Are you ready for a new way to look at your health and your life? Are you ready for a refreshing paradigm that treats you and does not simply aim to change your symptoms? Well then welcome to Ancient Traditions Natural Medicine, LLC, a medical practice incorporating Naturopathic medicine, Classical Chinese medicine and Acupuncture.

Naturopathic medicine is based on a philosophy that incorporates six vital concepts.

1.) The Healing Power of Nature
2.) First Do No Harm
3.) Identify and Treat the Cause
4.) Doctor as Teacher
5.) Prevention
6.) Treat the Whole Person

I am trained in multiple disciplines. As a Naturopathic physician, I incorporate a multitude of disciplines including nutrition, homeopathy, biotherapeutic drainage, flower essences, lifestyle counseling, botanical medicine, physiotherapy, physical medicine and stress management. As a Classical Chinese medicine practitioner and 5-Elements Acupuncture practitioner, I have been trained in an ancient form of medicine that utilizes acupuncture, moxibustion, Chinese herbs and medical Qi Gong. These many tools are added to my nineteen years of experience in deep tissue massage, injury rehabilitation and pain management along with my many years of dedication to my own healing.

Working from a different paradigm of health than many other physicians, I believe that optimal health is not simply the absence of disease but is instead the experience of thriving in life on numerous levels. These forms of healing are typically not "quick fix" medicine but instead include a journey into one's lifestyle, goals and challenges that takes time and dedication. I would be honored to work with you in your pursuit of health and wellness.

An initial visit lasts approximately 60 minutes. Follow-up visits will vary in length, depending on the complexity of the issues. Because I am a practitioner of many healing arts, I include many modalities in my assessment and treatments.

Attached is a copy of my Fee Schedule with this letter. In New Hampshire, a bill to cover Naturopathic medicine is currently in the legislature. Acupuncture is covered by some plans. While I am not a provider for any specific insurance plans, I am willing to bill some insurance companies with pre-approval. Please check with your policy regarding requirements, as you are ultimately responsible for reimbursement.

I thank you for your interest in health and wellness and look forward to working with you.

Yours in Health,
Dr. Angela

Dr. Angela P. Lambert, ND, MSOM, L.Ac
Naturopathic Physician
Masters of Science in Oriental Medicine
Licensed Acupuncturist

Ancient Traditions
natural medicine

Welcome to A Ancient Traditions Natural Medicine, LLC, the office of Dr. Angela P. Lambert. In order to provide you with the best possible care, I ask you to complete the entire form. Please provide me with all possible information regarding your health so that we may form a successful and long-term working relationship.

Thank you and I look forward to working with you.
Dr. Angela P. Lambert, ND, L.Ac.

Child Health History Intake (0-12 years)

Name: _____ Age: _____ Date: _____

Date of Birth: _____ Birth Weight: _____ Sex: _____

Parent's Name: _____ Parent's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (home): _____ (work): _____ (cell): _____

How did you hear about me? _____

Health History Questionnaire

What are your child's **most important health problems**? List as many as you can in order of importance.

1.) _____

2.) _____

3.) _____

4.) _____

What have you done for the above mentioned problems (not applicable for a well-child visit)?

_____

_____

Does your child have any contagious diseases at this time? Yes ◯ No ●

If yes, what? _____

Birth History

List any major patterns of illness present in the child's birth mother, father or families:

_____

_____

Did the mother receive prenatal care? Yes: ◯ No: ● Prenatal Vitamins: Yes: ◯ No: ◯

Medication: Yes: ◯ No: ◯

Did the mother smoke cigarettes? Yes: ◯ No: ◯ Drink Alcohol? Yes: ◯ No: ◯

Illicit Drugs? Yes: ◯ No: ◯ If yes, what type? _____

Any previous pregnancies not carried to term? Yes: ◯ No: ◯ How many?_____ When?_____

Any difficulties with pregnancy? (nausea, vomiting, bleeding etc): _____

_____

_____

Type of birth (eg. home, hospital, c-section): _____ Carried to term? Yes: ◯ No: ◯

If not, how premature?_____ Complications of labor or delivery: _____

Please list any prescription medications, over the counter medications, vitamins or other supplements your child is taking.

1.)_____ 2.)_____

3.)_____ 4.)_____

5.)_____ 6.)_____

Allergies

Is your child hypersensitive or allergic to:

Any medications?_____

Any foods?_____

Any environments/ pets? _____

Breast Fed? Yes: ◯ No: ◯ How long?_____

Formula Fed? Yes: ◯ No: ◯ How long?_____ Type:_____

Age solid food was introduced:_____

Habits

Main interests and hobbies: _____

Day-care ☐ School ☐ Home School ☐ Grade Level:_____

Does your child watch TV? Yes: ☐ No: ◯ How many hours per day? _____

Does your child read? Yes: ◯ No: ◯ How many hours per day? _____

Does your child play video games? Yes: ◯ No: ◯ How many hours per day? _____

Does your child play sports? Yes: ◯ No: ◯ How many hours per week?_____

Are there any pets in the home? Yes: ◯ No: ◯ What kind?_____

Anyone in the home smoke? Yes: ◯ No: ◯

Social History

Whom does the child live with?_____ Are the parents divorced/ separated? Yes: ◯ No: ◯

If so, what are the arrangements made with the other parent (eg. visitation etc.)?_____

_____

List the age and gender of siblings. Indicate half, step or deceased as applicable.

1.)_____ 2.)_____

3.)_____ 4.)_____

5.)_____ 6.)_____

Previous Illnesses

Describe difficulties during infancy (colic, skin, lung problems etc):_____

_____

Has your child had any of the following:

Rheumatic Fever Yes: ◯ No: ◯ German Measles Yes: ◯ No: ◯

Chicken Pox Yes: ◯ No: ◯ Measles Yes: ◯ No: ◯

How often does your child get the following:

N – Never O – Occasionally F – Frequently C – Constantly

Sore Throat:_____ Colds:_____ Earaches:_____ Coughs:_____

Diarrhea:_____ Constipation:_____ Abdominal Aches:_____

Other (Please explain):_____

Has your child had any of the following? When? Where?

Electroencephalogram?_____

Psychological Evaluation?_____

Hearing Test?_____

Speech/ Language Test?_____

Please fill out both sides of this page.

What hospitalizations/ surgeries/ injuries has your child had? When? _____

_____

_____

Immunization History

	U – Up to date		P – Partial		N – Not done
Pre-School	_____	HBV (Hepatitis B)		_____	Hib (Hemophilus influenza type B)
	_____	HAV (Hepatitis A)		_____	DTaP (Diphtheria, Tetanus, Pertussis)
	_____	IPV (Polio)		_____	MMR (Measles, Mumps, Rubella)
	_____	Varicella (Chicken Pox)		_____	PCV (Pneumococcal Bacteria)
School Age	_____	Td (Tetanus, Diphtheria)		_____	MCV4 (Meningitis)
Other	_____	Influenza		_____	Other (Please List): _____

Reactions to immunizations? _____

_____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Describe your child's

Personality: _____

_____

Intelligence: _____

_____

Temper: _____

_____

Socialabilty: _____

_____

Please fill out both sides of this page.

Environmental

What type of dwelling do you live in?_____ How Old?_____

Water Supply?_____Type of Heat?_____

Any difficulties in school? Please describe:_____

_____

Other Health Related

Describe problems in the following areas:

Digestion: _____

_____

Skin: _____

_____

Respiratory: _____

_____

Urinary: _____

_____

How much sleep does your child get? From _____ pm to _____ am Quality: _____

At what age did your child first: Roll Over _____ Begin Teething _____ Begin Talking _____

Other

Anything not covered in this questionnaire that you feel is importland for your doctor to know about?

_____

_____

_____

Thank You! I look forward to working with you and your family. Please feel free to ask any questions along the way.

_____ _____

Signature of Parent **Printed Name**

_____ _____

Signature of Parent **Printed Name**

Please fill out both sides of this page.

Informed Consent and Request for Naturopathic Medical Care, Classical Chinese Medicine Treatment and Acupuncture

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Angela P. Lambert, ND, L.Ac, MSOM, having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, _____, hereby request and consent to examination and treatment with Naturopathic Medicine, Classical Chinese Medicine (CCM) by Dr. Angela P. Lambert, ND, L.Ac, MSOM, and/or other licensed doctors of naturopathic medicine or licensed acupuncturists or licensed massage therapists serving as backup for her, hereafter called allied health care provider. I can request that students and preceptors not be included in my evaluation and treatment.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Angela P. Lambert, ND, L.Ac, MSOM, and/ or with the allied health care provider providing backup:

1.) my suspected diagnosis(es) or condition(s)
2.) the nature, purpose, goals and potential benefits of the proposed care
3.) the inherent risks, complications, potential hazards or side effects of treatment or procedure
4.) the probability or likelihood of success
5.) reasonable available alternatives to the proposed treatment procedure
6.) potential consequences if treatment or advice is not followed and/ or nothing is done

I understand that a Naturopathic evaluation and treatment may include, but are not limited to:

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Common diagnostic procedures (including venipuncture, pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Soft tissue and osseous manipulation (including therapeutic massage, deep tissue massage, neuro-muscular technique, naturopathic/osseous manipulation of the spine and extremities, pregnancy massage (to relieve muscular discomfort associated with pregnancy), muscle energy technique and cranio-sacral therapy)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
- Trigger point injection therapy with vitamin substances
- Botanical/ herbal medicines (prescribing of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, tropical creams, pastes, plasters, washes or other forms
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water, may include transcutaneous electrode stimulation)
- Counseling (including but not limited to visualization for improved lifestyle strategies)
- Over the counter and prescription medications (including only those medications on the Formulary of Oregon Naturopathic Physicians)

The scope of practice of acupuncture is outlined below. I understand that Classical Chinese medicine and Acupuncture evaluation and treatment may include, but are not limited to:

- Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the bodies surface)
- Use of electrical, mechanical and magnetic devices
- Moxa (indirect or direct burning of herbal material in the form of a loosely compacted herb or stick
- Cupping (used to relieve symptoms of pain and chest congestion in which glass cups are placed on the skin with a vacuum created by heat)
- Gua sha (rubbing on an area of the body with a blunt or round instrument)
- Dietary advice (based on traditional Chinese medicine theory)
- Herbs (use of herbal formulas in the form of teas, powders, tinctures, pastes, and plasters, which may be taken internally

or used externally as a wash. Formulas may include shells, minerals and animal materials)

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, hydrotherapies; allergic reaction to prescribed herbs, supplements, prescription medications; soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms.

Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy. Labor- stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor and any treatment intended to induce labor requires a signed letter from a primary care provider authorizing or recommending such treatment.

Notice to individuals with bleeding disorders, pace makers, and/ or cancer. For your safety it is vital to alert your provider, Dr. Angela P. Lambert, ND, L.Ac, MSOM, LMT, of these conditions. Please Initial:

- ☐ I understand that Dr. Angela P. Lambert, ND, L.Ac, MSOM is not licensed to prescribe any controlled substances.
- ☐ I understand that Dr. Angela P. Lambert, ND, L.Ac, MSOM will only prescribe medications if she believes that they are in the best interest of myself, the patient. Appropriate referrals will be provided to manage my prescriptive medication needs.
- ☐ I understand the US Food and Drug Administration has not approved nutritional, herbal and homeopathic substances; however these have been used widely in Europe, China and the USA for years.
- ☐ I understand that Dr. Angela P. Lambert, ND, L.Ac, MSOM is not a psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies.

I do not expect Dr. Angela P. Lambert, ND, L.Ac, MSOM and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that Dr. Lambert explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment

_____ _____

Printed Name of Patient Signature of Patient

_____ _____

Printed Name of Guardian Signature of Guardian

_____

Date Signed

Fee Schedule

New patient office visit, Acupuncture or Naturopathic (Approximately 60 - 75 minutes)	$275.00 - $325.00
Routine Return Patient (30+ minutes)	$95.00 - $135.00
Routine Return Patient (15 Minutes)	$68.00 - $88.00
Return Acupuncture Visit (60 - 90 Minutes) (Approximately 20-30 minutes)	$95.00 - $165.00

Phone consultation AND email fees same as Return Visit Fees.

Please note: Patient is responsible for payment at the time of service, unless previously arranged by Dr. Lambert.
You will be billed for phone consultations and e-mail correspondence, except those regarding questions about prescribed treatments and conditions already being treated.

While I am not a provider for any specific insurance plans, I am willing to bill some insurance companies with pre-approval. Please check with your policy regarding requirements, as you are ultimately responsible for reimbursement.

Cancellation policy: Any appointments cancelled with less than 24 hours notice will be subject to a $60.00 cancellation fee.

I have reviewed the above fees and understand that I am responsible for payment at the time of service, unless previously arranged by Dr. Lambert. I also understand that I will be billed for phone consultations and e-mail correspondence, except those regarding questions about prescribed treatments and conditions already being treated.

In addition, I understand that lab work may or may not be covered by my insurance plan and that I am responsible for payment of lab work ordered if my insurance company does not cover it. I also understand that I will be charged $60.00 for appointments cancelled without 24 hours notice, except in cases of emergency.

Signed: _____ Date: _____

Day of Service Discounts will apply when fee is paid in full on the Day of Service only.

Notice of Privacy Practices
Ancient Traditions Natural Medicine, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care options.

- **Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include a physical examination.**
- **Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.**
- **Health care operations include the business aspects of running this practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.**

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Signature _____ Date Signed _____

Printed Name _____ Relationship to Patient _____

E-Mail Authorization and Consent Agreement Between Ancient Traditions Natural Medicine, LLC Clinician and Patient

I have been advised that:

E-mail is never, ever appropriate for urgent or emergency problems.

E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose; system operators for most e-mail systems have access to all e-mail that passes through their systems.

E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee.

There is not a way to assure the privacy of e-mail on a shared computer or e-mail account.

All e-mail correspondence will become a part of my medical record at Ancient Traditions Natural Medicine, LLC. It is extremely important to include my name on each and every e-mail sent to Ancient Traditions Natural Medicine, LLC and/or Dr. Lambert.

Since e-mail may not be monitored while my clinician is away on business or on vacation, I will follow-up by tele phone or in person if I do not receive a response within a week.

I have been provided with information about the use of Internet e-mail to communicate matters pertaining to my health and healthcare, and I understand the issues and concerns inherent in this use.

I have been provided with information about the use of Internet e-mail communications between my health provider, including information concerning my healthcare and personal medical information. I understand that I may revoke this agreement at any time by contacting my clinician.

I designate that all e-mail correspondence coming from me or to me should be sent to the following Internet e-mail address:

E-mail address: _____

Signature: _____ Date: _____

Name: _____ DOB: _____

Printed Name of Clinician: _____

Signature of Clinician: _____