LAKESIDE HOLISTIC HEALTH, PLLC

New Patient Intake Packet ~ Adult

The information you provide here helps the provider understand your physical, mental, and emotional condition more completely in order to help you attain your health goals. Please answer all the questions as completely as possible.

Name: _____ Date: _____

Social Security #: _____ Date of Birth: _____ Age: _____ Sex: ___M ___F

Mailing Address: _____ City/State/Zip: _____

Contact Phone Number: _____ May we leave detailed message? (i.e. appointment reminders) ___Y ___N

Occupation: _____ Full / Part Time: _____

Email: _____

May we send you email appointment confirmations? ___Y ___N

Would you like to join our Platinum Wellness Club & receive our monthly newsletter? ___Y ___N

Marital Status:	With Whom do you live?:	How many Children do you have?	Number of Children at home?:
___ Single	___ Alone		
___ Married	___ Spouse		
___ Co-habitating	___ Friends	_____	_____
___ Divorced	___ Relatives		
___ Separated	___ Parents		
___ Widowed	___ Other		

Emergency Contact: _____ Phone: _____

Primary Health Provider: _____ Phone: _____

How did you hear about Lakeside Holistic Health, PLLC?

___ Personal Referral: Please provide their name so we may thank them: _____

___ Business Referral: Please provide their name so we may thank them: _____

___ Website ___Facebook ___Insurance: _____ ___ Print Ad: Which one? _____

PERSONAL HEALTH

Blood Type: _____

What are your current health concerns? Please list in order of importance.

Health Concern	How long have you had this condition?	What other treatment have you sought?	What helps your condition?	What aggravates your condition?

What diagnostic imaging studies have you had?

X-Rays	CT Scan	Bone Density Scan	Mammogram	EKG	MRI

What immunizations have you had? (Place a ? if you do not know)

Diphtheria	Measles/Mumps/ Rubella	Pertusis	Polio	Tetanus	Other
Specify Other:					

Have you had the following childhood illnesses? Mark Y or N

Scarlet Fever	Diphtheria	Rheumatic Fever	Mumps	Measles	German Measles	Other
Specify Other:						

Please indicate if any of the following pertain to you. (Marking Yes does not make you ineligible for acupuncture treatment, however, it may restrict some treatment modalities)

Hepatitis	HIV	HIgh Blood Pressure	Seizures	Pacemaker	Blood Thinning Meds	Pregnancy

Do you have any allergies to food, drugs, or environmental allergens (Cats, mold, dust) ___ Y ___ N

If Yes, Please explain:_____

HOSPITALIZATIONS OR SURGERIES

Hospitalization / Surgeries	Year

MEDICATIONS

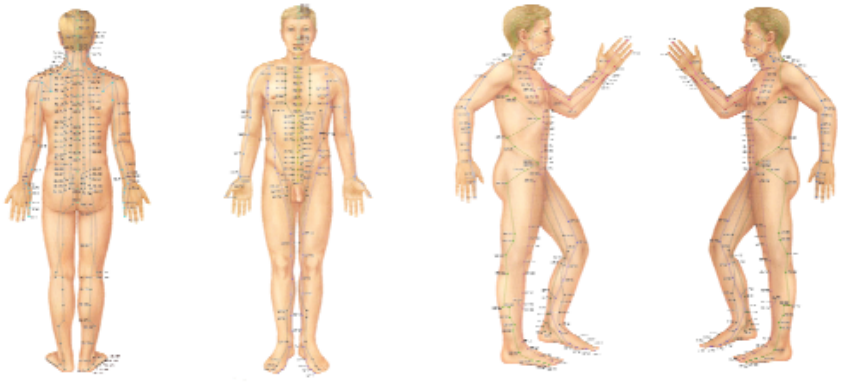
Medication	Reason

VITAMIN & HERBAL SUPPLEMENTS

Supplement	Reason

PAIN PATIENTS

Please indicate on the figures below the areas of the body you experience pain by placing an “X”.



How would you characterize your pain:

___ dull/achy

___ sharp/stabbing

___ tingling

___ electrical

___ burning

___ numbness

DIET

Meal	List the types of foods you typically consume.
Breakfast	
Lunch	
Dinner	
Snacks	
Beverages	
What do you crave?	
Any food intolerances?	
Do you eat three meals per day?	

HABITS

What are you main interests & hobbies? _____

Do you Exercise? ___Y ___ N Explain: _____

Do you smoke or chew tobacco? ___ Y ___ N If not currently, have you in the past? _____

Do you use recreational drugs? ___ Y ___ N Explain: _____

Have you been treated for drug dependence? ___ Y ___ N Explain: _____

FAMILY HISTORY

Please mark if you or your family have experienced:

Illness	Self	Father	Mother	Sister	Brother	Other
Anemia						
Arthritis						
Asthma						
Cancer						
Diabetes						
Epilepsy						
Gallbladder Disease						
Glaucoma						
Goiter						
Hay Fever, Hives						
Heart Disease						
Heart Murmur						
High Blood Pressure						
Kidney Disease						
Liver Disease						
Mental Illness						
Stroke						
Tuberculosis						
Ulcer						
Other						

THE INSTITUTE FOR FUNCTIONAL MEDICINE®

Medical Symptoms Questionnaire (MSQ)

Patient Name_____ Date_____

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale

0 – ***Never or almost never*** have the symptom
1 – ***Occasionally*** have it, effect is ***not severe***
2 – ***Occasionally*** have it, effect is ***severe***
3 – ***Frequently*** have it, effect is ***not severe***
4 – ***Frequently*** have it, effect is ***severe***

HEAD

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia

Total _____

EYES

_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
(Does not include near or far-sightedness)

Total _____

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss

Total _____

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation

Total _____

MOUTH/THROAT

_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores

Total _____

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating

Total _____

HEART

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain

Total _____

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing **Total** _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain **Total** _____

JOINTS/MUSCLE

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness **Total** _____

WEIGHT

_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight **Total** _____

ENERGY/ACTIVITY

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness **Total** _____

MIND

_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities **Total** _____

EMOTIONS

_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression **Total** _____

OTHER

_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge **Total** _____

Grand Total _____

METABOLIC ASSESSMENT

Please mark the appropriate number on all questions below. 0 as the least/never to 3 as the most/always

Category I	0	1	2	3
Feeling that bowels do not empty completely				
Lower Abdominal pain relief by passing stool or gas				
Alternating constipation and diarrhea				
Diarrhea				
Constipation				
Hard, Dry, or small stool				
Coated tongue or "fuzzy" debris on tongue				
Pass large amount of foul smelling gas				
More than 3 bowel movements daily				
Use laxatives frequently				

Category II	0	1	2	3
Increasing frequency of food reactions				
Unpredictable food reactions				
Aches, pains, and swelling throughout the body				
Unpredictable abdominal swelling				
Frequent bloating and distention after eating				

Category III	0	1	2	3
Intolerance to smells				
Intolerance to jewelry				
Intolerance to shampoo, lotion, detergents, etc.				
Multiple smell and chemical sensitivities				
Constant skin outbreaks				

Category IV	0	1	2	3
Excessive belching, burping, or bloating				
Gas immediately following a meal				
Offensive breath				
Difficult bowel movements				
Sense of fullness during and after meals				
Difficulty digesting fruits and vegetables; undigested foods found				

Category V	0	1	2	3
Stomach pain, burning, or aching 1-4 hours after eating				
Use antacids				
Feel hungry an hour or two after eating				
Heartburn when lying down or bending forward				
Temporary relief from antacids, food, milk, carbonated beverages				
Digestive problems subside with rest and relaxation				
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine				

Category VI	0	1	2	3
Difficulty digesting roughage and fiber				
Indigestions and fullness lasts 2-4 hours after eating				
Pain, tenderness, soreness on left side under rib cage				
Excessive passage of gas				
Nausea and/or vomiting				
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed				
Frequest loss of appetite				

Category VII	0	1	2	3
Abdominal distention after consumption of fiber, starches, and sugar				
Abdominal distention after certain probiotic or natural supplements				
Decreased gastrointestinal motility, constipation				
Increased gastrointestinal motility, diarrhea				
Alternating constipation and diarrhea				
Suspicion of nutritional malabsorption				
Frequent use of antacid medication				
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/Diverticulitis, or Leaky Gut Syndrome?	YES		NO	

Category VIII	0	1	2	3
Greasy or high-fat foods cause distress				
Lower bowel gas or bloating several hours after eating				
Bitter metallic taste in mouth, especially in the morning				
Unexplained itchy skin				
Yellowish cast to eyes				
Stool color alternates from clay colored to normal brown				
Reddened skin, especially palms				
Dry or flaky skin and/or hair				
History of gallbladder attacks or stones				
Have you had your gallbladder removed?	YES		NO	

Category IX	0	1	2	3
Acne and unhealthy skin				
Excessive hair loss				
Overall sense of bloating				
Bodily swelling for no reason				
Hormone imbalances				
Weight Gain				
Poor Bowel Function				
Excessively foul-smelling sweat				

Category X	0	1	2	3
Crave Sweets during the day				
Irritable if meals are missed				
Depend on coffee to keep yourself going or started				
Get lightheaded if meals are missed				
Eating relieves fatigue				
Feel shaky, jittery, or have tremors				
Agitated, easily upset, nervous				
Poor memory/forgetful				
Blurred vision				

Category XI	0	1	2	3
Fatigue after meals				
Crave sweets during the day				
Eating sweets does not relieve cravings for sugar				
Must have sweets after meals				
Waist girth is equal or larger than hip girth				
Frequent urination				
Increased thirst and appetite				
Difficulty losing weight				

METABOLIC ASSESSMENT CONT.

Please mark the appropriate number on all questions below. 0 as the least/never to 3 as the most/always assessment 0

Category XII	0	1	2	3
Cannot stay asleep				
Crave salt				
Slow started in the morning				
Afternoon fatigue				
Dizziness when standing up quickly				
Afternoon headaches				
Headaches with exertion or stress				
Weak nails				

Category XIII	0	1	2	3
Cannot fall asleep				
Perspire easily				
Under high amounts of stress				
Weight gain when under stress				
Wake up tired even after 6 or more hours of sleep				
Excessive perspiration or perspiration with little or no activity				

Category XIV	0	1	2	3
Edema and swelling in ankles and wrists				
Muscle cramping				
Poor muscle endurance				
Frequent urination				
Frequent thirst				
Crave salt				
Abnormal sweating from minimal activity				
Alteration in bowel regularity				
Inability to hold breath for long periods				
Shallow, rapid breathing				

Category XV	0	1	2	3
Tired, Sluggish				
Feel cold - hands, feet, all over				
Require excessive amounts of sleep to function properly				
Increase in weight gain even with low-calorie diet				
Gain weight easily				
Difficult, infrequent bowel movements				
Depression, lack of motivation				
Morning headaches that wear off as the day progresses				
Outer third of eyebrow thins				
Thinning of hair on scalp, face, or genitals or excessive falling hair				
Dryness of skin and/or scalp				
Mental Sluggishness				

Category XVI	0	1	2	3
Heart Palpitations				
Inward trembling				
Increased pulse even at rest				
Nervous and emotional				
Insomnia				
Nightsweats				
Difficulty gaining weight				

Category XVII (Males Only)	0	1	2	3
Urination difficulty or dribbling				
Frequent urination				
Pain inside of legs or heels				
Feeling of incomplete bowel evacuation				
Leg twitching at night				

Category XVIII (Males Only)	0	1	2	3
Decrease in libido				
Decrease in spontaneous morning erections				
Decrease in fullness of erections				
Difficulty in maintaining morning erections				
Spells of mental fatigue				
Inability to concentrate				
Episodes of depression				
Muscle soreness				
Decrease in physical stamina				
Unexplained weight gain				
Increase in fat distribution around chest and hips				
Sweating attacks				
More emotional than in the past				

Category XIX (Menstruating Females Only)	0	1	2	3
Are you perimenopausal	YES		NO	
Alternating menstrual cycle lengths	YES		NO	
Extended menstrual cycle, greater than 32 days	YES		NO	
Shortened menses, less than every 24 days	YES		NO	
Pain and cramping during periods				
Scanty blood flow				
Heavy blood flow				
Breast pain and swelling during menses				
Pelvic pain during menses				
Irritable and depressed during menses				
Acne breakouts				
Facial hair growth				
Hair loss/thinning				

Category XX (Menopausal Females Only)	0	1	2	3
How many years have you been menopausal?				
Since menopause, do you ever have uterine bleeding?	YES		NO	
Hot flashes				
Mental fogginess				
Disinterest in sex				
Mood swings				
Depression				
Painful intercourse				
Shrinking breasts				
Facial hair growth				
Acne				
Increased vaginal pain, dryness or itching				

LAKESIDE HOLISTIC HEALTH, PLLC

Coeur D Alene Office (208) 758-0568
Liberty Lake Office (509) 385-0218
Fax (833)810-1162

CONSENT FOR TREATMENT

Patient Name: _____ Date of Birth: _____

Notice of NON-Coverage for Laboratory Testing

Insurance carriers do not pay for **all** laboratory testing. If your insurance carrier does not pay for your laboratory testing ordered from Lakeside Holistic Health, PLLC, you may have to pay. Insurance carriers do not pay for everything, even some lab tests that you or your health care provider feel is medically necessary. WE CAN HELP. If we are not able to bill your insurance, we have negotiated pre-payment options available. These pre-payment options are only available in the Northern Idaho/Eastern Washington Regional labs, and they are non-refundable.

Return Policy

All purchased items are non-refundable. Lakeside Holistic Health, PLLC will not return or resale any item.

Medical Records

In our effort to provide you with the best possible service, your records are available through your secure patient portal that is provided to you free of charge. **For any and all medical record requests from the practice the fee is $50.00.** As a patient you have the right to see, copy and supplement your medical records. Medical records obtained in this office may only be used for health care related functions and Lakeside Holistic Health, PLLC will not share or release records without patient authorization.

Letter of Medical Necessity

In our effort to provide you with the best possible service, a treatment plan is provided to you at most office visits that includes the medical necessity. Lakeside Holistic Health, PLLC also provides you with a form to complete to have your provider sign for you free of charge. **For any and all other letters of medical necessity or forms the fee is $25.00.**

Hours of Operation

Lakeside Holistic Health, PLLC does not provide after hours or weekend services. **In case of emergency please contact your nearest urgent care center, or emergency room.** All Lakeside clinic locations have various hours of operation. Please connect with us on social media, website, or by phone to verify specific location hours of operation.

Financial

For your convenience we are Preferred Providers with most commercial insurance carriers. We are happy to complete and submit insurance claims when coverage is available for you. Please contact your insurance provider and understand what benefits are available to you.

We do not accept Medicare, Medicaid, United Healthcare, or any Medicare or Medicaid supplemental insurance. When a physician or practitioner opts out of Medicare and Medicaid, no payment may be made to the provider, or the patient/beneficiary.

CONSENT & ACKNOWLEDGEMENT

By signing below you acknowledge that you have read, fully understand and agree to all the information in the Introductory Patient Information Packet, and the consent for treatment. By signing below you acknowledge, agree, and understand the following;

1. My sole purpose and intent in seeking the services of Lakeside Holistic Health, PLLC is to obtain help for my personal health.
2. My signature is entirely voluntary and based upon informed choice.
3. I acknowledge this as a Notice of Information Practices.
4. I acknowledge that I am 18 years of age or older.
5. I am aware of Dr. Langenderfer's professional training as a Naturopathic Physician, Licensed Acupuncturist, and Certified Epigenetic Coach and have been informed to my satisfaction.
6. I am aware of Dr. Bailey's professional training as a Chiropractic Physician, Certified Acupuncturist, and Certified Epigenetic Coach and have been informed to my satisfaction.
7. I understand that I am financially responsible for all products and services that I receive from Lakeside Holistic Health, PLLC.
8. I understand that payment is due at the time of service for treatments and services not covered by my insurance plan.
9. I understand that some third party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment.
10. I hereby authorize Lakeside Holistic Health, PLLC to release all medical information necessary to secure payment of benefits from my insurance carrier.
11. I understand that Lakeside Holistic Health, PLLC and all our Providers have opted out of Medicare and Medicaid.
12. I agree not to submit a claim for payment under Medicare/Medicaid, even if such items and services would otherwise by covered by Medicare/Medicaid.
13. I agree to be responsible for payment of such items and services.
14. I acknowledge that no reimbursement will be provided by Medicare/Medicaid for such items and services.
15. I acknowledge that Lakeside Holistic Health, PLLC is not limited in the amount that will be charged to me.
16. I acknowledge that quoted benefits from my insurance plan is not a guarantee of coverage and agree I am responsible for all charges.
17. I acknowledges that it is my own responsibility to know my insurance benefit information.
18. I understand that my insurance may not pay for laboratory tests ordered.
19. I am aware that I am financially responsible for all laboratory tests ordered by Lakeside Holistic Health, PLLC.
20. I agree that if my insurance denies any claim for any reason, I acknowledge that I am financially responsible.
21. I understand that a laboratory may bill me directly when insurance does not cover.
22. I understand that if I prepay for my lab tests there are no refunds, and I can not submit any claim to any insurance for payment reimbursement, and labs must be performed in the Northern Idaho/Eastern Washington region.
23. I understand that any and all medical record requests from the practice there is a fee of $50.00.
24. I understand that any and all letters of medical necessity form requests from the practice there is a fee of $25.00.

Patient Printed Name _____Date _____

Patient Signature _____
(Or Guardian/Financially Responsible Party)

LAKESIDE HOLISTIC HEALTH, PLLC

Coeur D Alene Office (208) 758-0568
Liberty Lake Office (509) 385-0218
Fax (833) 810-1162

HIPAA Release of Information Form 2021

The Health Insurance Portability & Accountability Act of 1966 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form; whether electronically, on paper, or verbally, be kept confidential.

Doctors and the staff of Lakeside Holistic Health may release information including; **(check all the apply)** [ ] diagnosis, [ ]appointment details, [ ] billing information, [ ] treatment plans, [ ]medications, [ ]testing results, [ ] other _____

Information can be released to the following people:

Name:_____	Name:_____
Relationship to patient:_____	Relationship to patient:_____
Phone: _____	Phone: _____
Email:_____	Email:_____

[ ] Information is **NOT** to be released to anyone other than the patient.

I further agree that the practice may disclose health information to me in the following manner:

[ ] Phone #_____ [ ] Email_____

If unable to reach me: [ ] OK to leave detailed message [ ] leave message to call back

This Release of information will remain in effect until terminated by the patient in writing.

Patient/Guardian Printed Name Signature Date

LAKESIDE HOLISTIC HEALTH, PLLC

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Surprise Billing Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up this protections and pay more for out-of-network care.

IMPORTANT: You are not required to sign this form and shouldn't sign it if you didn't have a choice of healthcare provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less. If you'd like assistance with this document, or wish to speak to someone about this document please call our Billing Manager.

Request and/or keep a copy of this form for your records.

You're getting this notice because Lakeside Holistic Health, PLLC may not be in your health plan or specific health plan benefit's network. This means the Lakeside Holistic Health, PLLC may not have an agreement with your specific benefit plan. It is possible that Lakeside Holistic Health, PLLC or any provider herein may be a "Preferred Provider" with the insurance company, but may not be eligible to participate with ALL benefit plans within the insurance company.

Getting care from any or all of our providers or Lakeside Holistic Health, PLLC could cost you more. Any quote or estimate received from your insurance company is not a guarantee of coverage.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask our Billing Manager if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out of-pocket limit.

Contact your health plan for more information.

You shouldn't sign this form if you didn't have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change. Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility.

See the next page for your cost estimate.

Estimate of what you could pay:

Patient name:_____

Facility & Provider name:

Lakeside Holistic Health, PLLC
Pamela Langenderfer, ND, LAc, MSOM, FABORM
Naturopathic Physician, Licensed Acupuncturist
Jerry Bailey II, MS, DC, CAc, FIAMA
Chiropractic Physician, Certified Acupuncturist

Total cost estimate of what you may be asked to pay:

New Patients - COMPREHENSIVE INITIAL VISIT $375.00
Existing Patients - OFFICE VISIT(S) $302.00
Existing Patients - TELE-HEALTH/ZOOM VISIT(S) $285.00
Existing Patients - ACUPUNCTURE TREATMENT(S) $ 95.00
Existing Patients - CHIROPRACTIC TREATMENT(S) $115.00

▶**Review your detailed estimate.** You may request a detailed receipt emailed to you at each visit, or may review your transaction detail at any time through your available patient portal at: ***www.portal.kareo.com***

▶**Call your health plan.** Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.

▶**Questions about this notice and estimate?** Call our Billing Manager at (208) 758-0568 or (509) 385-0218

▶**Questions about your rights?** Contact 1-800-MEDICARE (1-800-633-4227) or visit cms.gov/nosurprises

Other Services/Treatments/Items Offered at Lakeside Holistic Health, PLLC

At this time, no other services, treatments, or items are eligible to submit to insurance carriers. Prices may vary. You can request a quote or estimate from our patient care team for intravenous therapy, injection therapy, and/or any nutrition therapies offered at Lakeside Holistic Health, PLLC Clinics.

Prior authorization or other care management limitations

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.

Understanding your options

You can also get the items or services described in this notice from providers who may be in-network with your specific benefit health plan if Lakeside is not.

More information about your rights and protections

Visit ***https://www.cms.gov/nosurprises*** for more information about your rights under federal law.

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care at Lakeside Holistic Health, PLLC.

With my signature, I am saying that I agree to get the items or services from (select all that apply):

□ Pamela Langenderfer, ND, LAc

□ Jerry L. Bailey, DC, CAc

□ Lakeside Holistic Health, PLLC

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on the DATE OF THIS NOTICE explaining that my provider or facility may not be in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I understand that any estimate, quote, or statements from my insurance company is not a guarantee of benefits.
- I received this notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I may end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You don't have to sign this form. If you do not sign, Lakeside Holistic Health, PLLC and the providers herein choose not to serve you. You can choose to get care from another provider elsewhere.

_____ _____

Patient **OR** Patient's signature Guardian/Authorized representative's signature Date and Time of Signature

_____ _____

Print Name of Patient Print Name of Guardian/Authorized Representative

I am self pay so this is not applicable to me, but I am signing below to acknowledge that I have received a copy of the Surprise Act and the cost of Lakeside Holistic Health, PLLC's appointment services. If I have insurance and do NOT sign above, I am choosing to not get services provided by Lakeside Holistic Health, PLLC.

_____ _____

Patient **OR** Patient's signature Guardian/Authorized representative's signature Date and Time of Signature

_____ _____

Print Name of Patient Print Name of Guardian/Authorized Representative

A copy of this form is always available within your patient chart. You may obtain a copy at any time.

LAKESIDE HOLISTIC HEALTH, PLLC

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Liberty Lake Office (509) 385-0218
Fax (833)810-1162

Informed Consent for Telehealth Naturopathic/Functional Medicine Treatment

I,_____, hereby authorize Dr. Pamela Langenderfer or Dr. Jerry Bailey to perform diagnosis, consultation, treatment, education, care management, self-management via information and communication technologies otherwise known as **Telehealth**. I understand that I will not be seeing her/him in an office setting and that she/he will not be my primary care provider and I must maintain a primary care provider for physical examinations and other diagnostic and screening procedures. I understand that I must be present in the state of Idaho or Washington when communicating with the doctor.

IMPORTANT: As of July 2021, select insurances have chosen to **NOT** cover Telehealth/Virtual appointments. We strongly encourage each of our patient's to contact their insurance to ensure they don't have any financial surprises. As of January 2022, most insurances have stopped covering Telehealth/Virtual visits. **The new patient Telehealth/Virtual appointments are NOT billable to insurance.** Please understand that there is a difference between Telehealth/Virtual (a.k.a. Zoom) appointments and Telephone appointments. Insurances will **NOT** cover Telephone visits and at this time they are not billable to insurance.

I recognize the potential risks and benefits of these procedures as described below:
Potential Risks: allergic reactions to prescribed supplements, medications, and herbs, which may be severe such as anaphylaxis, cardiac arrest and death. Side effects between natural medications and pharmaceuticals, inconvenience of lifestyle changes and aggravation of present conditions.

Notice to Women: all female patients must inform the doctor if they know, suspect, or may be pregnant as some of the therapies used could present risk to the pregnancy and fetus.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment in recommending the treatments that the doctor feels at the time, based on the facts then known, are in my best interest. I have had the opportunity to ask questions and discuss with Dr. Pamela Langenderfer or Dr. Jerry Bailey:

1) my suspected diagnosis or condition
2) the nature, purpose and potential benefit of the proposed care
3) the inherent risks, complications, potential hazards, or side effects of the treatment or procedure
4) the probability or likelihood of success
5) reasonable available alternatives to the proposed treatment / procedure
6) the possible consequences if treatment or advice is not followed and/or nothing done.

With this knowledge I voluntarily consent to the above procedures realizing that no guarantees have been given to me by **Dr. Pamela Langenderfer *or* Dr. Jerry Bailey** regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and discontinue participation at any time.

Signature of Patient or Guardian: _____ Date: _____

LAKESIDE HOLISTIC HEALTH, PLLC

Coeur D Alene Office (208) 758-0568
Liberty Lake Office (509) 385-0218
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Preparing for Your Upcoming Telehealth Appointment

Your first appointment may or may not be done via zoom, but this will be helpful to have for future appointments. The consent form prior is also helpful for us to have on file for future appointments; such as, you being sick, the doctor being sick, etc. so we can instantly send you a link and not have to worry if you've signed a consent form for zoom appointments yet.

We use HIPAA-compliant ZOOM for all of our Telehealth visits. Prior to your session with either Dr. Pam, or Dr. Bailey, if you would like us to submit a claim to insurance, please ensure you have contacted your insurance carrier to verify this specific benefit on your plan, as it is separate from your standard office visit coverage.

IMPORTANT: As of July 2021, select insurances have chosen to **NOT** cover Telehealth/Virtual appointments. We strongly encourage each of our patient's to contact their insurance to ensure they don't have any financial surprises. As of January 2022, most insurances have stopped covering Telehealth/Virtual visits. **The new patient Telehealth/Virtual appointments are NOT billable to insurance.** Please understand that there is a difference between Telehealth/Virtual (a.k.a. Zoom) appointments and Telephone appointments. Insurances will **NOT** cover Telephone visits and at this time they are not billable to insurance.

All patients will need to walk through the initial "log in" process; upon visiting the ZOOM website, it will prompt you to download the ZOOM application OR allow it to install on your desktop computer. You only have to do this once; if you have already downloaded the program, you are ready to go!

Listed below are some guidelines to set up the ideal environment for this type of appointment:

1. Find a space that is clutter-free and allows you to move around comfortably.

2. Your space should be well-lit, distraction-free and quiet.

3. Test out camera angles; you want to avoid any obstructions in the viewfinder, and ensure that your upper body and head/face can be clearly seen by the provider.

4. Test your webcam and microphone for proper functionality; you will also want to "Allow" ZOOM to access both of these components (when prompted).

If you are experiencing any difficulty during this process, please feel free to contact our office so we may assist you!

Our goal is to ensure a smooth and enjoyable experience as we "virtually" transition with you.