600 East State St. Ste 200
Eagle, ID
83616
P: (208) 939-6748
F: (208) 938-5524
Contact@healinghutclinic.com

WELCOME TO THE HEALING HUT!

We look forward to being a part of your journey to optimal health. It is our desire to provide you quality service and opportunities to enjoy wellness. Please read the following so you understand our policies and financial agreements.

Our Office Hours are Monday-Friday 9:00 AM – 4:00 PM
Each of our practitioners have different hours in which they treat patients. You can view this schedule online at www.healinghutclinic.com

Your First Visit (1 HR):

- Attached is the Intake Form. Please complete and bring it to your upcoming visit.
- Please bring all **supplements/medications you currently take and any labs done in the last year**. Please bring them in their original bottles.
- Please arrive to your appointment on time. If you happen to be more than 15 minutes late or do not show up for your appt, we will reschedule your appointment and charge you $100 for a missed appointment.

Clinic Policies:

- Many of our patients are sensitive to fragrances, in respect to them, we are a **fragrance free clinic**.
- Be mindful of noise levels in the clinic – we aim to provide a relaxing environment for those receiving treatment in the clinic.
- Out of respect for fellow patients and our staff please make phone calls outside.

Financial Policy and Costs:
Payment is expected at time of visit.

- Payment options are: cash, check, credit cards, and health savings cards.
- All sales are final. If an herb or supplement bottle has not been opened, we will offer a reimbursement.
- We do not take insurance. We can provide you with a Superbill to send to your insurance company for reimbursement depending on the service/lab. This is not a guarantee that your insurance will reimburse you. Note: Some services/labs can not be covered with a superbill.

Cancellation/Rescheduling Policy
Out of respect for other patients trying to schedule, we request that patients contact us if you need to cancel or reschedule an appointment with at least **24 BUSINESS hours notice**. Please be advised that Saturdays and Sundays are NOT business hours. A missed appointment **charge of $50** will be processed for no shows and cancelled/rescheduled appointments without at least 24 BUSINESS hour notice.

I have read and agree to the above information.

Patient Name (print) _____
Date:_____

Patient or Guardian Signature
_____

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PATIENT HEALTH HISTORY

All questions in this questionnaire are strictly confidential and will become part of your medical record.

Last Name:_____ First Name:_____ Middle Name:_____
Preferred Name:_____ SS#:_____-_____-_____
Date of Birth (required): ___/___/____ Gender:_____
Address:_____
Unit #:_____ City:_____ State:_____ Zip:_____ Email:_____
Would you like to receive our newsletter? (select one):☐ Yes or☐ No
Phone
Appointment reminders will be sent to 1st preference
1☐ Home☐ Work☐ Cell (___) _____ 2☐ Home☐ Work☐ Cell (___) _____
Confidential voicemails OK? ☐Yes or ☐No

Emergency Contact

Name: _____ Phone:_____
Relationship:_____

Who referred you or how did you hear about The Healing Hut? _____

WHAT IS YOUR MAIN REASON FOR COMING TO THE CLINIC TODAY?
PERSONAL HEALTH HISTORY
List all ongoing medical problems:

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HOLISTIC PRIMARY CARE

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Surgeries and/or Hospitalizations		
Year	Reason	Hospital

Please list any imaging or diagnostic tests you have had *in the past 2 years* (chest x-ray, EKG, colonoscopy, bone density scan, etc.)			
Year	Test	Year	Test

Do you currently see any other physicians (MD, ND, DO, DC, etc.)? Please list, and indicate your primary care doctor (if any).

List your prescribed drugs, over-the-counter drugs, and natural medications (vitamins, herbs, etc.). Attach additional list if needed.		
Name the Drug	Strength	Frequency Taken

Allergies to Medications	
Name the Drug	Reaction You Had

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain. **Attach any additional information if necessary.**

☐ Skin	☐ Chest/Heart	*Recent changes in:*
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Stomach/Upper Digestion	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel/Lower Digestion	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

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Exercise	Do you exercise regularly?			☐ Yes	☐ No
	How often and for how long?				
	What do you do for exercise?				
Height and Weight	Height:	Weight:			
	Weight 1 year ago:				
	Maximum weight:	When were you at your maximum weight?:			
Diet: *List all food consumed in the past 24 hours*	Breakfast:				
	Lunch:				
	Dinner:				
	Snacks:				
	Beverages (including water):				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	How many drinks per week?				
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day:	☐ Chew - #/day:	☐ Pipe - #/day:	☐ Cigars - #/day:	
	☐ # of years	☐ Or year quit:	If you use tobacco, are you interested in quitting?	☐ Yes	☐ No
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS	AGE AT DEATH	CAUSE OF DEATH
Parents and Grandparents				
Father				
GrandMOTHER *Paternal*				
GrandFATHER *Paternal*				
Mother				
GrandMOTHER *Maternal*				
GrandFATHER *Maternal*				
Siblings				
☐ M ☐ F				
☐ M ☐ F				
☐ M ☐ F				
☐ M ☐ F				
Children				
☐ M ☐ F				
☐ M ☐ F				
☐ M ☐ F				
☐ M ☐ F				

If you are seeking adjunctive cancer support, please provide the following information about your Oncologists Name:_____ _____ Phone: (____) _____

Date of last physical: _____/_____/_____ Date of last bloodwork: _____/_____/_____

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Consent to treat and right of refusal

General Consent to Treatment: Having come to ___The Healing Hut___ for evaluation or treatment, I (or my authorized representative on my behalf) hereby consent to and authorize _____ and other staff members involved in my care to administer such diagnostic procedures, treatment or both as they may consider advisable to maintain my health and to assess and to evaluate and treat my injury or illness. I understand that the provider responsible for my care has the responsibility to explain to me the purpose, the benefits and the most common risks involved in the diagnosis and treatment of my illness or injury, as well as alternative available courses or treatment, and I understand that I have the right to refuse any suggested examination, test or treatment.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

Print Name _____ Date _____

Patient Signature or Legal Representative _____

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MANDATORY INFORMED CONSENT FORM FOR VENIPUNCTURE

PROCEDURES

The procedure involves placing a needle in a vein in your arm or hand to take blood and will require no more than a few minutes if properly hydrated.

RISKS

Occasionally there are minor complications, and you may experience bruising, swelling, black and blue marks, fainting and/or infection at the site.

CONFIDENTIALITY

Test results and specimens collected will be confidential.

PAYMENT RESPONSIBILITY

I understand that in house, there is a $20 blood drawing fee, along with lab fees, due at the time of the blood draw. You will be given a copy of this consent form upon request.
We do not bill insurance for labs. We can provide you with a Superbill to send to your insurance company for reimbursement. This is not a guarantee that your insurance will reimburse you.

By signing below, you consent to participate in the procedure described above.

Print Name _____ Date _____

Patient Signature or Legal Representative _____

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HIPAA Compliance Patient Consent Form

Our notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of information but the practice does not have to agree with those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? Yes No

May we leave a message on your answering machine at home or on your cell phone? Yes No

May we discuss your medical condition with any member of your family? Yes No

Print Name _____ Date _____

Patient Signature or Legal Representative _____

Official Use Only:

_____ _____ _____
Signature Title Date