ROCKY MOUNTAIN
Natural Medicine

Welcome! We're so glad you're here and honored to support you on your journey to better health.

Our team of licensed Naturopathic Doctors specializes in natural, preventive, and personalized care. Your first step is completing this intake form, which helps us understand your health history, goals, and current concerns.

This information allows us to deliver individualized care as unique as you are. **If you need help with these forms please call us at 970-237-1062.**

To help us prepare for your visit:

- Please fill out all forms completely and **submit them at least 24 hours before your appointment. Failure to do so will result in your appointment being rescheduled.**

- **If applicable, please have your last 2 years of labs ready for us to review**
  - ➢ You can bring hard copies into the clinic before or at the time of your appointment.
  - ➢ You can upload and share them in our patient portal. To do this you will click on documents, upload the labs and then be sure to click the **share** button. Please note; if you are pulling labs from another portal, you will have to download them first, then follow the above prompts within our portal.
  - ➢ You can email them to reception@rockymountain-naturalmedicine.com

We look forward to working together toward better health.

Warmly,

Drs. Holly German, Sarah Kashdan, Jason Barker, and Lorraine Caron

Financial & Cancellation Policy Agreement

Thank you for choosing **Rocky Mountain Natural Medicine**. We are committed to providing you with exceptional care. Please review our financial and cancellation policies below. Your acknowledgment is required to keep your appointment.

💳 Financial Policy

- Payment is due at the time of service. We accept cash, checks, and major credit cards.
- A credit card is securely collected and stored when scheduling your initial visit.
- We reserve the right to charge your card on file for:
    - Phone/TeleHealth appointments
    - Missed appointments or late cancellations

- Our services are not covered by insurance in Colorado. You are responsible for all charges.
- We can provide applicable codes if you wish to submit a claim to your insurer.
- You may try to use a Health Savings Account (HSA) for some prescribed supplements.
- After 2 years of no appointments, you are then moved to “inactive” patient status and will need to repeat your new patient visit to become active again.

Service Fees (estimates):

- New Teen/Adult Patient Visit: $385
- New Patient Pediatric Visit: $285-$385
- Initial Well Child Visit: $250
- Follow-Up Naturopathic Visits: $99- $210 (based on length of time + complexity)
- New Acupuncture Patient: $175
- Acupuncture Follow-Up: $90
- B12 shot $30
- Cupping/Gua Sha $45-60

Lab Testing Estimates (discussed during your visit):

- Hormone Profiles: $250–$600

- Food Intolerance Tests: $275–$375
- GI Testing: $310–$555
- Bloodwork Panels: $75-350
- Many other functional labs we have access to will fall within these same fee ranges

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🕑 **Cancellation & Missed Appointment Policy**

New Patients:

- A $200 deposit is required at booking a new naturopathic visit, it will be applied to your visit
- A $100 deposit is required at booking a new acupuncture visit, it will be applied to your visit.
- 48-hour cancellation notice is required for all new patient visits
- Late cancellations, no shows or a late reschedule (less than 48 hours) will result in forfeiture of the deposit
- Intake forms must be completed at least 24 hours prior to your appointment. If not, your appointment will be rescheduled.

Returning Patients:

- A 24-hour cancellation notice is required.
- Same-day cancellations or no shows will be charged a $100 fee to the card on file.

☐ I have read the cancellation and financial policies above and I understand and agree with these policies

Patient Name (print): _____

Patient or Representative Signature:
_____ **Date:** _____

If signed by someone other than the patient:
Name of Legal Representative: _____
Relationship to Patient: _____

Consent to Naturopathic Care, Notice of Privacy Practices, and Required Disclosures

This document provides information about our services and policies, outlines your rights, and obtains your consent to care. Please read thoroughly and ask any questions before signing.

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1. CONSENT FOR TREATMENT

I voluntarily consent to receive care from the naturopathic doctors at RMNM. This care may include physical exams, diagnostic lab testing, nutrition and lifestyle counseling, botanical or nutritional supplements, and manual therapies as indicated. I understand that the scope of naturopathic medicine is individualized and emphasizes prevention and the support of the body's natural healing ability.

I understand that no guarantees or promises of cure or specific results have been made.

If the patient is a minor, I confirm that I am the parent or legal guardian and authorize the naturopathic doctors at RMNM to evaluate and treat my child. I understand that treatment recommendations may include the same types of services listed above, tailored appropriately for a minor, and that I may be asked to provide additional consent for specific therapies.

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2. SCOPE OF SERVICES

Naturopathic Medicine is a distinct branch of the healing arts that includes:

- Prevention, diagnosis, and treatment of conditions using non-pharmaceutical approaches
- Nutrition and lifestyle recommendations
- Botanical medicine and natural health products
- Manual therapies (soft tissue techniques, mobilizations)
- Evaluation of laboratory results and functional lab testing

RMNM's Naturopathic Doctors (NDs) are registered in the state of Colorado under the Colorado Naturopathic Doctor Act. They are not licensed Medical Doctors (MD), Doctors of Osteopathy (DO), Chiropractors (DC), or Nurse Practitioners (NP), and do not prescribe or administer controlled substances, perform surgery, or use ionizing radiation.

At this time, RMNM does not provide naturopathic care for children under 2 years old. We recommend that all pediatric patients maintain care with a licensed pediatric provider and follow the CDC's recommended vaccination schedule.

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3. RISKS

I understand that while naturopathic medicine is generally considered safe, it may involve some risks. These may include, but are not limited to:

- Allergic reactions to herbs, supplements, or treatments
- Side effects such as digestive upset, skin irritation, fatigue, or discomfort
- Temporary worsening of symptoms
- Changes in mood or energy
- Physical risks such as bruising or soreness after manual therapy, injections, or acupuncture
- In rare cases, serious adverse effects (e.g., pneumothorax with manual treatment or acupuncture)

I also understand that some naturopathic interventions may interact with prescription medications, and that naturopathic care may not be appropriate during certain phases of pregnancy or for specific medical conditions.

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4. ALTERNATIVES AND COLLABORATION

I understand that alternatives to naturopathic care include:

- Choosing not to pursue any treatment
- Receiving care from licensed conventional providers, such as MDs or DOs
- Exploring other licensed healthcare modalities

I acknowledge that naturopathic care is not a substitute for conventional medical treatment. I am encouraged to maintain a relationship with a primary care physician or specialist, and to seek immediate medical attention for urgent or emergency conditions. I may also authorize RMNM to collaborate with my other providers upon request.

Optional: Provider(s) you would like us to collaborate with:
Name: _____ **Phone**: _____

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5. EMERGENCIES

RMNM is not a primary care or urgent care clinic and does not provide 24-hour or emergency care.
If you are experiencing a medical emergency, **call 911 or go to the nearest emergency room**.

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6. NO GUARANTEE

I understand that every individual responds differently to treatment. I acknowledge that no outcome can be guaranteed, and that naturopathic care may or may not improve my condition.

PATIENT ACKNOWLEDGMENT

By signing below, I confirm that:

- I have read and understood the information above
- I have had the opportunity to ask questions and receive answers
- I understand the nature, scope, and risks of naturopathic care
- I consent to treatment with the providers at Rocky Mountain Natural Medicine

Patient Name (print): _____

Patient or Representative Signature:
_____ Date: _____

If signed by someone other than the patient:
Name of Legal Representative: _____
Relationship to Patient: _____

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1. PRIVACY PRACTICES (HIPAA NOTICE)

I have been provided access to Rocky Mountain Natural Medicine's **Notice of Privacy Practices**, which describes how my protected health information (PHI) may be used and disclosed, and how I can access this information. I understand:

- I may request a paper or electronic copy of the notice at any time.
- I have the right to request limits on the use or disclosure of my PHI.
- RMNM may share my PHI for treatment, billing, clinic operations, or when required by law.
- RMNM is committed to maintaining the confidentiality and security of my health records and will notify me if a breach of my PHI occurs.

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2. COLORADO SURPRISE/BALANCE BILLING DISCLOSURE

I acknowledge that:

- Rocky Mountain Natural Medicine is **an out-of-network provider** and does not bill or contract with any insurance plans.
- I am responsible for the full cost of services rendered at this facility.
- Under Colorado law, I am protected from "surprise billing" for emergency services or services received unintentionally from out-of-network providers at in-network facilities. These protections do not apply to nonemergency, elective care at RMNM, where services are intentionally sought out-of-network.

I understand that I have the right to receive care from an in-network provider and am under no obligation to receive services at RMNM.

PATIENT ACKNOWLEDGMENT & CONSENT

By signing below, I confirm the following:

- I have read and understood this document in full.
- I consent to receive naturopathic medical care from RMNM.
- I acknowledge receipt of the Notice of Privacy Practices and Colorado Surprise Billing Disclosure (these are on our website, in your patient portal, and available in hard copy form at our front desk)

- I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

Patient Name (print): _____

Patient/Representative Signature: _____
Date: _____

☐ I acknowledge receipt of the HIPAA Notice of Privacy Practices
☐ I acknowledge receipt of the Colorado Surprise Billing Disclosure

If signed by someone other than the patient:
Name of Guardian or Legal Representative: _____
Relationship to Patient: _____

Pediatric New Patient Health History

Thank you for taking the time to fill out this form as completely as possible before your visit.

Patient's name: _____ Date: _____

Age: _____ Date of birth: _____ Gender: _____

Address:

_____

City: _____ State:_____ Zip: _____

Parent/Guardian 1 name: _____
Occupation:_____

Telephone (home):_____

(parent's cell):_____

Parent's e-mail
address:_____

Parent, how would you prefer to be contacted? home cell text email

May we leave a message? home cell text email

Parent/Guardian 2 name: _____
Occupation:_____

Telephone (home):_____

(parent's cell):_____

Parent's e-mail
address:_____

Parent, how would you prefer to be contacted? home cell text email

May we leave a message? home cell text email

With whom does the child live?

_____

Emergency contact:_____
Phone:_____

Relationship to child:_____

Child's school/daycare:

_____

Name of current pediatrician:

_____

Pediatrician's contact information:

_____

When was your child's last visit to the doctor's office? What was the reason?

_____

Is your child under the care of a medical specialist? If yes, please explain.

_____

Is your child currently under the care of any other health practitioners?

_____

Has your child seen a naturopathic doctor before? _____ When? _____

May we thank someone for referring you?

_____

What are your child's most important health concerns?

1)

_____

2)

_____

3)

_____

4)

_____

What are your goals pertaining to your child's health, both short- and long-term?

_____

_____

_____

_____

Allergies

Is your child allergic or hypersensitive to any medications, foods, or environmental or chemical agents?

_____

Hospitalizations/surgeries/special tests

Please list any surgical procedures, hospitalizations, X-Rays, CAT scans, MRIs, EKGs, EEGs, hearing tests, vision tests, speech/language tests, psychological evaluations, or other evaluations your child has had:

_____

_____

Current medications

Please list any *prescription medications, over-the-counter medications, vitamins, herbs, or other supplements* your child takes:

_____

_____

Immunizations

MMR _____ DPT/Dtap _____ Varicella _____ Hib_____ Hep B _____

Hep A_____ Tetanus _____ Polio _____ RSV_____ Rotavirus_____

Pneumococcal_____ Meningococcal_____ COVID_____ Other _____

Up to date on vaccine schedule? Yes / No Adverse reactions? Yes / No

Family History (please circle any that apply)

Alcoholism Allergies Anemia Arthritis Asthma Autism/ADHD

Cancer Congenital Disorders Diabetes Eczema Epilepsy Heart disease

Hearing loss Hypertension Hypoglycemia Mental health Psoriasis Stroke

Thyroid disorder Other:

_____

Child's Health History (please check any that apply)

NOW	PAST		NOW	PAST	
☐	☐	Acne	☐	☐	Frequent illness
☐	☐	Allergies	☐	☐	Frequent headaches
☐	☐	Anemia	☐	☐	Frequent urination
☐	☐	Asthma	☐	☐	Hair loss
☐	☐	Bedwetting	☐	☐	Hearing loss
☐	☐	Bleeding gums	☐	☐	Heart murmur
☐	☐	Chicken pox	☐	☐	High fever
☐	☐	Chronic rashes	☐	☐	Hives
☐	☐	Cough	☐	☐	Hyperactivity
☐	☐	Colic	☐	☐	Infectious illness
☐	☐	Congenital disorder	☐	☐	Jaundice
☐	☐	Constipation	☐	☐	Joint pain
☐	☐	Cough/Wheeze	☐	☐	Learning difficulties
☐	☐	Cradle cap	☐	☐	Moodiness
☐	☐	Croup	☐	☐	Nightmares
☐	☐	Depression	☐	☐	Nosebleeds
☐	☐	Diarrhea	☐	☐	Sleep difficulties
☐	☐	Dizzy spells	☐	☐	Stomachaches

⬜	⬜	Earaches		⬜	⬜	Stuffy nose	
⬜	⬜	Ear infections		⬜	⬜	Thrush	
⬜	⬜	Easy bruising		⬜	⬜	Tonsils enlarged	
⬜	⬜	Eczema		⬜	⬜	Urinary tract infections	
⬜	⬜	Epilepsy/Seizures		⬜	⬜	Vomiting Spells	
⬜	⬜	Fatigue		⬜	⬜	Other _____	
⬜	⬜	Flat feet		⬜	⬜	Other _____	

Prenatal/Birth/Feeding History

Birthing person's health during the pregnancy with this child:

Age at child's birth: _____ Trauma/injury _____ Alcohol _____ Bleeding _____

Stress _____ Recreational drugs_____ Nausea _____ Smoking_____

High blood pressure _____ Illness _____ X-rays _____ Diabetes _____

Toxemia _____ Medications _____ Thyroid problems _____

Other _____

TERM: Full _____ Premature _____ Late _____

Birth weight: _____ Length of labor: _____

Was birth: Easy _____ Moderate _____ Difficult _____

Any complications? _____

Place of birth: Hospital _____ Home _____ Clinic _____ Other _____

FEEDING: Breast fed? _____ How long? _____

Formula? _____ How long? _____

What kind? _____

Age solid foods introduced: _____

Favorite foods: _____

Food intolerances: _____

Please describe your child's typical daily diet

breakfast:

_____

lunch:

_____

dinner:

_____

snacks:

_____

drinks:

_____

Developmental / School Concerns

Developmental concerns (sitting, walking, talking):

_____

School difficulties (learning, attention):

_____

Safety

Is there any old / peeling paint inside or outside the home?

_____

Is your child exposed to any toxic chemical in your home or at your work?

_____

Is there a working fire alarm on each floor of your house?

_____

Are there any firearms in your home?

_____

If so, are they securely locked? _____

Is your child always buckled into a securely fastened car seat or seat belt while riding in a car?

_____

Does your child wear a helmet while bike riding, skateboarding, skiing, etc?

_____

Are there any smokers in the home or childcare setting?

_____

Please list the names, ages, and any health problems of the child's siblings

_____

_____

_____

Please include any other information about your child that you would like to share

_____

_____

_____

_____