Natural Whole Body Health

Dr. Cheryl Vincent, D.C., DABCI
540 Hopmeadow Street., Simsbury, CT 06070
Phone: 860-651-3355 Fax: 860-408-9648

Welcome to Natural Whole Body Health, LLC.

This represents the functional medicine and nutrition counseling part of my practice. I created this to separate the wellness practice from the neuromuscular. And as such, to bring more awareness to natural medicine. **In office or telehealth appointments are available.**

Appointments and Fee Schedule:

The fee is based on the amount of time you spend at the appointment. This will vary with the complexity of your case and is selected at the discretion of Dr. Vincent.

> **New patient / Comprehensive Visit:** $225.00 - Consultation, history, physical exam, diagnostic recommendations and/or preventative counseling. All other wellness visits include: counseling, physical exam, treatment recommendations and/or preventative counseling:
> **Wellness Expanded:** $115.00 - 45 minutes
> **Wellness Intermediate:** $90.00 - 30 minutes
> **Wellness Brief:** $65.00 - 15 minutes

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT

All Natural Whole Body Health patients are required to have a current credit card on file with the office. Your personal information is secured and used only with your consent. This is to expedite ordering of nutraceuticals and functional lab tests not covered by insurance.

Credit Card Information:	
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other:_____	
Cardholder Name (as shown on card):	
Card Number:	CV:
Expiration Date (mm/yy):	Cardholder ZIP Code:

I, _____, authorize NWBH to charge my credit card for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

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Patient Intake Form

Today's date:_____

Name:_____ DOB:_____ Marital status:_____

Address:_____ City/State/Zip:_____

Home Tel:_____ Cell Tel:_____ Cell Carrier:_____

Employer:_____ Occupation:_____ Work Tel:_____

Employer's address:_____ SS#:_____

Nickname:_____ Email:_____

Spouse's name:_____ DOB:_____

Spouse's Employer:_____ Occupation:_____

Work Tel:_____ Spouse's Employer's address:_____

Dependent's name(s):_____

IN CASE OF EMERGENCY, NOTIFY:_____ Tel:_____

Referred by:_____ Family Physician:_____

Who is financially responsible for this bill?_____

I will be paying for today's visit by: _____cash _____check _____credit/debit card

PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARDS AND YOUR DRIVER'S LICENSE SO THAT WE MAY MAKE COPIES FOR OUR FILES. Thank you.

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INFORMED CONSENT

Office Hours: Tuesday 10:00am-6:00pm
(Zoom/phone consults available upon request)

Cancellations:

- If unable to keep an appointment; 24-hour notice is requested.
- For unforeseen emergencies or circumstances which necessitate cancellations, notification is requested as soon as possible.
- Missed appointments without notification will be billed to the patient for the time reserved.
- New patient appointments are typically 45-60 minutes. At the time of booking your initial consultation, we request a credit card on file to reserve the room for your visit. If you do not show up for your appointment, you will be charged the appointment fee of $225.00.

Office Hour Calls:

- Calls to the Doctor during office hours will be answered by the receptionist who will take the message. The Doctor will return all phone calls within 48 hours. If it is an emergency, please notify the receptionist.
- Zoom & Phone consultations are available for a fee and will be scheduled by the receptionist.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

The signature below gives consent for the treatment of the individual or minor for whom they are legally in charge.

May we leave a message on your answering machine or with the person answering the phone?

YES _____ NO _____ If yes, preferred phone number: _____

Email?: YES _____ NO _____ If yes, preferred email address: _____

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I am requesting records of Doctor: _____

Name of facility or person: _____

Address: _____ City/State/Zip: _____

Telephone number: _____ Fax number: _____

THE PURPOSE FOR THIS RELEASE:

> You are hereby authorized to furnish Dr. Cheryl Vincent information from my medical records. Please photocopy all pertinent written documents for blood test results and Diagnostic reports for NO MORE than 1-2 years previous.

This authorization can be revoked in writing at any time, except to the extent that disclosure made in good faith has already occurred in reliance of the authorization.

I hereby release Dr. Cheryl Vincent any and all of her employees, agents managing members, and any of the attending physician(s) that I am requesting records of and/or from any and all legal responsibility or liability from the release of the above information to the extent authorized. *A copy of the authorization shall be valid as the original.*

I understand that there may be a fee for this service depending on the number of pages photocopied. If such a fee is to be paid, it shall be paid by me, the requestor and not Dr. Cheryl Vincent. However, no such fee is usually charged if these records are requested for continuing medical care.

Patient's Name: _____ D.O.B.: _____

Patient's Address: _____ City/State/Zip: _____

Patient's Telephone number: _____

Signature:_____ Date: _____

Please send a copy of all records to:

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