



***Nicola McFadzean, N.D.***  
***Naturopathic Physician***

Dear New Patient:

Thank you for choosing Dr. Nicola as your healthcare provider. She is dedicated to making your experience a most satisfying one.

The following information is necessary in order for us to complete your in office file and for our participation in your health care. You are encouraged to make copies of these documents for your records. **Please fill out and submit these forms at least 48 hours prior to your appointment.**

- ✓ Patient Information Form
- ✓ Office Policies and Procedures
- ✓ Lyme Disease Consent Form
- ✓ Credit Card Authorization
- ✓ Health History Questionnaire

Please supply us with copies of any relevant lab work and medical records in electronic (PDF) format. A summary of your illness – symptoms, medications, supplements, timelines, treatments used etc, will also be very helpful. If you cannot provide them prior to your appointment, you may bring them with you.

Please don't hesitate to contact us should you have any questions. Dr. Nicola looks forward to assisting you.

**1111 Ft. Stockton Drive, #H**  
**San Diego, CA 92103**  
**(619) 546 4065 ph**  
**(619) 270 2582 fax**  
**Web: [www.restormedicine.com](http://www.restormedicine.com)**  
**Email: [info@restormedicine.com](mailto:info@restormedicine.com)**

**Nicola McFadzean, N.D.**

***Patient Information***

(PLEASE PRINT CLEARLY)

Patient Name \_\_\_\_\_  
Last First Middle initial

Home address \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary phone: Daytime ( ) \_\_\_\_\_ Evening ( ) \_\_\_\_\_

Cell phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Skype ID (or email) \_\_\_\_\_

Email address \_\_\_\_\_

Employed by \_\_\_\_\_

Occupation \_\_\_\_\_

What name do you prefer to be called?  
\_\_\_\_\_

Who referred you to our office?  
\_\_\_\_\_

Who is your medical insurance carrier? HMO \_\_\_\_ PPO \_\_\_\_  
\_\_\_\_\_

**In case of emergency contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ Work phone ( ) \_\_\_\_\_

**For children under 18 years of age:**

Mother's full name \_\_\_\_\_

Father's full name \_\_\_\_\_

## ***Nicola McFadzean, N.D.***

### ***Office Policies and Procedures***

#### **Hours:**

- San Diego office: Mondays, Wednesdays and Fridays 10am-5pm (PST).
- Office visits and telephone consultations are by appointment only.

#### **Fees:**

- Initial consultation (45-60 mins) - \$325.
- Follow up (20-30 mins) - \$165.
- Brief follow up (10-15 mins) - \$85.

#### **Appointments**

- Appointments are scheduled by telephone or email. Please leave possible dates and times. The staff at RestorMedicine will confirm your appointment time with you.
- Payment is due at the time of your consultation. Methods of payment are: Visa, MasterCard, Discover, check, and cash.
- First appointment: All initial paperwork must be completed, signed, and received by our office preferably 2 business days prior to your scheduled appointment. Please fax or email these forms (in a single PDF file if emailing). Also send an electronic photograph (JPEG format) for our medical records.
- First appointment: If paying by check for a phone consultation, the check must be received in advance of the consultation. If paying by credit card you may be asked to provide your credit card number at time of scheduling to hold the appointment.
- Follow-up consults may be scheduled in 15, 30 or 60-minute blocks of time.
- Consultations with other healthcare providers and/or any research requested by the patient are billable services and will be charged at the hourly rate.
- Scheduled consultations that include review of lab tests require that laboratory test results be received at least 24 hours prior to appointment.

#### **Medical Letters:**

- Medical letters to schools, insurance companies, disability, etc. are a billable service. If these items are requested there may be an additional charge based on the time involved at the hourly rate to complete your request.

#### **Office Consultations:**

- Please advise the doctor if wheelchair access is required.

#### **Phone Consultations:**

- Dr. Nicola will call you at the time of your scheduled consultation. Please allow a 10-minute window from your appointment time to hear from Dr. Nicola.
- Dr. Nicola requires patients outside of the USA to call the office at the time of their scheduled phone consultation. If this is not possible, then phone consultation phone bill charge will be billed to the patient. Dr. Nicola also uses Skype (user name is NicolaMcF).

**Cancellations:**

- Patients who forget their appointment or cancel less than 24 hours prior to the appointment will be required to pay 50% of the missed visit fee. Please understand that a missed appointment could have gone to another patient.

**Questions and Follow-up:**

- Please direct e-mails regarding you or your child’s care to [info@restormedicine.com](mailto:info@restormedicine.com). Questions must be brief and concise. Dr. Nicola will determine if a phone or office consult is needed to answer your question(s). Otherwise, she or an administrative assistant will respond to your inquiry. When leaving a voice mail message, please be brief and concise and always include your name and phone number, including the area code.
- **Please Note: We try to accommodate questions regarding treatment clarification at no charge. Simply put, if you have a quick question about a supplement or diagnostic test we recommended or a therapy reaction you may be experiencing, then by all means contact us. However, if the response to a question you submit requires doctor research and/or review, you may be billed for the time involved at the doctor’s hourly rate or requested to schedule a consultation.**

**Follow-up Office Consultations:**

- We generally recommend that all patients minimally have an office consultation with Dr. Nicola every 6 months.

**Insurance:**

- Dr. Nicola does not accept any insurance plan, nor bill insurance on your behalf. She can supply you with a “superbill” or medical receipt that you can submit to your carrier for reimbursement. She makes no guarantee of payment or reimbursement by your insurance carrier. Please request a superbill at the time of your appointment.
- Dr. Nicola does not accept insurance liens, assignments, or any reimbursement from your insurance carrier.

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**Acceptance of Policies and Procedures**

By completing the following you agree to the policies and procedures detailed above.

Patient (please print): \_\_\_\_\_ Date: \_\_\_\_\_

Signature (patient or responsible party): \_\_\_\_\_

If signed by party other than patient, print name: \_\_\_\_\_

***Nicola McFadzean, N.D.***

***Credit Card Authorization***

I, (print name) \_\_\_\_\_, authorize Nicola McFadzean, ND, dba RestorMedicine to bill my credit card as listed below.

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**Name on Credit Card** \_\_\_\_\_

**Credit Card Details**

Visa            Card # \_\_\_\_\_ Exp date \_\_\_\_\_

MasterCard    Card # \_\_\_\_\_ Exp date \_\_\_\_\_

3 digit code on the back of the card \_\_\_\_\_

**Billing Address for Credit Card**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (include area code): \_\_\_\_\_

**Authorization**

\_\_\_\_\_  
Card Holder's Signature

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Today's Date

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This authorization may be revoked at any time when the following stipulations have been performed.

1. Patient has already made new financial agreement that has been signed and dated or card holder/patient has submitted to our office a written request to revoke the card usage (stop billing credit card in writing signed and dated).
2. Patient's account is paid in full.

**Nicola McFadzean, N.D.**

**Health History Questionnaire**

(Please Print)

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_ Blood Pressure (if known) \_\_\_\_\_

Primary Health Concerns:

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When did your health concerns begin?

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Known tick bite? Yes/ No      When? \_\_\_\_\_      EM rash? Yes/ No

Medication Allergies? \_\_\_\_\_

Other Allergies (ie. Molds, Chemicals) \_\_\_\_\_

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Current Medications You Are Taking \_\_\_\_\_

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Current Supplements You Are Taking \_\_\_\_\_

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**Past and/or Current Medical History: (please circle)**

Arthritis	Asthma	Cancer	Diabetes	Hepatitis
High Blood Pressure	Heart Disease	Leukemia	Migraines	Headaches
Paralysis	Rheumatic Fever	Chronic Fatigue	Fibromyalgia	Chemical
Sensitivities	Menstrual Irregularities	Thyroid (low/high)	Stroke	Seizure
Kidney Disease	Celiac Disease	Venereal Disease	Autoimmune Disease (ie. MS,	
Lupus, Rheumatoid)	Lung Disease (ie. pneumonia, tuberculosis, etc.)	Other: _____		

**Surgical History:**

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**Family Medical History:**

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**Habits:**

Alcohol intake per week\_\_\_\_\_ Tobacco\_\_\_\_\_packs/day – Yrs. Quit\_\_\_\_\_

Cups of caffeinated coffee/day\_\_\_\_\_ Cups of caffeinated Teas/day\_\_\_\_\_

Colas or sodas\_\_\_\_\_cans/day Antacids taken\_\_\_\_\_/week

Laxatives\_\_\_\_\_/week

Do you use caffeine as a “pick-me up” drink, or to “get going in the morning” Yes\_\_ No\_\_

Travel history: Traveled/lived outside the USA? Yes\_\_ No\_\_ If Yes, where have you traveled/lived\_\_\_\_\_

Developed an illness as a result of your travels? \_\_\_\_\_

**Dental History:**

Orthodontics? Yes\_\_ No\_\_ If yes, explain\_\_\_\_\_

Braces? Yes\_\_ No\_\_ Did you have any complications with your braces? Yes\_\_ No\_\_ If yes, explain

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Mercury Fillings? Yes\_\_ No\_\_ How many\_\_\_\_\_ Root Canals? Yes\_\_ No\_\_ How many

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Previous Gum Inflammation (Gingivitis)/Infections? Yes\_\_ No\_\_

Occupation:\_\_\_\_\_

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Please Describe Your Hobbies: \_\_\_\_\_

\_\_\_\_\_

Please check any of the following that you have experienced in the last 30 days:

\_\_\_ Do you feel nauseous?

\_\_\_ Do you feel bloated?

\_\_\_ Do you have heartburn?

\_\_\_ Do you have constipation?

\_\_\_ Do you have gas?

\_\_\_ Do you belch after meals?

\_\_\_ Do you have abdominal/intestinal pain?

\_\_\_ Do you get bloated after meals?

\_\_\_ Do you have diarrhea?

\_\_\_ Are your stools compact and hard to pass?

\_\_\_ Do your bowel movements alternate between constipation and diarrhea?

**Please use this space below to share additional information with us regarding your health concerns.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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