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 $350 for initial visits and $250 per followup sessions. 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 QUESTIONAIRE

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?
_____
_____