MT Naturopathic Clinic
1425 West Main Street #F
Bozeman, MT 59715
1-406-556-1209

Dr. Paloma Defuentes
Naturopathic Physician

Patient Profile Intake Form – Short

Name ______________________________________ Age _________________ Birth Date _________________

Address ____ Social Security # ___________________

City ____ State ________________ Zip ___________________

Home Phone ____________________ Work Phone ________________ Email __________________________

How did you hear about us? ____

Please describe your reasons for today's visit, including date of onset (first noticed the symptoms) and how long the symptoms have been present.

What treatments have been used for the current illness?

Have you been treated for this in the past? If yes, when & by whom?

Do you have any existing health problems, acute or chronic?

Is the current illness improving, worsening, or staying the same?

Consent to Naturopathic Treatment Provided by Paloma Defuentes, N.D.

1. This is to acknowledge that I have been informed and understand that:

    a) Any treatment or advice provided to me as a patient of Paloma Defuentes, N.D. is not mutually exclusive from any treatment or advice that I may be receiving now or in the future, from another health care provider.

    b) I am at liberty to seek or continue medical care from a physician, surgeon, or other health care provider.

    c) I understand that Paloma Defuentes, N.D. is not preventing me from seeking or following the advice of another licensed health care provider.

    d) The treatment and therapies provided to me by Paloma Defuentes, N.D. may be different from those offered by another licensed health care provider.

2. I agree to pay for any fees for services, costs of supplements and homeopathic remedies, cost of laboratory tests, or other fees at the time of the visit.

3. I hereby authorize and consent to treatment.

4. I understand that what we talk about will remain confidential except in the case where I feel you or someone else will get hurt. This includes such things as: suicide, homicide, and reportable crimes such as physical or sexual abuse. If you have questions, please ask me.

5. I understand that the information I provide will be handled in accordance with patient confidentiality and HIPPA laws.

6. I understand that this office uses an outside billing agency for billing.

7. Authorization/Assignment: I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to be paid to Montana Naturopathic Clinic and I'm fully financially responsible for non-covered services. I understand and agree to pay any collection fees, interest, court fees, and attorney fees if my account is placed in collections or court for non-payment.

8. Please refer to the HIPPA policy on my website under the "Clinic Forms" tab.

9. I have read and agree to all terms and policies.

____ Date: ____________________

Patient Signature