Renew
Natural Weight Loss
Recenter | Redefine | Renew

Dear Patient,

Congratulations on your commitment to start the Renew Natural Weight Loss program. This is an important step in working towards optimal health. We are excited to share this journey with you.

We have included several important forms for you to complete and **bring with you to your initial visit.** Your detailed and thoughtful responses will help us to utilize our time more effectively.

If you are unable to keep your scheduled appointment time, please let us know at least 48 hours prior to the scheduled time so that we may allow other patients to have your appointment. We will be glad to reschedule your visit. Please help us to serve you better by keeping scheduled appointments.

Please remember to bring in all the bottles of supplements and/or medications you are currently taking.

We are a fragrance free facility so please refrain from wearing perfumes or colognes on the day of your appointment.

Our goal is to become a trusted partner in assisting you with your health care needs and we look forward to working with you.

Yours in health,

Renew Weight Loss Center

p: 704.708.4437 f: 704.708.4417
1126 Sam Newell Rd., Suite A Matthews, NC 28105
www.RenewWeightLoss.com

CONFIDENTIAL PATIENT REGISTRATION FORM

Date:_____

New Patient Information

Name:_____ _____ DOB: ___/___/___ Age:_____
(Last) ***(First)*** ***(Sex)***

Address: _____ City: _____ St: _____ Zip: _____

Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone: (___)_____

Email Address: _____Would you like to receive our email newsletter? Y N

Additional Patient Information

Primary Care Physician: _____Physician's Phone: (___)_____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Marital Status(circle): Single Married Separated Divorced With Partner Widow(er)

Number of Children:_____

Name of Spouse/Partner: _____

Emergency Contact: _____ Relationship to you: _____

Emergency Contact #: (___)_____

Referral Information

How did you hear of us? _____

Were you referred by a physician?: ☐ Yes ☐ No

If "Yes", could you provide us with as much information as possible for the Referring Physician?

Referring Physician's Name: _____

Address, City, State, Zip: _____

Telephone Number: _____

Entered by:_____

CAROLINAS
NATURAL HEALTH CENTER

FINANCIAL RESPONSIBILITY AND POLICY STATEMENT

Thank you for choosing Carolinas Natural Health Center (CNHC) for your healthcare needs. Our healthcare providers and staff are committed to enhancing the quality of your care and overall health. This policy statement is designed to inform you of our policies and answer questions regarding payment for services.

PAYMENT FOR SERVICES

CNHC is a fee for service clinic. Patients are to assume all financial responsibility for the office visit and services rendered during the time of service.

For your convenience, we accept cash, personal checks, Visa, MasterCard, Discover and American Express. Returned checks are subject to a $25 return fee and no further personal checks will be accepted.

PHONE SUPPORT

Phone support is to aid in answering any questions or concerns that may arise, or to clarify instructions. This is not intended to take the place of an office visit.

Phone consultations that *cover new material, require new information, take an extensive amount of time, or require a change in the treatment plan* are considered substitutes for an office visit. These will be billed for the same rate as the visit for which they substitute. For example, a phone consultation that substitutes for a limited visit will be billed at $100.

CANCELLATION POLICY

If you are not able to keep your scheduled appointment, please notify us within 48 hours of the appointment. There is no charge if an appointment is cancelled within 48 hours. A cancellation with less than 48 hours notice does not allow enough time for other interested patients to be scheduled, and is a great inconvenience for our center. Thus, for naturopathic visits there is a $100 charge for new patient and a $50 charge for follow-up cancellations. For all other services, 50% of the service will be charged for late cancellations. Full service fees will be charged if no notice is given.

I agree to the above defined financial policies. In case of default of payment, I am responsible for full payment of the balance, interest accrued, and any collection costs and legal fees incurred to collect on this account. I the undersigned, have read, understand and accept the information and conditions specified in this document.

Patient or Parent/Guardian Signature _____ Date _____

p: 704.708.4404 f: 704.708.4417
1126 Sam Newell Rd., Suite A Matthews, NC 28105
www.CarolinasNaturalHealth.com

Naturopathic Medicine Legal Disclosure

As a valued patient of Carolinas Natural Health Center, it is important to us that you are fully aware of the laws surrounding Naturopathic Medicine in North Carolina.

- The state of North Carolina does not offer a Naturopathic License to Naturopathic Physicians, but our physicians do hold current medical licenses from other states.

  _____ initial

- As a result, our physicians cannot legally prescribe pharmaceutical drugs, perform minor surgeries, administer injections, or diagnose illnesses.
  _____ initial

- Our Naturopathic Physicians are trained as primary care physicians. However, we are unable to fill that role in the state of North Carolina. Because of this, we ask you to maintain your relationship with a primary care physician. If you need a referral, we can provide a list of primary care physicians.
  _____ initial

_____ _____ _____

Signature Printed Name Date

1126 Sam Newell Road, Suite A *** Matthews, NC 28105
P: 704.708.4404 F: 704.708.4417
www.CarolinasNaturalHealth.com

Patient-Provider E-Mail Agreement

E-mail offers an easy and convenient way for patients and doctors to communicate. In many circumstances, it has advantages over office visits or telephone calls. But remember, there are important differences. E-mail is not the same as calling the office; there is no person at the other end of the e-mail – just a computer. You can't tell for certain when your message will be read or even if the doctor is in the office or on vacation. Nonetheless, we believe that the ease of communication e-mail affords is a benefit to patient care. It will further assist us if you could identify the nature of your request in the subject line of your message. Below are our rules for contacting us via e-mail.

- E-mail is never appropriate for urgent or emergency problems! Please use the telephone or go to the Emergency Room for emergencies.
- E-mail is great for asking those little questions that don't require a lot of discussion.
- E-mail should not be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- **E-mail is not confidential!** It is like sending a postcard through the mail. Our staff may read your e-mails to handle routine, non-clinical matters. You should also know that if sending e-mails from work, your employer has a legal right to read your e-mail if he or she chooses.
- E-mail may become part of the medical record when we use it; a copy may be printed and placed in your chart.
- **E-mail is not a substitute for seeing your physician**. If you think that you need to be seen, please call and schedule an appointment!
- E-mails may be forwarded to our staff for handling, if appropriate.

Finally either party can revoke permission to use the e-mail system at any time.

☐ I **DO** want to communicate with my doctor electronically. I have read the above information and understand the limitations of security on information transmitted.

Patient Name: _____

Patient Signature: _____

E-mail Address: _____

Date: _____

Renew
Natural Weight Loss
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Intake Form

While we help you shed excess weight once and for all, your health is also very important. Therefore please answer the following questions HONESTLY and in as much detail as possible.

What are your current health concerns? _____

Current medications/supplements and reason for taking? _____

Last blood pressure reading: _____ ***Date of this reading:*** _____

Previous Medical History (last five years): _____

Any comments you may have that could be relevant *(particularly of medical/psychological nature):* _____

What other weight-loss programs you have you tried? _____

What have been your challenges with these weight-loss programs? _____

List any cravings or hunger pangs that you have experienced while on a weight-loss program:

_____

Please leave this section blank until we interview and weigh you.

Height _____ ***Current Weight*** _____ ***Target goal weight*** _____

Total amount to lose _____ ***Realistic time frame in which to lose the weight*** _____

I believe that the above medical information I have provided is true and correct. ***I understand that Renew Natural Weight Loss Center has a 48 hour cancellation policy for all scheduled appointments. Providing no notice will result in a loss of the scheduled appointment.*** I understand that I undertake the Renew Natural Weight Loss program entirely at my own risk and that my Renew Natural Weight Loss practitioner will endeavor to take all due care.

_____ _____

Patient's Signature **Date**

1126 Sam Newell Rd., Suite A ☼ Matthews, NC 28105 ☼ Ph: 704-708-4404 ☼ Fax: 704-708-4417