Jennifer Gentry, NMD
42104 N. Venture Drive, Suite B122
Anthem, Arizona 85086
Phone: 623-251-5518 Fax: 623-249-4748

PATIENT INFORMATION

Patient Name _____ Date: _____
SS# _____ Date of Birth _____ Sex ☐M ☐F
Address, City State and Zip Code: _____
E-Mail _____
☐Married ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced ☐Partnered for _____ years
Occupation _____ Employer/School _____
Partner's Name _____
Whom may we thank for referring you? _____
If a minor who has custody?

PHONE NUMBERS

Home _____ Cell _____ Work _____
Best time and place to reach you: _____
I give permission for my doctor or staff to leave a message on my home telephone or cellular phone. ☐Yes ☐No
I give permission to speak on matters regarding my healthcare to: _____

IN CASE OF EMERGENCY CONTACT
Name _____ Relationship _____
Home _____ Work _____

INSURANCE

When requested we will provide an itemized receipt with diagnosis codes and additional forms when appropriate to submit to insurance for your reimbursement of office visits during your visit. We will also submit your insurance information for some labs submitted though the office. Please be prepared to submit your insurance card and photo ID so we may copy these items to your chart.

Who is responsible for this account if different from patient? _____
Relationship to patient: _____
Insured's date of birth if different from patient: _____ Insured's phone if different from patient: _____
Insured's address if different from patient: _____
If you have more than one insurance plan please list primary and secondary insurance:

INSURANCE ASSIGNMENT AND RELEASE
I understand I am financially responsible for all charges up front whether or not paid by my insurance. Dr. Jennifer Gentry will reimburse to me any payments my insurance company authorizes if a check is received by her office. I authorize the use of my signature on all insurance submissions.

Dr. Jennifer Gentry may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services for my reimbursement and determining insurance benefits or the benefits for related services. The consent will end when my current treatment plan is completed.

_____
Signature of Insured, Guardian, or Personal Representative

_____
Please Print Name of Insured, Guardian, or Personal Representative Date Relationship to Insured

FAMILY HISTORY

	Number ALIVE	Number DECEASED	PRESENT HEALTH OR CAUSE OF DEATH:
FATHER			
MOTHER			
SIBLINGS			
CHILDREN			

FAMILY ILLNESS: ☐ Diabetes ☐ Heart disease/Heart Attack ☐Stroke ☐High Blood Pressure ☐ Bleeding disorder ☐ Kidney disease ☐ Tuberculosis ☐ Alcoholism/Drug Use ☐Nervous/Mental Illness ☐ Autoimmune Disorder ☐Thyroid disease ☐ Cancer : TYPE: _____
☐Other Genetic condition or Significant Familial history: _____

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Patient Name _____ Today's Date _____

HEALTH HISTORY/SYMPTOMS: Check all conditions you have or have had in the PAST 3 MONTHS

What is your reason(s) for today's visit?:_____

GENERAL
- ❑ Chills
- ❑ Depression
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Fever
- ❑ Forgetfulness
- ❑ Headache
- ❑ Intolerant to exercise
- ❑ Irritable/Shaky when hungry
- ❑ Loss of sleep
- ❑ Loss of weight
- ❑ Nervousness
- ❑ Numbness
- ❑ Salt Cravings
- ❑ Sensitive to fumes/chemicals
- ❑ Stool changes
- ❑ Sweats

MUSCLE/JOINT BONE
Pain, weakness or numbness:

- ❑ Arms
- ❑ Back
- ❑ Feet
- ❑ Hands
- ❑ Hips
- ❑ Legs
- ❑ Neck
- ❑ Shoulders

GENITOURINARY
- ❑ Blood in urine
- ❑ Color change in urine
- ❑ Frequent urination
- ❑ Lack of bladder control
- ❑ Painful urination

GASTROINTESTINAL
- ❑ Poor appetite
- ❑ Bloating
- ❑ Bowel changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Excessive hunger
- ❑ Excessive thirst
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Nausea
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Vomiting blood
- ❑ Other: _____

CARDIOVASCULAR
- ❑ Chest pain
- ❑ Heart palpitations
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swollen ankles
- ❑ Water retention
- ❑ Varicose veins

PULMONARY
- ❑ Persistent cough
- ❑ Spitting up blood or phlegm

EYE, EAR, NOSE, THROAT
- ❑ Bleeding gums
- ❑ Crossed eyes
- ❑ Difficulty swallowing
- ❑ Double vision
- ❑ Ear ache
- ❑ Ear discharge
- ❑ Hay fever
- ❑ Hoarseness
- ❑ Loss of hearing
- ❑ Nasal congestion
- ❑ Nose bleeds
- ❑ Ringing in ears
- ❑ Sinus problems
- ❑ Vision - blurry
- ❑ Vision - night blindness
- ❑ Vision - flashes
- ❑ Vision - halos
- ❑ Vision - light sensitivity

SKIN/HAIR/NAILS
- ❑ Acne
- ❑ Bruise easily
- ❑ Discoloration of skin
- ❑ Hair loss
- ❑ Hair excess
- ❑ Hives
- ❑ Itching
- ❑ Change in moles
- ❑ Rash
- ❑ Scars/Stretch marks
- ❑ Sore that won't heal
- ❑ Weak/Brittle nails/Hair

MEN ONLY
- ❑ Breast lump
- ❑ Erection difficulties
- ❑ Lump or pain in testicles
- ❑ Penis discharge
- ❑ Sore on penis
- ❑ Other _____

Last PSA: _____

WOMEN ONLY
- ❑ Abnormal pap smear
- ❑ Bleeding between periods
- ❑ Breast lump
- ❑ Breast tenderness
- ❑ Decreased libido
- ❑ Extreme menstrual pain
- ❑ Hot flashes
- ❑ Irregular menses
- ❑ Miscarriages/Total: _____
- ❑ Nipple discharge
- ❑ Osteoporosis
- ❑ Painful Intercourse
- ❑ Vaginal discharge
- ❑ Vaginal dryness

Date of last period: _____
Date of last pap smear: _____
Date of last mammogram: _____
Date of last bone density: _____
Date of last colonoscopy: _____
Number of children/year _____

CONDITIONS: Check all conditions you have or have had. NOTE THE YEAR.

- ❑ AIDS/ HIV Positive
- ❑ Alcoholism/ Drug dependency
- ❑ Anemia
- ❑ Anorexia/ Bulimia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma/ Emphysema
- ❑ Bladder infections
- ❑ Bleeding disorders
- ❑ Cancer
- ❑ Diabetes/ Hypoglycemia
- ❑ Endometriosis/Ovarian Cysts
- ❑ Epilepsy Glaucoma
- ❑ Gallbladder disease
- ❑ Gout
- ❑ Heart disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ High cholesterol
- ❑ Infertility
- ❑ Kidney disease/Stones
- ❑ Liver disease
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis/CMV
- ❑ Multiple Sclerosis
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate problem
- ❑ Psychiatric care/ Suicide attempt
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Stroke
- ❑ Thyroid problem/ Goiter
- ❑ Tuberculosis
- ❑ Typhoid fever
- ❑ Ulcer: Type:_____
- ❑ Venereal disease
- ❑ Other:_____
- ❑ Other:_____
- ❑ Other:_____
- ❑ Other:_____

MEDICATIONS AND SUPPLEMENTS
List what you are currently using and the DOSE

Pharmacy Name _____ Phone: _____

ALLERGIES
Medications, Foods and EFFECT

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Have you had any surgeries or hospitalizations? (Please include date, condition treated, and adverse events/outcome of the procedure.)

What is your current level of commitment to addressing these issues? (Please choose the one that best fits.)

- ❑ I am willing to make **ANY** changes and do whatever is necessary.
- ❑ I am willing to make **SOME** changes in my lifestyle to feel better.
- ❑ I am specifically looking for a medical/surgical alternative but **do not want to change** my lifestyle.
- ❑ I am here to learn more about my healthcare options and what you offer.
- ❑ Other:_____

What spiritual or religious activities do you have if any?
What type of exercise and frequency of exercise do you prefer?
What occupation do you currently have?
What previous occupations have you had?
What hobbies do you have? (chemical or metal exposures)
Have you lived in industrial or agricultural areas? (pollution)
What would you rate your daily stress level? (0-10, 10 highest) For how many years?
How do you feel on waking in the morning?
How do you feel at night before bed?
How many hours of sleep do you get per night during the week? Is it interrupted?

Have you had all childhood vaccinations? When was your last tetanus vaccine?
Have you ever had a bad reaction to a vaccination? What reaction and to which vaccine?

Do you SMOKE or VAPE? ☐Yes ☐No How often? How many years? How many packs per day?
What motivates you to smoke? Do you want to quit? ☐Yes ☐No
Do you use recreational DRUGS? ☐Yes ☐No Type and with what frequency?
Do you consume ALCOHOL what type and what amount/frequency?
Do you experience gas, bloating or indigestion with any particular food, if so what food(s)?
Is there undigested food, mucus, or blood in your stools?
Are you following a special diet or do you have any food restrictions? (eg. dairy free, gluten free, Paleo, Adkins, I won't eat vegetables etc.)

If your condition is chronic (you have looked for answers for years without results), what do you think is the cause of your illness and what treatments have you tried successfully or unsuccessfully?

Please list any significant life event that you feel has affected your health and the date:

Is there anything else you would like the doctor to know which may help him/her to better understand your healthcare?

IF YOU ARE HERE FOR HOMEOPATHY, PLEASE COMPELTE THE HOMEOPATHY QUESTIONAIRE.
IF YOU ARE HERE FOR HORMONAL ISSUES, PLEASE COMPLETE THE HORMONE CHECKLIST.
THANK YOU FOR TAKING THE TIME TO COMPLETE THIS INFORMATION.

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PATIENT AFFIRMATION OF REVIEW OF CONTRACTS

Regarding the Health Services, Notice of Privacy Practices, & Consent to Treat Contracts

All contracts are available to read in their entirety in our office and on our website: www.DrJenGentry.com

HEALTH SERVICES CONTRACT

I have read the "Health Care Services Contract." I have read the contract and understand my patient rights and the financial policies of Calvo Naturopathic and agree to the terms and conditions. I understand that there may be fee for missed appointments and for lengthy phone consults. FEES MAY CHANGE, but I will always be made aware of any changes prior to my visit. Calvo Naturopathic will provide a copy of the "Health Care Services Contract" to me at my request or I may access this information at www.DrJenGentry.com

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided information on how my personal health information may be used in accordance with HIPAA federal regulations. I have read, or have had read to me the "Notice of Privacy Practices" and agree to the terms and conditions. Calvo Naturopathic will provide a copy of the "Notice of Privacy Practices" to me at my request or I may access this information at www.DrJenGentry.com. **Use of personal email and text messages are not HIPPA compliant. If I choose to relay messages to Dr. Gentry or her staff using email or text, I understand I am waiving my privacy rights.**

CONSENT TO TREAT CONTRACT

I am seeking medical health care services at Calvo Naturopathic. I have read, or have had read to me the "Consent to Treat Contract" and agree to the terms and conditions. I understand that treatment results are not guaranteed. Naturopathic medicine is not a substitute for conventional medical treatment. I will always have an opportunity to discuss the value of any treatment and will have an opportunity to verbally agree to a treatment before it is performed. If I refuse a particular therapy, this will be noted in my chart for future reference. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. Calvo Naturopathic will provide a copy of the "Consent to Treat Contract" to me at my request or I may access this information at www.DrJenGentry.com.

RELEASE OF INFORMATION

I give the physician the authority to share with any consultant all information deemed necessary to coordinate my medical care. This includes sharing/mailing/faxing information such as office notes, EKGs, laboratory results, x-ray reports, medication lists and other consultant's notes to physicians, hospitals, pharmacists and insurance companies.

INSURANCE AND ASSIGNMENT OF BENEFITS

Calvo Naturopathic is not contracted with an insurance provider. Itemized receipts with diagnosis codes are gladly provided to assist you in attempts to receive reimbursement on request; however, **REIMBURSEMENT IS NOT GUARENTEED. MEDICARE AND MEDICAID ARE NOT COVERED UNDER NATUROPATHIC CARE. NEITHER LABS NOR VISITS WILL BE COVERED BY MEDICARE OR MEDICAID.** I understand I am always responsible for pre-payment regardless of the insurance coverage I may have.

Insurance benefits will be reimbursed to me when requested if there is a credit made to my account. I understand that I am responsible for any charges not covered by this assignment. I authorize release of any medical or other information necessary to process my insurance claims. I authorize the physician to provide from my records any and all information requested by my insurance company or other third party payer, in connection with payment for my incurred charges. I also authorize the physician to provide any quality review organization affiliated with my insurer the information it requests for use in Utilization Management/Review. Some plans may require a referral from my primary care physician and it is my responsibility. I authorize disclosure of records to my insurance carrier, lawyer, or referring practitioner.

EMERGENCIES

I understand that if I have an urgent medical condition, and am unable to reach Dr. Gentry, it is my responsibility to seek appropriate medical care. I understand that **IF THERE IS A MEDIAL EMERGENCY I AM TO DIAL 911 IMMEDIATELY.**
In the event that Dr Gentry is absent and unable to be available to me due to personal illness or vacation, there is not a secondary provider on staff. If necessary, I agree to see an urgent care, same day care or other primary care provider.

Date: _____

Patient Name (Printed): _____

Parent or Legal Guardian if applicable (Printed): _____

Patient Signature (or Parent or Legal Guardian): _____

_____

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Medicare/Medicaid (AHCCCS)-Opt Out Contract
(Pursuant to #405, 415 of Medicare Regulations)

I, _____ understand that

- Dr. Jennifer Gentry, NMD is a naturopathic physician.
- DR JENNIFER GENTRY IS NOT A **Medicare/Medicaid (AHCCCS)** PROVIDER.
- **Medicare/Medicaid (AHCCCS)** WILL NOT PAY for services provided by this office.
- **Medicare/Medicaid (AHCCCS) WILL NOT PAY FOR LABS OR IMAGES ordered by this office.**

By signing this agreement I agree to the following:

- I agree not to submit a claim (or request that the physician submit a claim) to Medicare for items and services even if Medicare/Medicaid (AHCCCS) covers such items and services.
- I agree that I (or my legal representative) accept full responsibility for payment of services rendered to me at this office and agree that NO MEDICARE REIMBURSEMENT WILL BE PROVIDED for such services.
- I acknowledge under this contract that no Medicare limiting fees apply to amounts that may be charged for items and services.
- I acknowledge that MEDICARE GAP PLANS DO NOT MAKE PAYMENTS and other supplemental insurance plans may not elect to make payments for items and services since Medicare does not make payment.
- I acknowledge that I have a right to items and services provided by other physicians or practitioners for whom payment would be made by Medicare.
- I acknowledge that MEDICARE DOES NOT PAY FOR LABS ORDERS written by the physicians in this office. Labs drawn in this office would be paid for out of pocket. I can have labs ordered by physicians who are Medicare providers and have these results forwarded to this office.
- If Dr. Jennifer Gentry orders a lab at my insistence or as an oversight-MEDICARE WILL NOT PAY FOR LABS AND I WILL BE HELD RESPONSIBLE FOR PAYMENT.
- I (or my legal representative) understand that Jennifer Gentry, NMD is thus excluded from Medicare under #1128, 1156, 1892 or any other section of the social security act.

I enter this agreement on my own free will; I UNDERSTAND THAT
I WILL NOT BE SEEKING MEDICARE REIMBURSEMENT for items and services rendered.

	Jennifer Gentry, NMD
_____	_____
Patient Name	Physician Name
_____	_____
Patient Signature	Date

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Arizona law, and not by a lawsuit or resort to court process except as Arizona law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Article 2: **All Claims Must Be Arbitrated:** It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against a Physician, including any fee dispute, whether or not the subject of any existing court action shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing-the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Arizona Revised Statutes (ARS) 12-1501-12-1518 and the Federal Arbitration Act (9 U.S.C 1-4), and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 5: **Severability Provision:** In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with Arizona and federal law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Jennifer Gentry, NMD

By: _____
Physician or Duly Authorized Representative Signature (Date)
Jennifer Gentry Calvo, NMD

By: _____
Patient's Signature (Date)

By: _____
Print or Stamp Name of Physician, Medical Group or Association Name

By: _____
Print Patient's Name

By: _____
Signature of Translator (if applicable) (Date)

By: _____
Patient's Representative's Signature (Date)

_____
Print Name of Translator

_____
Print Name and Relationship to Patient

A signed copy of this document is to be given to the patient. The Original is to be filed in Patient's medical records.