Diamond Springs Wellness Center PC
Dr. Judith S. Moore
210 E. Main St., Suite 101, Midway, UT 435-657-1777 fax 435-657-0098

Appointment: Date:_____ Time:_____

Dear _____

Welcome to Diamond Springs Wellness Center! We are excited to meet you and get to know you, and we want your first visit with us to go as smoothly as possible. We want you to be among our many healthy and satisfied patients.

Your visit with Dr. Moore and the other practitioners at this office will probably be different than at other offices, as the practice of holistic medicine takes more time and communication. There may be treatments offered that you do not understand. Do not hesitate to ask questions, or even to admit that you are skeptical. Nothing will ever be forced on you. We will make our recommendations of what we feel would work best for you, but it is completely your choice to do them or not.

Please do the following ***before*** your first visit:

- ***FILL OUT THE ACCOMPANYING FORMS BEFORE YOUR VISIT.*** This will allow us to create your chart and get you into your appointment as soon as possible. It will also give Dr. Moore information that will assist her while she takes your history.
- **Bring any lab results and other medical testing results** that have been done in the last year. Please contact your doctor and pick them up (more reliable) or ask them to fax them to us.
- **Bring all medications and supplements that you are currently taking** to be able to show the nurse or doctor. Bring a list of other medications you have used in the past.
- Check with the receptionist to **make sure that we take your insurance.** If we don't carry your insurance, or if you have no insurance, the first visit will cost $ 265, with a cash discount of 20% when paid at time of service ($212).
- Most insurances will cover the basic labs that we order, whether we carry your insurance or not. **Check to find out if there are any restrictions on labs covered by your insurance.**
- Be aware that we often order **specialty tests that may only be partially covered or not covered by insurance.**
- Be aware that **many of our treatments are not covered by insurance**, and therefore will need to be paid for at the time of service. We will do our best to work with your financial capabilities.

Your first appointment is for an hour. Plan to spend about two hours at the office for this visit to account for check-in time before and labs and testing afterwards. Also, even though Dr. Moore works hard to stay on time, there are occasional emergencies or difficult problems which take extra time and she can run behind.

Thank you for choosing to experience Diamond Springs Wellness Center. Please let us know if anything is or is not working for you.

Sincerely,

Dr. Judith Moore and the Diamond Springs Staff

There is a $50 charge for not showing up for the visit or for a cancellation less than 24 hours in advance.

Patient Information Sheet

First Name_____ **Middle**_____ **Last**_____ **Age**_____

Street Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone ( )_____ **Cell Phone( )**_____

E-Mail Address_____

Social Security #_____ **Sex**_____ **Birth Date**_____

Nearest relative not living with you_____ **Their Address**_____

City_____ **State**_____ **Zip**_____ **Phone( )**_____

Patient's Employer_____ **Employer Phone( )**_____

Spouse's Name_____ **Employer**_____ **Work Phone**_____

Preferred Pharmacy_____ **Phone/Location**_____

I was referred to this office by_____

Party Responsible for Payment (If other than Patient)

"I authorize the doctor to release all information to my insurance company to process a claim"

Signature on file (we must have for all insurance Co.'s)_____ **Date**_____

Primary Ins_____ **Name of Policy Holder**_____ **DOB**_____

Primary Ins Group#_____ **ID/Policy#**_____

Secondary Ins Co._____ **Name of Policy Holder**_____ **DOB**_____

Secondary Ins Group#_____ **ID/Policy#**_____

Financial and collection Agreement

Note: Please carefully read and then sign this policy statement. WE REQUIRE PAYMENT IN FULL FOR YOUR CO-PAY AND FOR ANY NON-COVERED PROCEDURES AT THE TIME SERVICE ARE RENDERED, THERE ALSO IS A $50.00 CHARGE FOR NOT SHOWING UP FOR A VISIT OR CANCELLATION LESS THAN 24 HOURS IN ADVANCE. We accept cash, check, or credit card. Please be advised that some services offered by our office are not covered by most insurance companies.
My account must be paid in full within 90 days or a finance charge of $15.00 will be added to my account monthly unless special arrangements are made. All delinquent accounts will be charged interest at the rate of 1.5% per month (18% per annum). In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee equal to 33 1/3% of the unpaid balance. In the event legal action becomes necessary to collect the unpaid balance, the undersigned further agrees to pay all reasonable attorneys fees and court costs. A $20 fee will be charged for return checks. Rescheduling requires 24 hour notice. All phone consults with the physician that are greater than 5 minutes may result in a fee starting at $45 up to $95 depending on time spent with the physician unless covered by insurance.

I have read, understand, and agree to the provisions of this financial policy and agree to pay Diamond Springs Wellness Center.

Responsible Patient's Signature_____ **Date:**_____

Legal Guardian (patient under 18) Consent to treat_____ **Date:**_____

Designated "Durable Power of Attorney" Consent to Treatment_____ **Date:**_____

Diamond Springs Wellness Center

Family Practice and Integrative Medicine
Judith s. Moore, D.O.
210 E. Main ST. Suite 101 Midway , Utah 84049
435-657-1777 Fax: 435-657-0098

This form authorizes us to use and disclose protected health information (PHI) for the purpose of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your protected health information.

For further questions concerning our Notice of Privacy Policies, please contact:
Office Manager -Tyler Mitchell.

CONSENT

Patient's Name:_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Telephone:_____ **E-mail:**_____

** Acknowledgement of Receipt of**
Notice of Privacy Policies

I hereby acknowledge that I have received a copy of Diamond Springs Wellness Center, Notice of Privacy Policies.

_____
Name (Print)

_____ **Date:**_____
Signature

IF under the age of 18 Guardian must sign below

I,_____**,** have read your Notice of Privacy
(Patient's Guardian)
Policies and I consent to your use of our personal health information for the purpose of healthcare operations, treatment and payment activities.

Signature:_____ **Date:**_____

Relationship to Patient:_____

NAME:_____ Date of Birth:_____ Date of Visit:_____

Symptoms and Problems, in order of importance to you:

SYMPTOM/PROBLEM	HOW LONG?	SYMPTOM/PROBLEM	HOW LONG?
1._____		5._____	
2._____		6._____	
3._____		7._____	
4._____		8._____	

Current and recent previous physicians and health practitioners

1._____ 2._____

Medications and supplements

1._____ 4._____

2._____ 5._____

3._____ 6._____

Childhood illnesses_____

Past **Adult** illnesses/Age_____

_____

Surgeries/Age at time of surgery_____

_____

Car **accidents**, injuries, head injuries _____-___

_____

Dental work: Braces_____ Root Canals_____ Silver fillings_____ Other_____

History of **chemical exposure**? Which chemicals?_____

Birth: Problems during mother's pregnancy or your birth?_____

Problems in **infancy** (colic, milk allergy, freq. ear infections, etc.)_____

All **immunizations**?_____ Extra immunizations for travel?_____ Any reactions?_____

Allergies to medications_____

Allergies to inhalants (seasonal, dust, mold, etc.)_____

Allergies or sensitivities to foods_____

Chemical sensitivities (gasoline, perfume, etc.)_____

Other (electromagnetic, tape, etc.)_____

Allergy testing in the past? What type?_____

Have you ever been **abused** (physical/emotional/sexual/neglect)_____

Family history of Cancer (who and type)_____ Heart disease_____

Stroke_____ Diabetes_____ Thyroid_____

Arthritis_____ Autoimmune_____ __Other_____

Depression/Anxiety/Bipolar/other_____

DIET: Typical breakfast_____

Typical lunch_____

Typical dinner_____

Snacks_____What do you drink?_____

Symptoms if you miss meals?_____ Between meal fatigue?_____

Recent weight loss or gain for unknown reason? How much in what time?_____

Do you feel too fat/too thin?_____ By how many pounds?_____Difficult to lose/gain?_____

Current or past **substance use**/frequency: Alcohol_____ Tobacco_____Caffeine_____ Sugar_____

Marijuana_____ Cocaine_____ Meth_____ Heroin_____ Ecstasy_____Spice_____

Salvia_____Pain pills for emotional or recreational use_____ Other_____

Neuro: Headaches, numbness, diff. focusing, memory, etc.?_____

Heart: Chest pain, palpitations, murmer, circulation, etc.?_____

Lungs: Asthma, diff. breathing, freq. infections, etc.?_____

GI: Freq. constipation, diarrhea, acid reflux, bloating, gas, pain, etc.?_____

Endocrine: Thyroid problems? High or low blood sugar?_____

FEMALE
Menstrual history: Age of first menstrual period_____ Last menstrual period (date if still cycling)_____

# of pregnancies_____ Miscarriages_____Abortions_____ Live births_____Menopausal?_____

Symptoms with cycle (PMS, pain, irregularity, etc.)_____

Menopausal symptoms_____

Sexually transmitted diseases_____Bladder infections_____Yeast infections_____ Other_____

MALE
Problems with: urination_____starting/stopping stream_____night time urination_____prostate large/infections_____

erection_____ ejaculation_____ sexually transmitted diseases_____ other _____

Emotional: Depression_____ Anxiety_____ Bipolar_____ Stress/Overwhelmed_____

Other_____