has been written. Likewise, we may forward your email to a member of our staff if appropriate (i.e. for requests to reschedule an appointment or for a supplement refill order). Reserve more confidential requests for a telephone or in-person visit with your naturopathic doctor.
- All electronic communication with Riverbirch Holistic Health becomes a part of your medical record. We print a copy and file it in your chart. This means if you request that we send your records to another healthcare provider, they will receive copies of your email as well as our appointment notes.
- Email is never a substitute for seeing your naturopathic doctor. If you think that you need to be seen, please call and schedule an appointment!

By signing below, I agree that I have read and understand these policies. I have been given the opportunity to ask questions and clarify the information listed above. I guarantee payment of all charges incurred as a client of Michelle Drains, ND and Riverbirch Holistic Health, LLC. I understand that insurance does not routinely cover naturopathic services in the state of North Carolina. I also understand that there is a 24-hour cancellation policy for all appointments. I understand the inherent risks in electronic communication and may choose whether or not I wish to use email to communicate with Riverbirch Holistic Health, LLC.

Client or Responsible Party's Signature:_____

Printed name: _____ Date: _____