



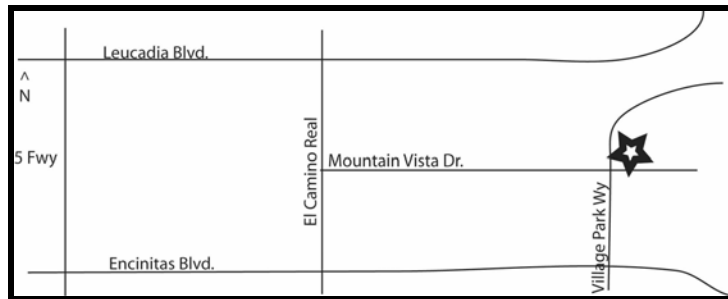
NATUROPATHIC FAMILY MEDICINE
Jennifer Zeglen, ND

Dear New Patient,

I look forward to welcoming you to my office and working together to improve your health and well-being. Listed below is some information that should be of help and importance to you. Please read it carefully and contact me if you have any questions or concerns. You will also find several forms attached that you should *complete and bring with you* to your first appointment.

Office Location/Hours

The office is located at 1991 Village Park Way, Suite 206A in the Village Park neighborhood of Encinitas. Park near and enter the complex **at suite 100** and check in with the receptionist. Office hours vary but include some evenings and Saturdays. I am also available by phone at 760-216-8769 and email at jennifer@drzeglen.com.



What To Expect

Most initial appointments are 90 minutes long. This allows plenty of time to discuss your health concerns and medical history, perform indicated physical examinations (please note I am not able to offer gynecological exams at this time), and come up with a basic treatment plan. Certainly any painful or uncomfortable symptoms will be addressed right away. Occasionally I will suggest we split the first visit in to two separate days if I need to review a complex medical history or order labs before starting treatment. Discounted weekly appointments are also available for situations where regular check-ups are helpful, such as weight loss or health coaching.

Phone/email consults are available, at no charge, following an appointment in order to answer questions and concerns about treatment. Consults for new problems or for patients who have not been seen recently may be charged at the same rate as an office visit. I also offer complementary phone and email consults from potential patients who would like to find out more about how naturopathic medicine may be able to help them.

Some of the possible treatments I will recommend include nutrient therapies, dietary changes, herbal medicines, hydrotherapy, homeopathy, and lifestyle counseling. All treatment plans are based on the Six Principles of Naturopathic Medicine: do no harm, treat the cause, work with the body to heal itself when possible, treat the whole person, educate the patient, and focus on prevention.

Natural Pharmacy

I carry numerous high-quality, professional-grade supplements and botanical products for patients to purchase as part of their treatment plans. These provide convenience and cost-savings for the patient (I discount many products compared to retail). They also insure that a high-quality product is being used. The supplement industry includes a broad range of quality and effectiveness. Some of the products available make overstated health claims, being more concerned with marketing than with clinical effectiveness and medical research. In addition, products that are not rigorously tested for purity are sometimes contaminated or contain cheaper, less-effective forms of key ingredients. These products are not regulated by the FDA, making it more important to use brands that have a record of purity, effectiveness, and independent testing. I am aware that there is potential for a conflict of interest in selling supplements and so I pledge to never prescribe products that are unnecessary and to discontinue prescriptions as soon as it is medically appropriate. If you prefer to purchase products from other sources, I will be glad to give you other options for finding high-quality items.



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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. I understand that this information is very personal and I am committed to protecting your confidentiality. I am also required by law to make sure that medical information that identifies you is kept private (with certain exceptions), to give you this privacy notice, and to follow its terms. Please review this notice carefully. If you have any questions, contact Dr. Zeglen at 760-216-8769.

How I May Use & Disclose Your Medical Information

For treatment: I may disclose your medical information to other doctors whom I consult with about your case, to medical student interns, other medical staff involved in your care, or your family (unless you have specified otherwise in writing) if they are involved in your health care or the payment of your health care.

For payment: I may disclose medical information about you if necessary to coordinate payment from an insurance company or health savings account.

In phone messages/correspondence: I may disclose medical information about you in order to remind you about an appointment you have, send a greeting card, inquire about your health, or send periodic health newsletters that pertain to your health. This may be in the form of a phone message, letter, or email.

Research: I may disclose medical information about you for research purposes, however your identifying information will be removed from your medical record unless your permission is specifically obtained.

As Required By Law: I will disclose medical information about you when required to do so by law, for example to report the incidence of certain diseases, to report suspected abuse or neglect of children or elders, in response to a court order or warrant, etc..

To Avert Serious Threat to Health or Safety: I may disclose medical information about you when necessary to prevent a serious threat to your health and safety or that of the public or another person. Any disclosure would only be to someone able to prevent that threat.

Your Rights Regarding Medical Information About You

Right to Inspect and Copy: You have the right to inspect and request a copy of medical information and billing records, but this may not include some mental health information. To inspect or request a copy, you must provide a written request in advance to Dr. Zeglen. You may be charged a fee for the costs of copying and mailing your request.

Right to Amend: You have the right to amend your medical information if you feel it is incorrect or incomplete. To request an amendment, you must provide a written request to Dr. Zeglen including a reason that supports your request.

Right to an Accounting of Disclosures: You have the right to request a list of the disclosures made of your medical information, other than those made for purposes of your treatment, payment, or correspondence.

Right to Request Restrictions: You have the right to request restrictions on the disclosure of your health information, for example, that I not disclose to a particular family member. I am not required to agree with that request, but will comply when possible.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Dr. Jennifer Zeglen directly, or with the Secretary of the Department of Health and Human Services.



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PRIVACY & FINANCIAL POLICIES

Last Name: _____ First Name: _____ DOB: _____

Privacy Practices

You will find a copy of "Notice of Privacy Practices" enclosed. This notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights, and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information, wish to inquire about your rights, or if you wish to view your medical record, please contact the office in advance.

Can phone messages with confidential health information be left on your:

Home Phone: Yes No Work Phone: Yes No Cell Phone: Yes No

Do you wish to receive periodic health newsletters and announcements by email and/or mail? Yes No

I hereby acknowledge that I have received a copy of Dr. Zeglen's "Notice of Privacy Practices".

X _____ Date: _____

(Patient's Signature)

X _____ Date: _____

(Guardian/Representative's Signature)

Relationship to patient: _____

Financial Policies

Services are billed at the following rates:

First Visit, comprehensive (90 min): \$225
First Visit, well-visit/basic (60 min): \$150

Return Visit (60 min) \$150
Return Visit (40 min) \$100

Weekly Check-ins (15 min per week) \$135/month

Phone or email consults for new problems or for patients who have not been seen recently may be charged at the same rate as an office visit (with advance notification).

- Any laboratory, imaging, and supplement costs are additional.
- Cancellations require 24 hours notice. A fee of \$25 may be charged for missed appointments.
- Full payment is due at the time of service.
- An insurance billing form will be provided if the patient wishes to request reimbursement from their insurance plan. This office is not able to provide insurance billing services.

X _____ Date: _____

(Patient's Signature)

X _____ Date: _____

(Guardian/Representative's Signature)

Relationship to patient: _____



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INFORMED CONSENT TO TREAT

I, _____, hereby authorize Dr. Zeglen to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g., venipuncture, Pap smears, laboratory, spirometry, TB testing.

Minor office procedures: e.g., dressing a wound, ear cleansing, nasal/sinus irrigation & dilation, immunization.

Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.

Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters, or suppositories.

Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.

Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

Psychological Counseling

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures.

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that my medical record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

X _____ Date: _____

(Patient's Signature)

X _____ Date: _____

(Guardian/Representative's Signature)

Relationship to patient: _____



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PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Social Security # _____ Sex: Male Female

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Mother's Name (*minors only*): _____

Father's Name (*minors only*): _____

Marital Status (*circle one*): Single Married Domestic Partnership Separated Divorced Widowed

Are you currently working? Yes (*describe*) _____ No

Emergency Contact Name: _____

Phone #: _____

Relationship: _____

Do you have a primary care physician? Name: _____

Address: _____

Phone #: _____

Do you have insurance? Yes (*company*): _____ No

Does your plan reimburse you for naturopathic medical care? . Yes . No

Do you have a Health Savings Account (HSA)? . Yes . No

Do you have any special needs? _____

Are you visually impaired? Yes No Are you hearing impaired? Yes No

How did you hear about Naturopathic Family Medicine?

X _____ Date: _____

(Patient's Signature)

X _____ Date: _____

(Guardian/Representative's Signature)

Relationship to patient: _____



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CONFIDENTIAL HEALTH HISTORY

Name: _____ Birthdate: _____ Sex: _____ Date: _____

Height: _____ Weight: _____

PRESENT HEALTH CONCERNS

Please list your most significant reasons for seeking naturopathic medical care, including diagnoses of any health conditions:

- | |
|----|
| 1. |
| 2. |
| 3. |

Is your health currently getting better, worse, or staying the same? _____

Please list medications that you are currently taking, with dosages:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Please list all supplements that you are currently taking (including brand name) with dosages:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Please list any severe or life-threatening allergies: _____

Explain: _____

Please list any other allergies/sensitivities (foods, chemicals, animals, dust/mold)

PERSONAL MEDICAL HISTORY

How was your health as a child? (*circle one*): excellent good fair poor

Date of last physical/annual exam _____ Date of last blood tests: _____

What is your blood type? (*circle one*): A B AB O unsure

Serious Illnesses/Injuries/Surgeries	Date	Outcome
1.		
2.		
3.		
4.		
5.		

Conditions: Check () conditions you currently have or have had in the past:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Intestinal disorder | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Candidiasis | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Chemical Sensitivity | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Lung problems | |

FAMILY MEDICAL HISTORY

Do any of your relatives (parent, grandparent, sibling, child) have (or have had) any of the conditions listed above? If yes, please list below:

Condition:	Relative(s):

LIFESTYLE

Do you drink coffee? yes no How many cups per day? _____

Do you drink tea? yes no How many cups per day? _____ Type? _____

Do you drink soda? yes no How many glasses/cans per day? _____

Do you drink alcohol? yes no How many drinks per week? _____ Type? _____

Do you smoke tobacco? yes no past # Packs per day? _____ How many years? _____

How often do you have a sugary snack/dessert? _____times per day OR _____times per week

How much water do you drink per day? _____

Are you satisfied with your current diet? yes no Are you satisfied with you current weight? yes no

Do you have any dietary restrictions (e.g. vegetarian, low salt, high protein)? yes _____ no

What percent of your food do you/your spouse prepare yourself? _____

Typical Daily Diet: Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Please list the most significant sources of stress in your life and indicate whether they were past events or are current situations: _____

Do you have difficulty relaxing? yes no Do you make time to relax each day? yes no

Do you get enough sleep? yes no How many hours per night? _____ Do you wake rested? yes no

Do you enjoy your work? yes no How many hours per week do you work? _____

Does your WORK environment have a supportive effect on your health? yes no

Does your HOME environment have a supportive effect on your health? yes no

Are you satisfied with your relationships?: spouse/partner yes no family yes no

co-workers yes no social contacts yes no spiritual connection yes no

Do you feel safe at home? yes no Do you feel that others in your house are safe? yes no

How is your emotional health? (*circle one*): excellent good fair poor varies

Are you currently involved in psychotherapy or counseling? yes no

Do you feel you have a good support network? yes no

Thank you for taking the time to complete this confidential health questionnaire. We will review this sheet as part of your office visit.