

Dear Prospective Patient,

Welcome to my integrative consulting practice!

Enclosed are patient intake forms. Before your scheduled appointment, please complete them as thoroughly as you possibly can.

Your consultation visit will consist of assessment of your medical history, a modified physical examination and recommendations, with discussion. This is scheduled for 1 1/2 hours. **Please bring with you photocopies of any recent lab work (for me to keep), as well as a list of all supplements or medications you are currently taking, including dosages.**

When you arrive with the above information, that maximizes the time we can spend together in discussion.

If you are not able to keep your scheduled appointment for any reason, please call the Integrative Medicine Center at 607-275-9697 so that your visit can be rescheduled to a more convenient time. We greatly appreciate a 24-hour notice for cancellation wherever possible so that your slot may be used by someone waiting for an earlier appointment.

I look forward to meeting you and supporting you in developing goals and recommendations for your best possible health.

Yours,

Nancy B. Stewart, M.D.  
Board-Certified in Family Medicine  
Graduate, Fellowship in Integrative Medicine, University of Arizona, 2003

**Patient Intake Form  
Nancy B. Stewart, M.D.  
Integrative Medicine Center**

Name:

Reason(s) for consultation:

What are your goals for this visit?

Name of current/last position:

Major current health issues/conditions:

Past medical history/medical conditions:

Operations you have had, and approximate year(s)

Allergies and reactions to medications:

Other allergies, and tolerances and reactions:

Please list all medications, supplements, herbs and medicinal foods you are currently taking:

Year of last tetanus booster:\_\_\_\_\_

Year of last cholesterol test:\_\_\_\_\_

If you are over 50, year of last colonoscopy:\_\_\_\_\_

Women: Please list the following: Last menstrual period or age at menopause\_\_\_\_\_

# Pregnancies\_\_\_\_\_ # Births\_\_\_\_\_ Approximate date of last Pap smear:\_\_\_\_\_

Family health history (please list all major medical conditions known in your family members):

Mother:

Father:

Sisters (how many? \_\_\_\_\_):

Brothers (how many? \_\_\_\_\_):

Grandparents:

Other:

Have any of your relatives had the following illnesses, and if so, who?

breast cancer\_\_\_\_\_ colon polyps or

cancer\_\_\_\_\_ diabetes\_\_\_\_\_

osteoporosis\_\_\_\_\_ hypertension\_\_\_\_\_

heart attack before 65 in women or 55 in men\_\_\_\_\_

Occupation:

Education (how far you went in school, degrees):

Hobbies/other recreational interests:

Do you smoke cigarettes or use tobacco? \_\_\_\_\_ How many packs per day? \_\_\_\_\_

For how many years? \_\_\_\_\_

If you have quit using tobacco, when did you quit? \_\_\_\_\_ How many years did you smoke? \_\_\_\_\_

How many packs per day? \_\_\_\_\_

Do you drink alcohol, including beer or wine? \_\_\_\_\_ How many drinks per week ( = 1 oz liquor,  
4 oz wine, 1 beer)? \_\_\_\_\_

Do you drink caffeine? \_\_\_\_\_ Is so, what kind of beverage, and how many cups per  
day? \_\_\_\_\_

Other drugs, past and present (how often, what substances):

Please describe what you typically eat and drink for the following meals:

Breakfast:

Lunch:

Dinner:

Snacks (and when you usually eat them):

How would you describe your relationship with food:

What physical activities do you participate in (how often, how many minutes at a time)?

What are the major stresses in your life?

What do you do to relax; what do you love to do?

How much sleep you get, and does it feel like enough? Any trouble sleeping (please elaborate)?

Who do you currently live with?

Do you feel safe in all your current relationships (family, at work)?\_\_\_\_\_ If not, please elaborate:

Spiritual or religious practice, present and past:

What is your general attitude toward life?

What or who are your sources of hope and strength?

**Review of Systems:** Please place a check in front of any problems you are **currently** having or wish to discuss.

- Fever, chills
- Night sweats
- Hair loss
- Unintended weight loss
- Loss of appetite
- Unusual headaches
- Fainting or blackouts
- Numbness or tingling
- Loss of memory
- Chronic fatigue or weakness
- Trouble sleeping
- Wide mood swings
- Crying or depression
- Anxiety or nervousness
- Ringing ears
- Dizzy spells
- Hearing loss
- Visual change
- Eyes itching or draining
- Persistent nasal congestion/drip
- Excessive sneezing
- Excessive snoring
- Chest pains with exercise
- Other chest pain or tightness
- Palpitations or irregular heart
- Cough
- Wheezing
- Shortness of breath
- Coughing up blood
- Frequent heartburn
- Trouble swallowing
- Abdominal pain
- Persistent nausea or vomiting
- Frequent diarrhea
- Frequent constipation
- Blood in stools
- Frequent urination
- Slow urinary stream
- Painful urination
- Excessive urination at night
- Urinary leakage
- Blood in urine
- Neck or back pain
- Joint pains
- Leg pain when walking
- Leg or ankle swelling
- Rash
- Non-healing sore
- Changing or bleeding mole
- Unexpected lump

**WOMEN**

- Spotting/irregular menses
- Heavy menses
- Unusual vaginal discharge
- Breast pain or lump

**MEN**

- Difficulty with erection
- Discharge from penis
- Pain or lump in testicle

**HAVE YOU EVER HAD**

- Cancer
- Abnormal pap smear
- Kidney stones
- Positive tuberculin test (PPD)
- Clots in legs or lungs
- Depression
- Positive HIV test
- Hepatitis
- Blood transfusion
- Seizure
- Ulcer or stomach bleeding
- Asthma
- Exposure to radiation
- Needle drug use
- Sexual transmitted disease

**Nancy B Stewart, MD  
301 West State St  
Ithaca, NY 14850**

**Notice of Privacy Practices (10/03)**

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective Oct 1, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

**Treatment:** We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

**Payment:** We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for

our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

**Operations:** Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials' information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in all settings.

**Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

**Communication Barriers and Emergencies:** We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of

treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy, and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the address below (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, <http://www.hhs.gov/ocr/hipaa>.

All questions concerning this Notice or requests made pursuant to it should be addressed to  
NANCY B STEWART, MD  
301 W. STATE ST  
ITHACA, NY 14850

***Insurance Information***  
***(Please attach Insurance cards & please print)***

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ female: \_\_\_ male: \_\_\_

Date of birth: \_\_\_/\_\_\_/\_\_\_ Soc. Sec #: \_\_\_\_\_

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Primary Ins Co: \_\_\_\_\_ policy #: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured Address: \_\_\_\_\_

Insured DOB: \_\_\_/\_\_\_/\_\_\_ Insured Soc. Sec \_\_\_\_\_

Patient's relationship to insured: \_\_\_\_\_

Secondary Ins Co: \_\_\_\_\_ Insured name: \_\_\_\_\_

Insured address: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Patient's relationship to insured: \_\_\_\_\_ Insured Soc. Sec: \_\_\_\_\_

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Expired Insurance name: \_\_\_\_\_ Exp. date: \_\_\_\_\_

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Patient's Employer: \_\_\_\_\_ Job title: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Who is financially responsible for the bill: \_\_\_\_\_

It is the Patients responsibility to request a referral from your doctor to obtain  
Pre-authorization for a medical encounter, if you insurance company requires it.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I have read the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes to the above

I have been offered a copy of the privacy policy.

\_\_\_\_\_ Date: \_\_\_\_\_

(Signature required to release information to insurance company for billing purposes only)