

**ANDREW LANGE N.D.
NATUROPATHIC DOCTOR**

PRACTICE POLICY

My patients consent to treatment understanding that naturopathic medicine is an alternative to orthodox medical practices, often focusing on the body's inherent abilities to heal rather than just the elimination of symptoms. I would hope to work in coordination with any other health care providers you may be seeing.

I am a Naturopathic Physician, licensed in the State of California as a primary health care provider. Naturopathic Doctors attend an accredited four year graduate naturopathic medical school. This includes a standard curriculum in medical sciences and clinical medicine.

In order to provide quality care my fees for treatment are as follows:

Consultations fees are \$250 per session. Extended sessions will be charged accordingly.

Payment can be made before appointments through PayPal or Credit Card.

Phone consultations requiring prescribing are charged the same rates as office visits. Brief questions are of course welcome and free.

We do not bill insurance companies, except in limited circumstances, and ask that payment be given when services are rendered. Some insurance companies will reimburse you for our services. We will provide you with an itemized bill to submit with your insurance claim. This bill will include the information most insurance companies request.

Referrals to specialists may be necessary to provide full service medical care. I no longer provide services for emergency or acute conditions and would advise you in all urgent situations to call 911.

In fairness we ask that you give at least 24 hours advance notice of any appointments you cannot keep. If this is not done you will be expected to pay for the appointment.

This policy provides the guidelines I have found applicable to almost everyone. If you feel your situation requires special attention, please feel free to discuss it with me. Most importantly all patients agree to get well in cooperation with treatment.

Name: _____

Signature: _____ Date _____

HEALTH HISTORY QUESTIONNAIRE

Date _____

Name	_____
Home Phone	_____
Cell	_____
Email	_____
Address	_____
City	_____
State	_____
Code	_____
Height	_____
Weight	_____
Marital Status	_____
Soc. Sec. No.	_____
Date of Birth	_____
Place of Birth	_____
In Emergency Notify	_____
Phone No.	_____

Past Medical History (diseases, infections, etc. including dates)	_____
_____	_____
_____	_____
_____	_____
Surgeries	_____
Significant Traumas (emotional or physical)	_____
_____	_____
Underline any appropriate: Cancer Diabetes Hepatitis Venereal Disease	
High Blood Pressure Heart Disease Thyroid Disease Seizures	
Depression Anxiety Alcohol or Drug Use Suicidal Tendencies	
Significant Family History:	
Mother	_____
Father	_____
Siblings	_____
Grandparents or Others	_____

Main Problems you would like help with:	_____
_____	_____
When did this problem begin?	_____
_____	_____
Have you been given a diagnosis?	_____
_____	_____
How does this interfere with daily functions (work, sleep, sex, etc.)?	_____
_____	_____
What other treatments have you tried?	_____
_____	_____
What medications or supplements do you take?	_____
_____	_____
_____	_____