Heidi Peterson, ND
7005 NE Glisan St, Suite A
Portland, OR 97213
Tel: 503-546-7663 ~ Fax: 503-505-7672
Website: doctorheidi.com

CONSULTATION - INFORMATION FORM

Name_____ Age:_____ Date of Birth: _____

Gender: _____ Email Address: _____

Address:_____ City:_____ State:_____

Contact Phone: _____ Zip Code:_____

PARAMETERS FOR DISTANCE CONSULTATIONS: **Policies & Procedures**

By law Dr. Peterson may not diagnose or treat your condition without seeing you in person first. Specifically, she cannot order tests or prescriptions for you, diagnose you or be your doctor. Your primary care physician and/or other doctors should always be regarded as a primary source of information about diagnosis, treatment, prescriptions drugs, and medical conditions.

You agree to the following:
I have solicited Dr. Peterson for an educational consultation.

The information Dr. Peterson discusses is not medical advice, and should not be treated as such. The information provided is for informational, educational and entertainment purposes only. The information discussed is in no way intended to supplant the information provided by one's doctor(s).
I understand that no portion of any consultation is to be interpreted as diagnosis or treatment of anyone for anything.

_____(Please initial)

COMMUNICATION WITH DR. PETERSON:
You will be given access to a ***patient portal through Elation Passport*** which is HIPAA compliant. Please do not send regular emails. All requests, except for appointment requests, should go through this portal. Please contact Audra at the office for appointments.

APPOINTMENT REMINDERS AND CANCELLATION POLICY:
Appointment reminders are sent via email or text 2 days before your appointment from the Elation scheduling system. We do not give phone call reminders. Appointments missed or canceled in less that 48 hours prior to their scheduled time will incur a $75 fee. Last minute cancellations of scheduled appointments are difficult to fill and costly. **I ask that cancellations be made at least 48 hours before your appointment- not including weekends.** Exceptions to this policy may be made for emergency situations on a case by case basis.

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DISTANCE CONSULTATION PAYMENT:

The cost is $300 per consultation. Each appointment is scheduled for an hour.
Payment must be made in full prior to your consultation.
Insurance cannot be billed for these appointments. Please contact Audra at the office for payment arrangements.

RETURNED CHECK FEE:
Returned checks will incur a fee of **$45.00**.

I have read and understand ALL of the above policies. I agree to accept full responsibility for payment of services prior to the scheduled appointment.

Dr. Peterson is not:

- diagnosing or treating any disease or condition that I may have
- managing my health care
- providing medical services to me
- acting as my doctor and we have not entered into a doctor-patient relationship

_____ _____
Signature Date

_____
Printed Name

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CONSULTATION - INTAKE FORM

Name_____ D.O.B._____

What Expectations do you have for this consultation?_____

_____

_____

What are your major health concerns in order of importance?_____

_____

_____

_____

Date of last Physical Exam:_____ Date of last Dental Exam:_____

List any medications, over the counter drugs, vitamins, or other supplements you are taking.
Feel free to use an additional page_____

_____

_____

_____

List any allergies to drugs, foods or chemicals_____

_____

_____

List any medical problems that you have had in the past.
Have you ever been hospitalized or had surgery? If so, when and why?

_____

_____

_____

_____

_____

DIET:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Number of alcoholic beverage consumed per week?_____

Do you smoke or use illicit drugs? Y N

SLEEP: Hours of sleep per night?_____ Do you wake rested? Y N

EXERCISE: Hours spent in physical activity per week?_____

Type of exercise:_____

HOBBIES?_____

TOXICITY EXPOSURE: Number of crowns and fillings?_____ How many mercury (silver)?_____

Have you ever lived near or worked in agriculture or major industry? Y N

Any known exposures?_____

Please print name:_____

Signature:_____ Date:_____