Date of First Office Call: _____

Dr. Gretchen Imdieke, ND

NATUROPATHIC FAMILY MEDICINE

4270 Kilauea Rd Kilauea, HI 96754 p: 808-652-6407

PATIENT INFORMATION

Legal 1st Name		Date of Birth	
Middle Name		Sex	
Last Name		Race	
Address		Occupation	
City		Name of Spouse or Partner	
State		Are you married	
Zip		Any Children	
Secure Phone #			

PRIMARY INSURANCE (Please present your insurance card at first visit)

Name of Insurance (Insurance Company) _____

Type of Plan (HMO, PPO, Medicaid) _____

Policy/Group Number: _____

ID/Subscriber Number: _____

Person Insured if not yourself: _____

ASSOCIATIONS

Employer or School if student _____

Primary Care Provider (physician) _____

How were you referred to us?

- ☐ Physician (name):
- ☐ Patient (name):
- ☐ Website
- ☐ Other

CUSTOM FIELDS

Your E-mail address: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Patient Name: _____ **Date of First Office Call:** _____

Gretchen Imdieke ND, LLC 4270 Kilauea Rd, Kilauea, HI 96754 Phone: 808-652-6407

REASON FOR VISIT

Please list your present health concerns, problems or symptoms:

PATIENT INFORMATION

When was your last: Physical exam: _____ Blood work: _____

Physician's name: _____ Phone #: _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
Please describe: _____		
2. Have you had any serious illnesses or operations?	☐	☐
Please describe: _____		
3.Women only		
Do you have regular periods?	☐	☐
Are you on birth control?	☐	☐
Have you ever been pregnant?	☐	☐
Number of Pregnancies:_____		
4. Are you currently taking any medications including over the counter medications?	☐	☐
Please describe: _____		
5. Have you ever had a reaction to:	Yes	No
Local anesthetics (eg. Novocaine)……	☐	☐
Antibiotic – which one: _____	☐	☐
_____		
Sedatives……...	☐	☐
Iodine……	☐	☐
Aspirin……..	☐	☐
Other…….	☐	☐

Have you ever had :	Yes	No		Yes	No		Yes	No
Anemia	☐	☐	Heart Murmur	☐	☐	Polio	☐	☐
Anorexia	☐	☐	Heart Disease	☐	☐	Prostate Problem	☐	☐
Arthritis	☐	☐	Hepatitis-Type_____	☐	☐	Psychiatric Care	☐	☐
Asthma	☐	☐	Hernia	☐	☐	Respiratory Disease	☐	☐
Back Problems	☐	☐	Herpes	☐	☐	Rheumatic Fever	☐	☐
Bleeding Tendency	☐	☐	High Blood Pressure	☐	☐	Shortness of Breath	☐	☐
Blood Disease	☐	☐	HIV/AIDS	☐	☐	Sinus Trouble	☐	☐
Cancer	☐	☐	Jaundice	☐	☐	Skin Rash	☐	☐
Chemical Dependency	☐	☐	Kidney Disease	☐	☐	Stroke	☐	☐
Chemotherapy	☐	☐	Latex Sensitivity	☐	☐	Thyroid Problems	☐	☐
Chicken Pox	☐	☐	Liver Disease	☐	☐	Tonsillitis	☐	☐
Chronic Fatigue syndrome	☐	☐	Low Blood Pressure	☐	☐	Tuberculosis	☐	☐
Circulatory Problems	☐	☐	Measles	☐	☐	Ulcer	☐	☐
Congenital Heart Lesions	☐	☐	Migraine Headaches	☐	☐	Sexually transmitted Disease	☐	☐
Cough-persistent or bloody	☐	☐	Mitral Valve Prolapse	☐	☐	Any other condition	☐	☐
Diabetes	☐	☐	Mumps	☐	☐	Please describe:	☐	☐
Emphysema	☐	☐	Multiple Sclerosis	☐	☐	_____		
Epilepsy	☐	☐	Pacemaker	☐	☐	_____		
Glaucoma	☐	☐	Pneumonia	☐	☐			

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Gretchen Imdieke ND, LLC for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or the behalf of my dependants. I authorize Gretchen Imdieke ND, LLC to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I authorize Gretchen Imdieke, ND to leave personal medical information for me on the secure phone number, which I have indicated on this form.

→ **Signature of Responsible Party**_____ **Date**_____

Informed Consent for Treatment

→ I, _____, acknowledge that I am accepting treatment from a Naturopathic Physician at Gretchen Imdieke ND, LLC. I understand that there are intrinsic differences between the care of naturopathic doctors and medical doctors. At this time, it is my decision to pursue naturopathic treatment for any condition I have. Also, I understand that, as with medical treatment, there is no guarantee that this treatment will offer complete resolution to any or all conditions that I may have.

→ _____ _____
Signature of Responsible Party Date

Informed Consent for Email/Text Policy

Gretchen Imdieke ND, LLC provides email and text consultations according to the following guidelines:

1. For established patients of Gretchen Imdieke ND, LLC
2. For non-emergent issues;
3. In cases where the doctor determines that an office visit is not possible;

Doctors generally respond to emails and texts within 48 hours, Monday through Friday only. **If you have not received a response within these parameters, call the office at 808-652-6407 and leave a phone message for the doctor**, stating your question or concern. If your concern becomes an emergency, call 911.

→ I, _____(**Patient Name**), have read the above policy of Gretchen Imdieke ND, LLC for consultation by email or text. I have had an opportunity to ask questions about this policy. I understand the policy, and the conditions that are required for email and text consultation. I understand email and text communication are NOT HIPPA compliant. I realize that I may not receive a response for up to 48 hours, and am expected to call the office to leave a message for the doctor by phone if I have not received a reply in that time frame. I agree to abide by the above policy if I contact my doctor by email or text.

→_____ _____
Signature of Responsible Party Date

Client Fees and Payment Policies of Gretchen Imdieke ND LLC.

We plan for your experience at our clinic to be an excellent one. To further that goal, we want you to be fully informed about our fees and payment policies. Full payment for all charges is required at the time of service. In special circumstances, the doctor may arrange differently. If you have other insurance coverage and you wish to submit a bill to request reimbursement for services received here, please ask for a **superbill** from the doctor during each visit. These can also be provided for you at a later date at a charge of $5.00 each.

We accept payment by check, cash, Discover, MasterCard, Visa or American Express. Checks that are denied for lack of funds will incur a fee of $35.00. Slight fee increases occur in January of each year to accommodate increases in expenses. ***We reserve the right to make changes in our fees and/or policies without advance notice***. We are committed to providing quality economical health care. Thank you for selecting Gretchen Imdieke ND for your health needs.

1. **First Office Call**: Variable: $275
   Fee scale applies also to first visits by phone; additional charges for supplement mailings may occur. This First Office Call price also applies to those patients who return for a visit after more than two years of absence.

2. **Return Office Call:** Variable: $139
   Visits that extend past 30 minutes will be charged for an extended office call.

3. **Extended Return Office Call:** Variable: $165 - $225
   Visits 45-60 minutes.

4. **Phone/ Email Consultations**: Variable: $86.00 -$225
   Insurance may not cover this expense—this fee is your responsibility. Phone or email consultations are provided for established clients only under special circumstances determined by the physician. The minimum fee is charged for any phone consultation up to 15 minutes and for email responses where a single reply suffices. Phone consultations that extend beyond 15 minutes will incur a greater charge. ***We strongly suggest phone consultations occur while you are at home—not while you are driving in your car.*** This fee is not charged in the following cases: when you require clarification of on-going therapy and when the doctor has asked you to call. However, email consultations that require multiple communications will incur additional charges. If there is any question about this service you are welcome to ask in your call or your email inquiry.

5. **Urgent Page**: $86.00 -$165
   Insurance does not cover this expense—this fee is your responsibility.
   In cases of medical emergency, call 911.

6. **Cancellation Charge: We require 48 hours notice received during our normal business hours for canceled or rescheduled visits, or a charge will be billed to you**.
   There is no charge for visits canceled with 48 hours notice. Half the cost of the scheduled visit will be charged for cancellations with less than 48 hours notice. Full fee is charged if no notice is received.

7. **Insurance**: **All charges incurred at our office are your responsibility, regardless of insurance coverage. You are responsible to know your coverage.**

8. **Purchase & Return of Pharmacy Items: All pharmacy items must be paid for at the time of purchase.** Refunds will be given for unopened items in perfect condition if returned within 30 days. Injection supplies or, products made in the clinic, cannot be returned.

9. **Mailing of Pharmacy Items:** We will mail you items for which you have pre-paid, including a handling fee of $7.00 plus postage. Unfortunately, we cannot be responsible for your

reception of these items. **No refund can be made, or unpaid replacement sent, if the items fail to reach you**. **Mailings can take up to a week to send out, so please plan ahead.**

10. **Other Services**: There are numerous other services that Gretchen Imdieke ND LLC offers. Please call the clinic for descriptions and prices at 808-652-6407

11. **Interest Fee:** If, for any reason, payment in full is not received at the time of service, an interest charge of 1% will be charged after 30 days of non-payment. This charge will accrue each month until the patient no longer carries a balance. If a phone, email consultation, or pager fee was not paid at the time of service, there will be no interest if balance is paid prior to 30 days. Pre-arranged payment plans will accrue interest on unpaid balances.

12. **Normal Business Hours**:
    Monday: 9:00 am to 1:00 pm
    Wednesday: 9:00 am to 12:30 pm
    Friday: 9:00 am to 1:00 am
    Saturday: 10:00 am to 1:00 pm

Urgent messages left during our stated business hours for the day will be responded to within that day if we are able to reach you or your phone machine.

I agree to make payment according to the policies of Gretchen Imdieke ND, LLC. I understand that payment is due in full at the time of service. By receiving a service at Gretchen Imdieke ND, LLC I am agreeing to pay for that service even if my insurance company denies payment. I give permission for the release of information requested by my insurance company to assist in processing my insurance claims.

→_____
Patient Name (Please Print)

→_____ _____
Signature of Patient **or** Guardian of Dependent Date

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