Inside Passage Natural Medicine
Debbie Gillespie ND, CDM
Doctor of Naturopathic Medicine

853 Basin Road
Juneau, AK 99801
phone: (907) 463-2600
fax: (907) 463-2675

Client Registration

Date: _____ Social Security Number: _____
Name: First _____ Middle. _____ Last: _____
Address: _____ City: _____ Zip: _____
Mailing Address: _____
Home Phone: _____ Cell/other phone: _____
Birth date: _____ Marital Status: _____ email: _____
Employer: _____ Occupation _____
Work Status: Full ___ Part time___ Retired___ Student____
Spouse/Partner's Name: _____ Occupation: _____
Emergency Contact: _____ Phone: _____

Responsible Party (Primary Insurance Holder. If same as above leave blank)
First Name: _____ M.I.___ Last Name: _____
Address: _____
Home Phone: _____ Birth date: _____ Marital Status: S M D W
Social Security Number: _____ Employer: _____
Occupation: _____
Work Status: Full___ Part time___ Retired____ Student___

Payment and Insurance Information

Primary Insurance: _____
Address: _____
Phone Number: _____
ID#: _____ Group Name: _____ Group #: _____
Policy Holder: _____ Birth date: _____ Relation: _____

Other Insurance: _____
Address: _____
Phone number: _____
ID#: _____ Group Name: _____ Group #: _____
Policy Holder: _____ Birth date: _____ Relation: _____

Assignment of Benefits, Release of Information & Payment Agreement

I understand that Inside Passage Midwifery and Natural Medicine will be filing my insurance on my behalf. I agree to have the benefits from my insurance assigned to Inside Passage.

I permit Inside Passage to release any information deemed necessary to any insurance or third party, within the guidelines of HIPAA (Health Insurance Portability & Accountability Act)

I agree that I am responsible for full payment on this account. I agree if 60 days pass without payment or discussion of a payment plan, my account will be sent to collections and I will be responsible for the outstanding balance and any fees incurred in the collections process.

Client signature: _____ Date: _____

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INSURANCE AND FINANCIAL INFORMATION

I understand and agree that health and accident insurance are an arrangement between an insurance company and me. I hereby authorize Debbie Gillespie ND to furnish medical information to my insurance carriers concerning this condition. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

As a courtesy, we will bill your insurance company for you. Any amount not covered by your plan will be billed to you monthly. Vitamins and other supplements are not typically covered by insurance. If this naturopathic doctor recommends supplements as part of the treatment plan, you will be responsible for those costs should you choose to purchase them from Inside Passage or elsewhere.

In accordance with State of Alaska Naturopathic Regulations (12 AAC 42.900) please be advised that Deborah Gillespie is a Naturopath licensed by the state of Alaska. She earned her degree at Southwest College of Naturopathic Medicine and Health Sciences, which is accredited by the Council on Naturopathic Medical Education, the accrediting agency for naturopathic colleges and programs in the United States and Canada. She is not covered by malpractice insurance at this time.

Please also be advised that in addition to her Naturopathic practice, Dr. Gillespie is also a midwife. There is a possibility your appointments may need to be rescheduled in event of a labor/birth. Every effort will be made to reach you with as much notice as possible should the situation arise.

If you are unable to make your scheduled appointment, please call to cancel within 24 hours or as soon as possible.

By signing below, I have read and understand this policy.

Signature: _____ Date: _____

Printed Name: _____

Parent or Guardian signature: _____

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Colon Hydrotherapy Intake Form

Name: _____ **Date**: _____

Have you ever had colon hydrotherapy treatment before? _____

Please state your reasons for and expectations from receiving colon hydrotherapy:

_____
_____
_____
_____

Are you currently under a doctor's care? _____ If yes please explain below:

_____
_____

Have you ever been treated for any of the following conditions? (check all that apply)

	Rectal Bleeding		Cancer		Appendicitis
	Low Blood Pressure		Ileitis		IBS
	Abdominal Surgery		Crohn's Disease		Ulcerative Colitis
	Leaky Gut Syndrome		Severe Anemia		Diverticulitis
	Renal Insufficiency		High Blood Pressure		Colitis
	Fissures/Fistulas		Cardiac Disease		GI hemorrhage/perf.
	Cirrhosis		Abdominal Hernia		Aneurysm
	Hepatitis		HIV		AIDS

Are you currently pregnant? _____

Please list all prescription medications you are currently taking:

_____
_____

Please list all vitamins or supplements you are currently taking:

_____
_____
_____

Please list all known allergies or sensitivities:

_____
_____

Please list all surgeries and dates:

_____
_____

Please list any digestive issues or complaints:

_____

_____

_____

How often do you have a bowel movement? _____

Yes **No**

__ __ Do you suffer from constipation? For how long? _____

__ __ Do you suffer from diarrhea?

__ __ Do you suffer from hemorrhoids?

__ __ Have you ever had hemorrhoids surgically corrected?

__ __ Do you take laxatives? What type? _____

__ __ Do you exercise? If yes, describe: _____

Please describe your dietary intake: (vegetarian, vegan, gluten free, dairy free, paleo, etc)

_____

_____

On a scale from 1 to 5, what best describes your usual daily stress level?

1 2 3 4 5

Are circumstances in your life increasing your usual stress level?

_____

_____

_____

Is there any other information you think I should know?

_____

_____

_____

I understand that I am having Colon Hydrotherapy at my own risk and that Inside Passage Midwifery & Natural Medicine, LLC assumes no liability of any kind. I have been truthful answering all of the above statements and am solely responsible for such.

Signature: _____ Date: _____

Name: _____