AVANTE
MEDICAL CENTER LLC

915 W. Northern Lights Blvd
Anchorage, AK 99503
770.6700

Hello and welcome to your first visit as a patient at Avante Medical Center!

Enclosed in this packet are forms that need to be completed prior to your visit. Please take the time to fill them out as completely as possible and bring them to your first visit.

Our providers are very conscientious of your valuable time, and make a strong effort to run on time with their appointments. The time spent during your initial visit is best utilized when the paperwork is completed prior to your arrival. To optimize your time with them, we ask that you come 15 minutes early to have your vital signs taken, and have your paper work already filled out. If you cannot have your paperwork filled out prior to your appointment, please come 25 minutes early.

We cater to many patients with allergies and environmental sensitivities. Please avoid wearing perfume or cologne to your appointment.

Insurance Billing Information

Make sure to bring your insurance information card to your appointment and please fill out the insurance billing information sheet in this packet as completely as possible.

We ask that you take time to contact your insurance carrier prior to your visit to find out if they cover Naturopathic care if you are seeing any of the following doctors: Gary Ferguson, Abby Laing, Jana Nalbandian or Torrey Smith. If your carrier will cover these services, we will be happy to bill them for you. If your insurance company does not cover our services, you will be responsible for the fee at the time of service. *Insurance Billing is a service we provide, not an expectation*.

We serve a large community. If you are unable to keep your appointment, please call us at least 24 hours prior to your scheduled appointment so that other patients may have time to schedule an appointment.

We look forward to seeing you.

The Staff at Avante Medical Center

AVANTE
MEDICAL CENTER LLC

Acupuncture Intake Form

CONSENT TO TREATMENT

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, herbal therapy, massage, Qi Gong, and nutritional counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage.

Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or spooning. I fully understand that there is no implied or slated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by the acupuncturist are safe in the recommended doses. Large doses or herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged the receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequentially, a minimum of 24 hours notice is required to reschedule or cancel an appointment. In signing this form, I acknowledge any inherent risks, give my consent for treatment, payment and healthcare operations received, and incurred or carried out at this practice.

Patient Signature and Date:_____

T 907.770.6700
F 907.770.6707
915 West Northern Lights Blvd
Anchorage, Alaska 99503

AVANTE
MEDICAL CENTER LLC

Acupuncture Intake Form

GENERAL HEALTH

Chief Complaint: What is the primary concern associated with your visit today?
Onset: How long have you had this/these issues?
Does anything make the condition better? ☐ Yes ☐ No If yes, what?
Does anything make the condition worse? ☐ Yes ☐ No If yes, what?
Have you been treated for this condition before? ☐ Yes ☐ No If yes, what?
Are you currently being treated for any other medical problems? ☐ Yes ☐ No If yes, what?
Are there any other issues or health concerns you are hoping to work on?
Have you tried acupuncture before? ☐ Yes ☐ No If yes, please describe.
How did you hear about the clinic? ☐ Website ☐ Another Health Care Provider ☐ Advertisement ☐ Friend ☐ Other:_____

T 907.770.6700
F 907.770.6707
915 West Northern Lights Blvd
Anchorage, Alaska 99503

AVANTE
MEDICAL CENTER LLC

Acupuncture Intake Form

WOMEN'S HEALTH

Age of first menstruation:	First day of last menses:	Duration of flow (days):
Clots: ☐ Yes ☐ No	Number of days in cycle:	Color of Blood:
Consistency:	PMS: ☐ Pain ☐ Cramps ☐ Breast Tenderness ☐ Other If Other, please specify:	

Current method of Contraception:		Contraception History:	
Have you ever been pregnant? ☐ Yes ☐ No	Are you trying to get pregnant? ☐ Yes ☐ No	Are you currently pregnant? ☐ Yes ☐ No	Due Date:
Date of menopause:		Hormone Replacement Therapy? ☐ Yes ☐ No	
I understand that I must notify my provider if/when I become pregnant. Please initial and date →			

MEN'S HEALTH

Check all that apply

☐ Reduced sexual energies	☐ Pain with urination	☐ Groin pain
☐ Premature ejaculation	☐ Prostate problems	☐ Infertility
☐ Seminal emission	☐ Impotence	☐ Other:

SEXUAL ACTIVITY

Are you sexually active? ☐ Yes ☐ No	Number of current or recent sexual partners:	Do you currently practice safe sex? ☐ Yes ☐ No

FAMILY HEALTH HISTORY

Has any blood relative had any of the following? ☐ Cancer ☐ Allergies ☐ TB ☐ Diabetes ☐ Stroke ☐ Hypertension ☐ Heart Disease ☐ Thyroid Disease Others:	General state of health/age of your parents & siblings: (If deceased, state cause)

PERSONAL MEDICAL HISTORY

Past major illnesses:	Major accidents, falls, etc.:
Hospitalizations/surgeries/radiation treatments:	Location of all major scars:
Allergies to drugs, chemicals, foods, environment:	

T 907.770.6700
F 907.770.6707
915 West Northern Lights Blvd
Anchorage, Alaska 99503

AVANTEmedical.com

AVANTE
MEDICAL CENTER LLC

Acupuncture Intake Form

金

木

水

火

土

LIFESTYLE

Work environment (what type of stress (chemical, physical, psychological) do you have?):	Exercise (do you have a regular exercise program? If yes, describe):
Sleep: Average hours of sleep each night:_____ Do you have diffculty sleeping? Often ☐ sometimes ☐ never ☐ Do you dream? Often ☐ sometimes ☐ never ☐ What type of dreams?	Leisure (primary interests and/or hobbies):

Diet:
Are you satisfied with your present diet? ☐ Yes ☐ No explain:
List any foods that you crave:
List any foods that give you a bad reaction:
List all foods and the time you eat on an average day:

Breakfast at:_____ Lunch:_____ Dinner:_____ Snacks:_____

Food: Food: Food: Food:

Medications / Suppements (list any medications, vitamins, and herbs that have been taken in the last month)

Smoking: ☐ Non-smoker ☐ Quit, when: _____ ☐ Current smoker Cigarettes per day:_____ Cigars per day:_____	Drinking: ☐ Coffee / Tea / Cola How often? ☐ Beer / Wine How often? ☐Liquor How often?	Other drugs used: (Marijuana, cocaine, etc.) ☐ Never / Rarely ☐ Sometimes ☐ Often

T 907.770.6700
F 907.770.6707
915 West Northern Lights Blvd
Anchorage, Alaska 99503

AVANTE
MEDICAL CENTER LLC

Acupuncture Intake Form

REVIEW OF SYSTEMS

General

past current

- ☐ ☐ Insomnia
- ☐ ☐ Dreams / Nightmares
- ☐ ☐ Cold hands / feet
- ☐ ☐ Chills
- ☐ ☐ Fever
- ☐ ☐ Night sweats
- ☐ ☐ Decreased ability to taste or smell
- ☐ ☐ Sweet taste in mouth
- ☐ ☐ Metallic taste in mouth
- ☐ ☐ Crave spicy food
- ☐ ☐ Crave sweets
- ☐ ☐ Crave salty food
- ☐ ☐ Crave sour food
- ☐ ☐ Crave bitter food
- ☐ ☐ Often feel sad
- ☐ ☐ Often feel afraid
- ☐ ☐ Often feel angry
- ☐ ☐ Usaully feel happy
- ☐ ☐ Irritability
- ☐ ☐ Mood swings
- ☐ ☐ Fatigue
- ☐ ☐ Often worried
- ☐ ☐ Indecisiveness
- ☐ ☐ Poor memory
- ☐ ☐ Other:

Neuropsychological

past current

- ☐ ☐ Seizures
- ☐ ☐ Easily stressed
- ☐ ☐ Crying spells
- ☐ ☐ Don't know how to relieve stress
- ☐ ☐ Overwhelming joy
- ☐ ☐ Frequent headaches
- ☐ ☐ Anxiety / Fear
- ☐ ☐ Depression
- ☐ ☐ Treated for mental problem
- ☐ ☐ Concussion
- ☐ ☐ Bad temper
- ☐ ☐ Other:

Head and Neck

past current

- ☐ ☐ Migraines
- ☐ ☐ Stiff neck
- ☐ ☐ Dizziness
- ☐ ☐ Swollen glands
- ☐ ☐ Other:

Eyes

past current

- ☐ ☐ Corrective lenses
- ☐ ☐ Blurred vision
- ☐ ☐ Poor night vision
- ☐ ☐ Spots or floaters
- ☐ ☐ Eye inflammation
- ☐ ☐ Dryness
- ☐ ☐ Tearing
- ☐ ☐ Glaucoma
- ☐ ☐ Cataracts
- ☐ ☐ Other:

Ears

past current

- ☐ ☐ Ringing in the ears
- ☐ ☐ Hearing loss
- ☐ ☐ Infections
- ☐ ☐ Ear ache
- ☐ ☐ Vertigo
- ☐ ☐ Other:

Nose, Throat, Mouth

past current

- ☐ ☐ Sinus infections
- ☐ ☐ Allergies
- ☐ ☐ Dry throat
- ☐ ☐ Feeling of something stuck in throat
- ☐ ☐ Sore throat
- ☐ ☐ Difficulty swallowing
- ☐ ☐ Bad breath
- ☐ ☐ Bleeding gums
- ☐ ☐ Grinding teeth
- ☐ ☐ Nasal congestion
- ☐ ☐ Nosebleeds
- ☐ ☐ Loss of voice
- ☐ ☐ Other:

Respiratory

past current

- ☐ ☐ Frequent colds / flu
- ☐ ☐ Difficulty breathing with exertion
- ☐ ☐ Difficulty breathing when lying down
- ☐ ☐ Wheezing
- ☐ ☐ Asthma
- ☐ ☐ Chronic cough
- ☐ ☐ Wet cough
- ☐ ☐ Cough with phlegm
- ☐ ☐ Cough with blood
- ☐ ☐ Other:

If coughing mucus up, what color is it?

Cardiovascular

past current

- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Chest pain or tightness
- ☐ ☐ Palpitations
- ☐ ☐ Fainting
- ☐ ☐ Rapid heart beat
- ☐ ☐ Irregular heartbeat
- ☐ ☐ Poor circulation
- ☐ ☐ Leg pain
- ☐ ☐ Leg vein issues
- ☐ ☐ Swollen ankles
- ☐ ☐ Anemia
- ☐ ☐ High cholesterol
- ☐ ☐ Other:

Gastrointestinal

past current

- ☐ ☐ Nausea
- ☐ ☐ Vomiting
- ☐ ☐ Acid reflux / GERD
- ☐ ☐ Stomach pain
- ☐ ☐ Abdominal bloating
- ☐ ☐ Indigestion
- ☐ ☐ Poor appetite
- ☐ ☐ Change in appetite
- ☐ ☐ Gas: Belching
- ☐ ☐ Gas: Flatulence
- ☐ ☐ Diarrhea
- ☐ ☐ Constipation
- ☐ ☐ Dry/hard stool
- ☐ ☐ Blood in stool
- ☐ ☐ Rectal pain
- ☐ ☐ Hemorrhoids
- ☐ ☐ Jaundice
- ☐ ☐ Liver disorder
- ☐ ☐ Gall bladder disorder
- ☐ ☐ Other:

Bowel movement frequency:_____

Skin / Hair

past current

- ☐ ☐ Dry Hair
- ☐ ☐ Brittle Hair
- ☐ ☐ Hair loss
- ☐ ☐ Premature greying
- ☐ ☐ Hair thinning
- ☐ ☐ Hives
- ☐ ☐ Rashes
- ☐ ☐ Eczema
- ☐ ☐ Psoriasis
- ☐ ☐ Dry skin
- ☐ ☐ Easy bruising
- ☐ ☐ Changes in moles
- ☐ ☐ Itching
- ☐ ☐ Measles
- ☐ ☐ Shingles
- ☐ ☐ Acne
- ☐ ☐ Other:

Genito-Urinary

past current

- ☐ ☐ Frequent urination
- ☐ ☐ Painful urination
- ☐ ☐ Urgent urination
- ☐ ☐ Blood in urine
- ☐ ☐ Unable to hold urine
- ☐ ☐ Incomplete urination
- ☐ ☐ Bedwetting
- ☐ ☐ Wake to urination
- ☐ ☐ Kidney stone
- ☐ ☐ Increased sex drive
- ☐ ☐ Decreased sex drive
- ☐ ☐ Pain/itching of genitalia
- ☐ ☐ Genital lesions and/or discharge
- ☐ ☐ Infertility
- ☐ ☐ Other:

Infection Screening

Check the box if you have been tested and circle the (+) if you have the conditoin.

Tested

- ☐ (+) HIV
- ☐ (+) TB
- ☐ (+) Hepatitis A/B/C
- ☐ (+) HPV
- ☐ (+) Gonorrhea
- ☐ (+) Chlamydia
- ☐ (+) Syphilis
- ☐ (+) Genital warts
- ☐ (+) Herpes: oral / genital

T 907.770.6700
F 907.770.6707
915 West Northern Lights Blvd
Anchorage, Alaska 99503

AVANTEmedical.com

AVANTE
MEDICAL CENTER LLC

Acupuncture Intake Form

MUSCULOSKELETAL SYSTEM

金

Muscles / Bones / Joints

Do you have pain or tightness? ☐ Yes ☐ No
If Yes, please indicate the location on the chart below. The pain is (check all that apply):

☐ Sharp	☐ Dull	☐ Aching	☐ Numb	☐ Superficial pain
☐ Burning	☐ Tingling	☐ Shooting	☐ Deep pain	
☐ Pain worse in am/pm		☐ Pain worse/better with cold		
☐ Pain worse/better with heat		☐ Pain worse/better with pressure		

木

I have (check all that apply):

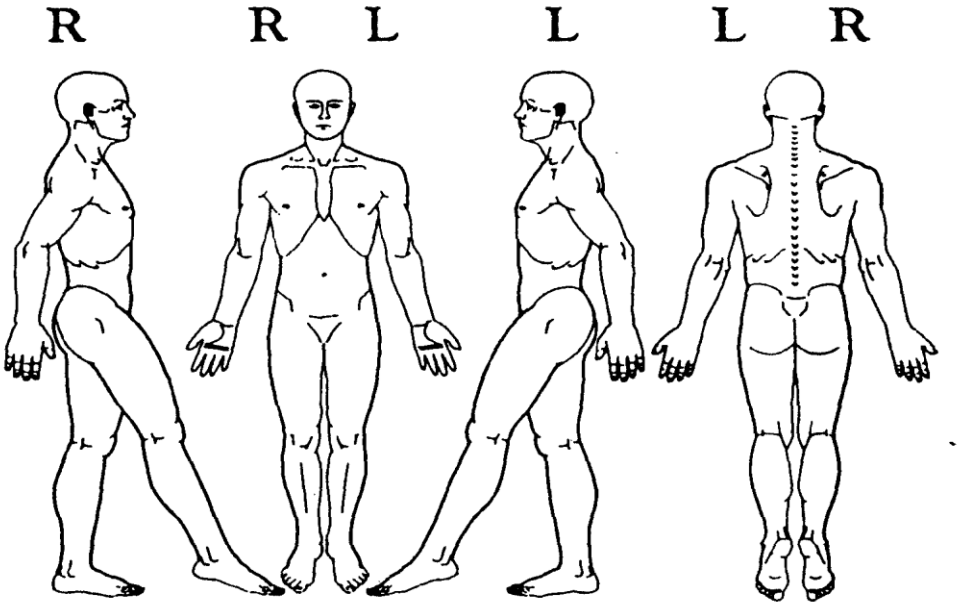
☐ Swollen joints	☐ Arthritis / Joint pain	☐ Tendonitis	☐ Muscle cramping
☐ Muscle pain	☐ Repetitive Strain Injury	☐ Bone pain	
☐ Fractured Bone(s) Where:			

水

Please explain any injuries in the space provided:
Date of onset:
Location:
Duration of pain:
Aggravating factors: (ex: Heat)
Alleviating factors: (ex: Cold)
Treatments: (ex: Ibuprofen, chiropractic)

火

Please indicate areas of pain or distress:



土

T 907.770.6700
F 907.770.6707
915 West Northern Lights Blvd
Anchorage, Alaska 99503

AVANTEmedical.com

FILL OUT THE FOLLOWING INFORMATION IF THIS IS YOUR FIRST VISIT TO AVANTE.

IF YOU HAVE SEEN A DIFFERENT PROVIDER AT AVANTE, YOU CAN DISREGARD THE FOLLOWING INFORMATION.

Insurance Billing and Collection Guidelines

As a service to our patients, we bill most primary and secondary insurance when possible. This is performed as a courtesy. Here are some very important things to know about Avante Medical Center and Insurance Billing:

Medicare: It has been the decision of our Nurse Practitioners at Avante to **"opt out"** of Medicare and naturopaths are not eligible. Therefore, all services provided at our facility cannot be submitted, either by the patient or Avante Medical Center, to Medicare. However, if you have a secondary coverage, please see the Insurance Benefits section listed below.

Insurance Benefits: It is important to know your coverage ***before*** coming in for an appointment. Although we bill most primary and secondary insurance carriers, our providers are only contracted with Blue Cross Blue Shield and Aetna. Please contact your insurance carrier prior to your visit and fill out the answers to the questions on the following page. **This information will be required at check in**. If you are seeing a naturopathic or acupuncture provider, we strongly urge you to contact your insurance to verify if the **type** of provider is covered under your plan. Your plan may not cover those types of providers regardless if they are participating or not. Many out of state plans do not cover naturopaths or the services they order. Any services not covered by the insurance will be the patient's responsibility. We do not offer cash discounts for non covered services.

Appointment: Please come to your appointment with your insurance card and with the Insurance Billing Information Sheet completely filled out. After your appointment we will collect any outstanding deductible, co-pay, and/or coinsurance for covered services. All non-billable services (i.e. supplements, injections, procedures not covered by insurance) will require payment in full at the time of service. Due to most common insurance policies, we are unable to schedule two appointments for the same day. If you would like to see multiple providers in one day, you will be responsible for paying in full for one of your visits.

Payment Due at Visit: The amount of payment due at the time of visit depends upon your insurance plan and your preparation. Avante Medical Center will collect in full at the time of visit if you do not have an insurance card, or have not completed the attached insurance form. **Deductible, co-pay, coinsurance, and non-covered services will be collected at the time of service. We will also collect on any balance due on your account.**

Balance Due: If you have service at Avante and have a balance due for current or previous services, we will require payment in full. We will not schedule any future appointments until the balance is paid in full. If your insurance company denies your claim or pays less than expected; you will be responsible for paying the balance, in full, within two billing cycles

Collections: In the event of nonpayment and/or delinquent account within two billing cycles, your balance, including any fees and or interest that are accrued, may be sent to a collection agency.
Credit Card: You may choose to leave a credit card on file. In the event of patient nonpayment and/or a delinquent account, we can run your balance on your credit card, which will insure your account does not go to collections. Credit card information will be stored for 12 months.

I have read and understand all of the information above. In signing below, I authorize Avante Medical Center to release any information required to process claims and that my insurance benefits are to be paid directly to Avante Medical Center. I understand that although my insurance might be billed, I am financially responsible for the services provided. I understand that deductibles, copays, coinsurance, non covered services, and balances are due at check out. I understand that payment in full is due within two billing cycles. I understand that in the event of my nonpayment and/or delinquent account, my balance, including any fees and interest that are accrued, will be sent to a collection agency.

Signature: _____ Date: _____

Avante Medical Center, LLC
Insurance Information Form

Name of patient:_____ Date of Birth:_____

Do you have Medicare, Medicaid, or Tricare? ____ Yes ____ No If yes, please circle which one

Effective date of change_____

Primary Insurance

Primary person insured_____ DOB_____

Primary insured address_____ Phone#_____

Primary insured employer_____ Phone#_____

Relationship of primary insured person to patient_____

Name of Insurance Co_____ Phone#_____

Insurance ID#_____Group#_____

Address_____

Deductible $_____ Deductible met $_____ Copay/Coinsurance_____

Secondary Insurance

Primary person insured_____ DOB_____

Primary insured address _____ Phone#_____

Primary insured employer_____ Phone#_____

Relationship of primary insured person to patient_____

Name of Insurance Co_____ Phone#_____

Insurance ID#_____ Group#_____

Address_____

Deductible $_____ Deductible met $_____ Copay/Coinsurance_____

1) Is the type of provider you are seeing covered on your insurance plan? (Naturopathic doctor, ANP, Medicare Opt-out ANP, etc..?_____

2) Does your plan require you see a contracted provider & how does it affect your coverage?

_____

Avante Medical Center is only contracted with Blue Cross Blue Shield at this time. We do not bill Tricare, Medicare, or Medicaid. All ANP's have opted out of Medicare. Please contact our billing department if you have any questions regarding this form.

AVANTE
MEDICAL CENTER LLC

FACE SHEET Date:_____

PATIENT INFORMATION- PLEASE COMPLETE IN FULL

Name: _____ Date of Birth: _____

SSN #: _____ Drivers License #_____

Home Address (include city, state, zip):_____

Mailing Address (include city, state, zip):_____

Home #: _____ Work #: _____ Cell #: _____ Fax #: _____

E Mail Address: _____
Your email address will only be used to inform you of important updates pertaining to Avante Medical Center, LLC.

Employer: _____ Occupation: _____

SPOUSE / PARENT / LEGAL GUARDIAN INFORMATION (Circle**):**

Name: _____ Date Of Birth: _____

Employer: _____ Occupation: _____

Cell #: _____ Work #: _____

EMERGENCY INFORMATION:

Name: _____ Relationship: _____ Phone #:_____

Who referred you? Provider Friend Advertisement (Circle) Name:_____

Past/current medical provider/s:_____

Preferred Pharmacy & Location:_____

Internal Use Only

___ Picture
___ History Form
___ Face sheet/Drivers License Copy
___ Insurance Form/Card Copy
___ HIPAA
___ Financial Agreement
___ Missed Appt.

Intake Initials _____

Tricare Medicare Medicaid Circle if Yes___ No___
___ Medicare Opt Out Form ___ Tricare Waiver Explanation
BCBS: Federal ____ Blue Card (out of state) ____

___ SOAPware Custom Tab Completed
___ SOAPware Demographics Completed
___ Insurance Loaded for Billing

Scan Initials _____

AVANTE
MEDICAL CENTER LLC

Missed Appointment Policy

There is a new policy in effect related to missed appointments.

Avante Medical Center, LLC will has a four-step process for missed appointments and cancellations received less than 24 hours prior to appointment time, except for cases of medical emergency. If you make the cancellation call to Avante after hours or weekends, please leave the cancellation message with the answering service.

1) The first missed appointment and/or cancellation less than 24 hours prior to appointment time does not have a charge.
2) For the second missed appointment and/or cancellation less than 24 hours prior to appointment time there will be a $50.00 charge.
3) For the third missed appointment and/or cancellation less than 24 hours prior to appointment time there will be a $50.00 charge.
   Any future services will not be pre-scheduled; they would be available on a Walk-in basis only. This means you would come to Avante to see if a provider has an opening to see you at that time. We cannot guarantee that a provider will be available.

At Avante, we strive to perform the best care and services to our ability. We work very hard to care for and respect your time and needs. We thank you for your assistance in supporting our staff and providers with this signed agreement.

Signature: _____

Date: _____

*Policy effective as of July 8, 2011
KH

AVANTE
MEDICAL CENTER llc

HIPAA Acknowledgement Form

Avante Medical Center, LLC, in accordance with HIPAA regulations, requires a written medical records release in order to send or copy any records from your Avante chart. Avante Medical Center is only responsible for providing records that were from in-house providers and are unable to transfer any records that may be in the chart from other providers.

Please note that a medical records release must be signed EACH time you want to transfer/share records and there must be a separate one for each provider we are requesting or sending records to.

Signing below states that you understand and have read the above paragraph and have reviewed the Notice of Privacy Practices.

_____

Signature Date

_____

If personal representative appears above, please describe your relationship to patient.

In the event that medical records are requested, Avante Medical Center, LLC has up to 30 days to review and send records to the requesting person(s).

Medication History Consent

By signing below I give permission for Avante Medical Center, LLC to access my pharmacy benefits data electronically through SureScripts. This consent will enable Avante Medical Center, LLC to:

• Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
• Download a historic list of all medications prescribed for a patient by any provider.

_____

Signature Date

_____

If personal representative appears above, please describe your relationship to patient.