Elemental Medicine
165 Rochester Hill Road Rochester, NH 03867 (603) 516-3696
Beth Devlin, ND George Savastio, ND

Today's Date:

Full name: ____

Preferred name: ____

Date of birth: _____________ Age: _________ Gender: ____ Married / Single / Other

Address: ____________________________ City: __________________State: ______ Zip: ________

Telephone: Home: ____________ Cell: ______________ Other: _________ Preferred #: []Home []Cell []Other

May we contact you via text? YES/NO

Email address: ____

May we contact you via email? YES/NO Would you like to receive our online newsletter? YES/NO

Emergency contact: ___________________ Relationship: ___________ Tel: _____________

How did you hear about us? ____

Other Current Health Care providers (medical doctors, specialists, chiropractors, etc.)

Name: ____________________ Profession: __________________ Tel: _______________

Name: ____________________ Profession: __________________ Tel: _______________

Insurance Company &ID ____

Subscriber: __________________________________

Relationship: _____________________________ DOB: ___________

Specialist co-pay: $____________ Deductible: $________________

- [ ] My Insurance does not cover your practice
- [ ] I am choosing to be a "Self-Pay" patient
- [ ] I do not currently have health insurance

We do our best to verify your plan benefits with your insurance company as a courtesy to you. However, benefits that we are quoted by your insurance company are not a guarantee of payment. Actual benefits are determined by your insurance company at the time the claim is processed. Co-pays, Co-insurances, and deductibles will be collected at the time services are rendered. When payment from your insurance company is received, we will know then if we need to modify your payments, and any other monies due will be billed to you with a payment due upon receipt.

Please Initial

____ I understand that if any changes are made to my personal insurance information while being treated it is my responsibility to inform the facility of said changes in a timely manner.

____ I give my consent for Elemental Medicine to furnish medical care and treatment considered necessary and proper in diagnosing or treating his/her condition.

____ I acknowledge that my insurance company may determine that the services provided are not covered under your policy and agree that, if my insurance company determines that any services are not covered, I shall be responsible for, and shall pay, the cost of any such services.

____ I authorize Elemental Medicine to release to appropriate agencies, ie my insurance company, any information acquired during my, or the above-named patient's, examination and treatment necessary to secure payment for services provided.

____ I acknowledge I have received a copy of Elemental Medicine's Policies and I agree to adhere to the policies described.

____ I acknowledge that the **Notice of Privacy Policy** is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.

Signature: _________________________ Date: ___________

3 Mos. Review Initial: ________________ Date: ___________

6 Mos. Review Initial: ________________ Date: ___________

Demographic and Consent Form to be reviewed every three (3) months.

Patient Intake Form

Name: ____ **Date of Birth:** ____________________

List any known allergies (medicines, environmental, food, other)

____

Other Current Health Care providers (medical doctors, specialists, chiropractors, etc.)

Name: _________________________ Profession: _______________________ Tel:________________

Name: __________________________Profession:_______________________ Tel: ________________

Goals for Visit: Please list in the order of priority

____

____

____

Medical Conditions

Condition	Severity	Date Diagnosed

Medications/Supplements

Medication	Condition	Date started	Adverse effects

Health Habits

Exercise Habits

How many times do you exercise per week? __________ What kind of activity? ______________________

Substance Use

How many cups of coffee/cola per day? __________ How many alcoholic drinks per week? ___________

Do you currently smoke? YES/NO Have you smoked in the past? YES/NO how long? _______________

Do you use recreational drugs of any kind? YES/NO What kind?__________________________________

Energy

How many hours of sleep do you get at night? ___________________________________

What is your energy level, with 1 being the worst and 10 the best? ________

What is the biggest source of stress in your life? ____

Review of Symptoms Form

Please put a check in the "now" or "past" boxes as applicable for each condition listed.

If more than one condition is given, please circle which applies to you.

CONDITION	now	past	CONDITION	now	past
Skin and Hair					
Acne			Eczema/psoriasis		
Hives			Excessive hair loss/growth		
Itching/rashes			Changes in moles(size/color)		
Eyes					
Wear glasses or contacts			Floaters		
Impaired vision/blurring			Macular degeneration		
Cataracts			Glaucoma		
Ear, Nose and Throat					
Recurrent ear infections			Frequent colds/ sore throat		
Impaired hearing			Allergies		
Tinnitus/ringing in the ears			Hoarseness		
Ruptured ear drum			Bleeding gums/mouth		
Excess ear wax			Mercury dental fillings		
Frequent nose bleeds			Thyroid nodules		
Nasal or sinus congestion			Lumps, swollen glands in neck		
Respiratory					
Cough			Frequent chest infections		
Pain when breathing			Tuberculosis		
Shortness of breath			Emphysema		
Asthma/wheezing			Pneumonia		
Cardiovascular					
Chest pain/angina			High cholesterol		
Heart disease			Coldness of hands/legs/feet		
Irregular heartbeat			Varicose veins		
Palpitations			Leg pain/cramps		
High blood pressure			Leg swelling/ edema		
Gastrointestinal					
Nausea or vomiting			Bloating/flatulence/gas		
Acid reflux or regurgitation			Hernia		
Indigestion			Hemorrhoids		
Peptic ulcer			Diarrhea		
Gall bladder stones/removal			Irritable bowel syndrome		
Blood in stool			Constipation		

Musculoskeletal					
Joint pain/stiffness			Osteopenia/ osteoporosis		
Back pain			Sciatica/nerve pain		
Carpal tunnel syndrome			Muscle cramps/ weakness		
Neurological					
Headaches/migraines			Slurred speech		
Fainting/loss of consciousness			Loss of sensation		
Numbness/tingling			Seizures		
Paralysis/weakness			Loss of memory		
Mental/Emotional					
Anxiety			Phobias		
Bipolar disorder			Thoughts of suicide		
Depression			Insomnia		
Obsessive compulsive disorder			Treated for substance abuse		
Schizophrenia			Excessive stress		
Endocrine					
Low iron/other blood disorder			Excessive thirst or hunger		
Unusual fatigue			Diabetes		
Feeling "wired but tired"			Low blood sugar/ hypoglycemia		
Sensitivity to hot or cold			Excessive sweating/ urination		
Hot flashes			Thyroid problems		
Urinary					
Kidney disease			Frequent urinary tract infections		
Kidney stones			Blood in urine		
Gout			Difficulty urinating		
Incontinence			Pain or burning on urination		

Family History

Who in your immediate family has any of the following? Place appropriate letter in the blank.
(F=father, M=mother, S=sibling, G=grandparent)

_____Alcoholism or Substance abuse
_____Anemia (Sickle cell or other)
_____Liver disease (Hepatitis, etc)
_____Seizure, Epilepsy
_____Stroke
_____Easy bleeding
_____Suicide
_____High Blood Pressure
_____Ulcers
_____Headaches (Migraines, etc)
_____Allergy
_____Diabetes
_____Kidney disease

_____High cholesterol
_____Arthritis
_____Cancer (specify type____________________)
_____Lung disease)Asthma, COPD, etc)
_____Mental trouble/Depression/Anxiety
_____Digestive (Ulcerative colitis, Crohn's, etc)
_____Glaucoma
_____Tuberculosis (TB)
_____Heart attack, Heart disease, Heart failure
_____Hay fever
_____Eczema
_____Thyroid disease
_____Other

Women's Health

CONDITION	now	past	CONDITION	now	past
Breast lumps/ nipple discharge			Yeast/candida infections		
Breast cancer			Abnormal PAP test		
Breast pain/ tenderness			Pain on intercourse		
PMS-premenstrual syndrome			Ovarian cysts		
Irregular menstruation			Infertility		
Pain with menstruation			Menopausal symptoms		
Endometriosis			Hormone replacement therapy		
Vaginal itching/ discharge			Family history of breast cancer		
Other					

Age at first period: _______
Date of last period: _________
Sexual Preference: _______
Are you sexually active? YES/NO
Number of pregnancies: ______
Number of live births: ______
Number of miscarriages: ______
Number of abortions: ______

Do you use birth control? YES/NO
Type: birth control pill
IUD
barrier method
natural family planning
tubal ligation

Men's Health

CONDITION	now	past	CONDITION	now	past
BPH-enlarged prostate			Erectile dysfunction		
Difficulty urinating			Penile lesions or discharge		
Prostate cancer			Problems with sperm count		
Testicular pain/masses			Other fertility problems		

Are you sexually active? YES/NO
Sexual Preference: _______
Do you use birth control? YES/NO
Type: condom
vasectomy
natural family planning
other: ____________________

Signature: ____ Date: __________________

Thank you for taking the time to complete this form.

165 Rochester Hill Road, Rochester NH 03867
603-516-3696
health@elementalmednh.com

WELCOME TO OUR PRACTICE

OFFICE POLICIES

Here at Elemental Medicine, our mission is to engage our patients in a healing relationship for the treatment and prevention of disease using time-honored concepts along with modern scientific research. We seek to understand your individual needs based on your constitution and by getting to know you as a person.

Our goal is to help you feel your best. We rely on the wisdom of traditional healing methods combined with modern scientific research to do just that.

Our Services Include:

- Personalized natural treatment plans
- Botanical and nutritional medicine
- Full natural pharmacy
- Homeopathic remedies
- Wellness and nutrition education
- Advanced laboratory testing
- Physical and gynecological exams
- Personalized cleansing programs
- IV therapy
- Acupuncture
- Foot evaluations
- Craniosacral treatments
- Pancha karma
- Spinal manipulations
- Steam/massage

WHAT TO EXPECT

New Patient Establishing Care – First Visit

A typical first office visit for a naturopathic patient is 1 ½ hours long. This includes an extensive health history, physical exam, possible laboratory work and/or orders, and development of a treatment plan.

New Patient Establishing Care – Follow-Up Visit

A 30-45-minute follow-up appointment will be scheduled in two to six weeks to discuss lab results and/or evaluate the progress and initial therapies. We are here to assist you in healing and achieving wellness. This requires a commitment on your part to keep scheduled appointments, so we may work together as a team.

Laboratory Tests

We do a variety of lab testing (**additional cost is incurred**). In some cases, additional blood work may be required, and it is the responsibility of the patient to cover the additional fees of testing. *If there is urgent cause for concern regarding your results, you will be contacted by your doctor or staff.* We do not routinely call patients with lab results that are normal. Lab results will be reviewed during your scheduled follow-up visit. If you wish to have a copy of your labs prior to your follow-up appointment, please provide a minimum of 48 hours advance notice to our office as labs will not be released, under any circumstances, until the doctor has reviewed them.

REACHING YOUR NATUROPATHIC DOCTOR BETWEEN VISITS

We understand you may have questions about your treatment plan or you may need to inform your doctor of new developments. If you have a question that cannot wait until your next visit, we encourage you to call. Our staff will attempt to get your questions answered promptly or to schedule you with your doctor as needed.

Email Usage

Email use is for established patients only. It may be used for clarification of an on-going treatment, or treatment received in the last 30 days. It must be a simple and straight-forward request requiring minimal staff/doctor time. Emergency concerns should never be sent via email. New conditions or treatments will not be discussed via email. Charges may incur for long emails that require more than a single reply. Our email address is: health@elementalmednh.com Please do not send business related emails to any other address.

For Urgent Concerns

Please let our front desk know you have an urgent concern and they will schedule an appointment that day or as soon as possible with your doctor. If it is difficult for you to come in for an office visit, a phone appointment may be arranged. Phone appointments for urgent concerns are at the discretion of the doctor.

Phone Appointments

Phone appointments are offered as a courtesy to our patients who are unable to make an office visit due to long distance or other factors. We ask you to pay for phone appointments by credit card at the time of the appointment. Phone appointments are charged by the minute for the time incurred. Keep in mind the doctor may need to see you in person. Medications requiring a prescription such as antibiotics, controlled substances, thyroid or hormone medicines require an *in-office* visit.

After-Hours Emergencies

If you feel you have a medical concern that cannot wait until the next business day, you may call Dr. Devlin's cell phone, (207) 251-0529. Leave your name and phone number starting with the area code. Patients using our after-hours emergency service, please note that while brief conversations are generally free of charge, this service will be billed as if it were an office visit for lengthy conversations. *Excessive use of this service for non-urgent concerns will also incur a charge*.

Medical Emergencies

Please call 911 or go directly to your local emergency room.

NATURAL DISPENSARY

You will usually be prescribed specific nutritional, botanical, hormonal, or homeopathic medicines at the time of your visit. These products have been chosen for their quality, potency, and specifically to meet your needs. We offer a fully stocked natural pharmacy, with products that have demonstrated clinical effectiveness and safety. We recognize that people are cutting costs and we make every effort to keep our prices reasonable for you. We discourage from buying supplements on line from unauthorized dealers, such as Amazon, eBay, Craigslist, etc., as they cannot guarantee the quality or safety of items sold. Also, buying from Elemental Medicine helps to support us in our goal of offering lower cost services and supplies while we support you in achieving optimal health.

Please allow 48 hours advance notice to fill your order when calling!

Providing the manufacturer's name, product name, quantity and size will greatly increase your chances of getting your order filled faster.

Methods of Delivery and Payment Options

- Payment for supplements is expected at the time of order. For your convenience, you may pay with a credit or debit card over the phone, or a credit/debit card can be securely stored.
- You may pick up your items during our hours of operation.
- We can ship your items by Priority Mail, a $9.00 shipping fee will apply (subject to change).
- Email your order to health@elementalmednh.com, or call the office at (603) 516-3696.
- You can also place your orders at https://wellevate.me/beth-devlin/#/ after creating an account.
- Special orders, prescriptions, and emergency online orders may need extra time to process and *must be prepaid*. There may be an additional charge for special orders.

Dispensary Return Policy

- Items may be returned for refund within 15 days.
- The product must be sealed and in its original condition.
- Items may be returned for a credit within 30 days, also sealed and in its original condition.
- We *cannot refund or credit items* that are special orders, custom tinctures, require refrigeration, or that have been opened.

FINANCES

***we do offer a time of service discount**

First Office Visit – Establishing Care: The fee for a first office visit with Dr. Devlin or Dr. Savastio is $310.00. This is discounted to $265 if you pay in full at your first visit.

Regular Follow-up Visits: The fee for follow-up visits range from $110.00 - $195.00 depending on length and complexity of visit. The fee for an annual exam is $245.00. All visits are discounted if you pay in full at your visit. We also offer discounts for Medicare, Medicaid and Active Duty patients.

Method of Payment

Payment is expected at the time of service. We accept cash, checks, and credit or debit cards. Returned checks are subject to a $40 administration and banking fee.

Missed Appointments and Cancellation Policy

We consider it an honor and privilege to be of service to you and hope to establish a long and mutually satisfying relationship.

We do understand that extenuating circumstances can prevent you from keeping an appointment; however, we request that any cancellation or rescheduling be made ***at least 24 hours in advance of your appointment***. We value your time and hope you value ours! Missed appointments or appointments cancelled less than 24 hours in advance affect us all and prevent us from being able to serve others who are ill and in need of care.

Appointments that are not cancelled or rescheduled 24 hours in advance will incur a charge of 50% of the scheduled visit. This charge includes all appointments and therapies in our office.

We provide email reminders before your appointment as a courtesy. If your email does not state the type of appointment you believe you have scheduled please contact the office as soon as possible. Keep in mind, you are ultimately responsible for remembering scheduled appointments. Stating that you did not receive a reminder email or that the email was made after the 24-hour deadline, does not make your missed or cancelled appointment an exception to our policy.

Thank you. We look forward to working with you to achieve your health and wellness goals.

~The Elemental Medicine Team