Patient Information Hotsheet

Patient Legal Name: (First)_____(Middle)_____(Last)_____

Patient Nick Name _____ **Date of Birth** ___/___/_____ **Male Female**

Mailing Address Street: _____ **City** _____ **State** ___ **Zip** _____

We must call on occasions to discuss confidential protected health information. Below is a list of ways for us to communicate this information with you. Please check how you would like us to get this information to you in the order we should try. Please indicate any restrictions, e.g. "**only leave name and callback number**", "**do not speak to family members**", "**ok to leave detailed message**", etc.

Phone #1 Home Cell Work (_____) _____ - _____ **Restrictions:** _____

Phone #2 Home Cell Work (_____) _____ - _____ **Restrictions:** _____

Phone #3 Home Cell Work (_____) _____ - _____ **Restrictions:** _____

E-mail is sometimes convenient but e-mail delivery is not always reliable and privacy cannot be assured. My e-mail address for general announcements and/or protected health information is as follows. Please indicate any restrictions, e.g. "**only request phone callback**", "**only reply to my messages**", "**ok to initiate a detailed message**", "**general announcements only**", etc.

E-Mail _____ **Restrictions:** _____

I give permission **only** to the following individuals listed below to receive my protected health information; **I circle names of emergency contacts.**

Name _____ **Date of Birth** ___/___/_____ **Contact Info:** _____

Name _____ **Date of Birth** ___/___/_____ **Contact Info:** _____

Name _____ **Date of Birth** ___/___/_____ **Contact Info:** _____

I DO / DO NOT have a Living Will or Health Care Power of Attorney on file with Dr. Weyrich.

Preferred Pharmacy: _____ **Phone:** (_____) _____ - _____

Known Drug Allergies: _____

I request treatment by Dr. Orville Weyrich, Jr., PhD NMD, a licensed Naturopathic Medical Doctor in the State of Arizona by any appropriate method that is within his scope of practice, including (but not limited to) nutritional, botanical and pharmaceutical agents, manipulation, exercise, acupuncture, IV, IM, and SC injections, biofeedback, electrical modalities, homeopathy, mind/body techniques, and minor surgery. I understand that while Dr. Weyrich's scope of practice overlaps with other health care professionals such as MD, DO, DC, LAc, and LMT, he does not possesses any of these designations. I understand that the methods listed above may cause pain or superficial lesions such as bruising, and that I have the right to request discontinuance of treatment at any time. I understand that Dr. Weyrich follows HIPAA privacy guidelines and will only disclose protected healthcare information to third parties as authorized above, by a records release form signed by the patient, or as required by law. This constitutes disclosure of Dr. Weyrich's HIPAA policy and I have been given a copy thereof. I understand that Dr. Weyrich does not participate in any insurance plan and requires payment by cash, check, or PayPal at the time of service. I understand that I am responsible for payment of any labs ordered by Dr. Weyrich, and that Medicare, Tri-care, or other government insurers do NOT cover the cost of any lab or service ordered by Dr. Weyrich.

This authorization/agreement supercedes all previous information provided to Dr. Weyrich, and can be revoked or modified by written notification IN WRITING at any time.

Patient's Signature _____ **Date** _____

Orville R. Weyrich, Jr. PhD NMD BCN

Consent to Treat (2019-2020)

I request treatment by Dr. Orville Weyrich, Jr., PhD NMD, a licensed Naturopathic Medical Doctor in the State of Arizona, by any appropriate method that is within his scope of practice, including (but not limited to) nutritional, botanical and pharmaceutical agents, manipulation, exercise, acupuncture, IV, IM, and SC injections, biofeedback, electrical modalities, cold laser, homeopathy, mind/body techniques, and minor surgery. I understand that the methods listed above may cause pain or superficial lesions such as bruising, and may require touching or other invasion of my personal space; that I have the right to request discontinuance of treatment at any time. I understand that while Dr. Weyrich's scope of practice overlaps with other health care professionals such as MD, DO, DC, PsyD, MSW, LAc, PT, and LMT, he does not possesses any of these designations.

- Dr. Weyrich's education includes BA in Chemistry, Math, and Physics (triple major magna cum laude; Union College of Kentucky), AM in Chemistry (Duke University), PhD in physical organic chemistry (University of Tennessee, Knoxville), ABD in Computer Science and Engineering (Auburn University), Naturopathic Medical Doctor (Southwest College of Naturopathic Medicine, 2007), and additional graduate level studies in Math and Statistics (Grand Canyon University). He is Board Certified in Neurofeedback by the Biofeedback Certification International Alliance.
- Dr. Weyrich has received training in Pain Medicine from the American Academy of Pain Medicine, but there is currently no board certification process for NMD. His license does not allow him to prescribe opiate narcotics, benzodiazepines, gabapentin, trazodone, Valium, or Soma. Therefore, Dr. Weyrich does not offer conventional pain-management services, but does offer various complementary and alternative modes of treatment (physical medicine, electro-magnetic therapies, biofeedback, neurofeedback, acupuncture, herbs, nutrition, etc) in coordination with your conventional doctors.
- Dr. Weyrich has received the standard training in Mind-Body medicine as part of his NMD degree, and provides limited counseling services. He has been trained as a "Lay Counselor" by Scottsdale Bible Church (AZ) and a "Crisis-line Counselor" by Contact Teleministries (TN), and has obtained additional training from Christian Leaders Institute. He has no professional counseling certification beyond his basic NMD degree. Prayer is available at no cost upon request.
- Generally speaking, insurance will pay for drug prescriptions written by Dr. Weyrich, but may impose limits, require co-pay, or restrict prescriptions to drugs listed on their list of approved drugs (formulary). Insurance companies rarely pay for compounded medications such as low dose naltrexone (LDN), bio-identical hormones, or drugs used "off-label."
- Most insurance (in particular all HMOs, AHCCCS, Medicare, Medicaid, Tri-Care, or other government-sponsored program) will NOT pay for office visits, lab tests or radiology exams ordered by Dr. Weyrich. You either have to pay out of pocket for these services when required, or request a doctor "in network" of your insurance company to order these. Dr. Weyrich will prepare a "coordination of care" letter to request such services from your in-network health care provider, but there is no guarantee that the HCP will sign-off on the requests.
- Dr. Weyrich does NOT participate in any insurance program. Some private insurance plans will reimburse the patient for "out of network services" provided by Dr. Weyrich, but it is the patient's responsibility for submitting statements for reimbursement. No representation is made that third parties will reimburse all or part of services/products billed or that coding complies with third-party regulations. All amounts billed remain the responsibility of the patient.
- Payment of all new charges are expected at time of service. Prescriptions will be withheld by the front office until scheduled payments are made. Dr. Weyrich no longer accepts deferred payment for personal injury cases.
- Due to increasing costs, office visits with Dr. Weyrich will be increased to $75 per half hour session. Acupuncture, physical medicine, energetic medicine, bio-feedback, etc require separate appointments. Multi-session discounts may be available.

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- Phone consultations (including prescription renewals or treatment plan modifications) are billed via PayPal at a rate of $25/15 minutes. There is no cost to schedule an appointment or explain/troubleshoot the current treatment plan).
- I understand that Dr. Weyrich follows HIPAA privacy guidelines and will only disclose protected healthcare information to third parties as authorized by a records release form signed by the patient, or as required by law. Records pertaining to private-paid services will not be released to insurance companies without a records release form signed by the patient, but in order to obtain certain services from insurance companies (e.g. prior authorization), I may be required to allow disclosure. This constitutes disclosure of Dr. Weyrich's HIPAA policy and I have been given a copy thereof.
- Due to legal constraints, Dr. Weyrich does not respond to text or voice messages to his cell phone.
- Due to legal constraints, all patients being treated by Dr. Weyrich must have a designated primary care physician (PCP), and Dr. Weyrich must coordinate care with that PCP (exchange SOAP notes and discuss treatment). If the patient has no other PCP, then Dr. Weyrich must assume the role of PCP and provide full standard of care (which includes general health screening and treatment, or appropriate referral), at additional cost to the patient. In order to access many insurance services, your PCP acts as the "gate-keeper." Since Dr. Weyrich is not recognized by most insurance companies (especially HMOs, AHCCCS, Medicare, Medicaid, Tri-Care, or other government-sponsored programs), Dr. Weyrich may not be able to function effectively as your PCP.
- Dr. Weyrich aims to provide treatment that maximizes a patient's ability to engage in the activities of daily living (and participate in the workplace). This usually does not mean that pain is completely eliminated, since higher doses may interfere with proper mentation and reflexes for safely engaging in these activities. Dr. Weyrich expects that patients will actively engage in such exercises, nutritional programs, and other treatments as Dr. Weyrich deems to be appropriate, and that patients will not simply rely on drugs for their treatment.
- Dr. Weyrich expects that patients will follow directions given for use of medications, patients will not take any medications not approved by Dr. Weyrich, and patients will not in any way sell/give/loan/etc their medications to other persons. Dr. Weyrich will NOT replace lost drugs. Patients are responsible for securing their medications from theft and misuse by others, including children in the household.
- Failure to follow these principles can result in a patient being IMMEDIDIATELY dismissed from Dr. Weyrich's practice or Dr. Weyrich refusing to prescribe additional medications to the patient.

Understood and agreed by patient:

Print name: _____

Sign name: _____ **Today's date:** _____

A. Notifier: Dr. Orville Weyrich

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Office visits, lab tests, diagnostic procedures	Medicare does not recognize Naturopathic Medical Doctors	Variable

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION and Coordination of Care

(One for each doctor Dr Weyrich is coordinating care with)

Requesting Records and Information from Healthcare Provider:

Name of Facility or Person: _____

Address: _____

Telephone number ( ) ___ - _____ Fax number ( ) ___ - _____

You are hereby authorized to furnish and release to **Dr. Orville R Weyrich, Jr** (check all that apply):

☐ All my health information and records including, but not limited to, HIPPA-protected records and information, radiology and tests, **including** the following **only if checked**:

- ☐ AIDS/HIV and Other Communicable Disease Information,
- ☐ Behavioral Health Care/Psychiatric/ Psychotherapy information,
- ☐ Alcohol and/or Drug Abuse Treatment,
- ☐ Other as specified: _____

☐ My health information relating to the following treatment or condition: _____

☐ My health information for the date(s): _____

☐ Other: _____

This authorization ends: ☐ On (date) _____

☐ When the following event occurs _____

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release the healthcare provider named above; its employees, agents, managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

I understand the there may be a fee for this service depending on the number of pages photocopied. However; no such fee will be charged if these records are requested for continuing medical care.

Patient's Name: _____ D.O.B. _____
Please Print

Signature: _____ Date _____

Records Requested by / Please send to:

Dr. Orville R. Weyrich, Jr PhD NMD

Payson Health and Wellness

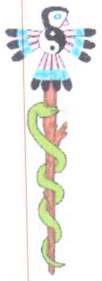
801 E State Highway 260

Payson, AZ 85541

Phone: (928) 474-7409 (o); (480) 766-6007 (c); Fax: (888) 391-0414

Doctor's Signature: _____ Date _____

NEW PATIENT INTAKE FORM



Patient Name: _____ Date of birth ___/___/_____ Today's Date ___/___/_____

Please list your chief symptoms and complaints in order of decreasing severity, starting with the worst one. Please note how long each symptoms has been present. Attach additional paper as necessary.

Problem	Onset	Frequency	Severity
e.g. Headaches	June 2007	4 times per week	Severe = 10/10
1.			
2.			
3.			
4.			
5.			
6.			
7.			

What diagnosis or explanation has been given to you? _____

Do you have any OTHER chronic health problems or other diagnosis? *(Please list and give date when each was diagnosed)* _____

When was the last time you felt well? (e.g. High School, before last child was born, before I moved to AZ, etc)

Did something trigger your change in health? _____

What makes you feel **worse**? _____

What makes you feel **better**? _____

What factors do you feel may be contributing to your current state of health? _____

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NEW PATIENT INTAKE FORM

Patient Name: _____ Date of birth ___/___/_____ Today's Date ___/___/_____

Please check all the treatments you have tried for your condition(s) and indicate the results (e.g. no change, gave me hives, helped slightly, helped a lot, etc.)

Treatment	Describe / Results
☐ Pharmaceuticals (drugs)	
☐ Surgery	
☐ Chiropractic	
☐ Acupuncture	
☐ Homeopathy	
☐ Herbs	
☐ Colonics	
☐ Biofeedback	
☐ Massage	
☐ Environmental medicine	
☐ Nutritional Therapy	
☐ Chelation Therapy	
☐ Prayer / Meditation	
☐ Other (describe)	
☐ Other (describe)	
☐ Other (describe)	

Please list name and contact information for all Current (or your most recent) health care provider(s)

Name of Provider	Specialty (e.g. primary, endocrine, acupuncture, Naturopathic MD, etc)	Phone	Fax	Approximate date last office visit

When was your last complete medical check-up? ___/___/_____ By what provider? _____

Date and type of last labs: _____

Results of these labs: _____

_____

_____

Do you have any known allergies to drugs, foods or substances? YES / NO

If "yes", please specify: _____

_____

Have you been immunized for any of the following (please circle): Tetanus Pertussis MMR Chicken Pox Flu HepB Pneumonia HPV Other: _____

Have you ever had a bad reaction/complications to a vaccine? YES / NO

If "yes", please explain: _____

_____

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NEW PATIENT INTAKE FORM

Patient Name: _____ Date of birth ___/___/_____ Today's Date ___/___/_____

Surgical & truma history (Approximate date, operations/reason, Auto accident, fell off horse, workplace accident, etc):

_____
_____
_____
_____
_____
_____
_____
_____

Social status (circle): Single Married Divorced Widowed Separated Other _____

Children? (birth year of each) _____

Current living situation (own home, rent apartment, etc) _____

Employment status / field _____

Prior occupations (other than above) _____

Do you enjoy your work? YES / NO If no, why not? _____

How would you describe your current emotional state? _____

How many hours do you sleep at night? _____ hrs Do you wake up rested? YES / NO

Please fill in below with the foods and beverages that represent a typical day for you:
Breakfast: _____
Lunch: _____
Dinner: _____
Snack: _____

Which, if any particular food(s) do you strongly crave? _____

Amount of fluids you drink daily (oz): Water___ Soda: ___ Milk: ___ Coffee ___ Tea: ___ Energy ___ Other _____

How often do you eat out weekly? ___times/week What restaurants do you frequent? _____

Do you use artificial sweetener? YES / NO If yes, type _____

Would you say you read food labels (circle)? Always Sometimes Never I don't know how

Do you exercise? YES / NO If yes, type and frequency _____

Have you ever smoked or used tobacco? YES / NO If yes, number of years _____ Packs per day ?_____

Have you quit? If yes, when and how did you quit? _____

Do you drink alcohol? YES / NO If yes, # of drinks per week ____ type: _____

Do you use medical marijuana? YES / NO If yes, why? _____

Do you use recreational drugs? YES / NO If yes, type/frequency _____

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NEW PATIENT INTAKE FORM

Patient Name: _____ Date of birth ___/___/_____ Today's Date ___/___/_____

PAST MEDICAL HISTORY AND FAMILY HISTORY
(Mark the number of cases if you or your family ever have been diagnosed with the any of these diseases – leave blank otherwise)

Disorder	You	Parents	Siblings	Children	Grand-parents	Aunts / Uncles	Spouse
Adrenal problems							
AIDS							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Autoimmune disease							
Birth defects							
Bleeding disorder							
Cancer, colon							
Cancer, lungs							
Cancer, breast							
Cancer, ovarian or testes							
Cancer, prostate or uterine							
Cancer, cervical							
Cancer, other							
COPD							
Depression							
Diabetes							
Drug dependence							
Emphysema							
Epilepsy							
Genetic disease							
Glaucoma							
Heart attack							
Heart trouble							
Hypertension							
Irritable bowel							
Kidney disease							
Liver disease							
Mental illness							
Migraines							
Pneumonia							
Sickle cell anemia							
Stroke							
Substance abuse disorder							
Suicide							
Thyroid problems							
Tuberculosis							
Ulcers							
Other (specify)							

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NEW PATIENT INTAKE FORM

Patient Name: _____ Date of birth ___/___/_____ Today's Date ___/___/_____

REVIEW OF SYSTEMS

Please score the symptoms you are currently experiencing or have experienced in the past. If there are one or more words in a line that describe your specific problem, please circle those words. Add additional complaints on the blank lines.

Blank = no; 1 = rare / minor symptom; 2 = occasional / moderate symptom; 3 = frequent / severe symptom

HEAD	Now	Past	Comments
Injury or Blow to head			
Surgery			
Headache			
Hair loss			
Swelling/nodules			

EYES	Now	Past	Comments
Injury			
Surgery			
Blurry vision			
Double vision			
Poor night vision			
Pain			
Eyebrow loss			
Discharge			

EARS	Now	Past	Comments
Injury			
Surgery			
Pain			
Loss of hearing			
Discharge			
Ringing			

NOSE	Now	Past	Comments
Injury			
Surgery			
Loss of smell			
Discharge			

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NEW PATIENT INTAKE FORM

Patient Name: _____ Date of birth ___/___/_____ Today's Date ___/___/_____

Blank = no; 1 = rare / minor symptom; 2 = occasional / moderate symptom; 3 = frequent / severe symptom

MOUTH	Now	Past	Comments
Injury			
Surgery			
Loss of taste			
Mercury amalgam fillings			
Composite/plastic fillings			
Cavities			
THROAT	**Now**	**Past**	**Comments**
Injury			
Surgery			
Pain			
Hoarse			

NECK	Now	Past	Comments
Injury			
Surgery			
Pain			
Swelling/nodules			
LUNGS/CHEST	**Now**	**Past**	**Comments**
Injury			
Surgery			
Pain			
Difficulty breathing			
HEART/CIRCULATION	**Now**	**Past**	**Comments**
Injury			
Surgery			
Angina			
Palpitations			
Arrhythmias			

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NEW PATIENT INTAKE FORM

Patient Name: _____ Date of birth ___/___/_____ Today's Date ___/___/_____

Blank = no; 1 = rare / minor symptom; 2 = occasional / moderate symptom; 3 = frequent / severe symptom

DIGESTION/ABDOMEN	Now	Past	Comments
Injury			
Surgery			
Pain			
Gas			
Bloating			
Constipation			
Diarrhea			

KIDNEYS/URINATION	Now	Past	Comments
Injury			
Surgery			
Pain			
Bladder problems			
Difficult urination			
Uncontrolled urination			
Discharge			
BACK	**Now**	**Past**	**Comments**
Injury			
Surgery			
Pain			
ARMS/SHOULDERS			
Injury			
Surgery			
Pain			
LEGS/HIPS/KNEES	**Now**	**Past**	**Comments**
Injury			
Surgery			
Pain			

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NEW PATIENT INTAKE FORM

Patient Name: _____ Date of birth ___/___/_____ Today's Date ___/___/_____

Blank = no; 1 = rare / minor symptom; 2 = occasional / moderate symptom; 3 = frequent / severe symptom

SKIN	Now	Past	Comments
Injury			
Surgery			
Rash			
Swelling/nodules			
Abnormal color			

Blank = no; 1 = rare / minor symptom; 2 = occasional / moderate symptom; 3 = frequent / severe symptom

HAIR	Now	Past	Comments
Injury			
Surgery			
Unwanted/excess hair			
Hair loss			
Premature graying			

NEUROLOGICAL	Now	Past	Comments
Injury			
Surgery			
Numbness			
Tingling			
Dizzy, vertigo			
Fainting, loss of consciousness			
Poor balance			
Seizures/convulsions			
Tremors			
Psychological disorder			
Paralysis/weakness			

FEMALE	Now	Past	Comments
Injury			
Surgery			
Tubule ligation			
Abnormal bleeding			
Abnormal discharge			
Breast problems			
Fertility problems			
Miscarriage			
Swelling/nodules			
Use birth control pill, injection, or implanted device			

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NEW PATIENT INTAKE FORM

Patient Name: _____ Date of birth ___/___/_____ Today's Date ___/___/_____

Blank = no; 1 = rare / minor symptom; 2 = occasional / moderate symptom; 3 = frequent / severe symptom

MALE	Now	Past	Comments
Injury			
Surgery			
Vasectomy			
Difficulty urinating			
Fertility problems			
Erection problems			
Swelling/nodules			
Discharge			

SLEEP	Now	Past	Comments
Injury			
Difficulty falling asleep			
Difficulty staying asleep			
Wake unrefreshed			

WEIGHT	Now	Past	Comments
Unexpected weigh loss			
Unwanted weight gain			
Difficulty losing weight			
Difficulty gaining weight			
Over-weight			
Under-weight			

GENERAL	Now	Past	Comments
Injury (other)			
Surgery (other)			
Tired, weak, lack energy			

ANTIBIOTIC USE

Antibiotics: How often have you taken antibiotics?

Infancy/Childhood	☐ less than 5 times	☐ 5 or more times
Teen	☐ less than 5 times	☐ 5 or more times
Adulthood	☐ less than 5 times	☐ 5 or more times

STEROID USE

Oral Steroids: How often have you taken oral steroids (e.g. Prednisone, Cortisone, etc.)?

Infancy/Childhood	☐ less than 5 times	☐ 5 or more times
Teen	☐ less than 5 times	☐ 5 or more times
Adulthood	☐ less than 5 times	☐ 5 or more times

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NEW PATIENT INTAKE FORM

Patient Name: ______________________________ Date of birth ___/___/______ Today's Date ___/___/______

Have your medications or supplements ever caused you unusual side effects or problems?
☐ No ☐Yes. If yes, please describe: ____

____

____

____

____

____

____

____

MEDICATION and SUPPLEMENT LOG

Please indicate the type of prescription medications, over-the-counter medications, and dietary supplements you have taken in the past month. Indicate who prescribed/recommended each (may be "self").

Medication Name	Who prescribed	Dosage each	# Per Day	Reason for Use (Purpose)

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