

Print Name \_\_\_\_\_

**TINA MARCANTEL, NMD**  
NATUROPATHIC PHYSICIAN

201 W. Guadalupe Rd. Suite 202  
Gilbert, AZ 85233  
Tel: 480-892-0211 Fax: 480-892-0216

**PATIENT REGISTRATION and PERSONAL INFORMATION**

(Please Print Clearly)

PATIENT'S FULL NAME \_\_\_\_\_ SEX \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

AGE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_ MAY CALL WORK PHONE YES NO

E-MAIL ADDRESS \_\_\_\_\_

SIGNIFICANT RELATIONSHIP STATUS : (Please circle one that applies)

MARRIED    NON-MARRIED PARTNER    SINGLE    WIDOWED    SEPARATED    DIVORCED

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ PHONE \_\_\_\_\_

HOW DID YOU HEAR OF DR. TINA MARCANTEL? \_\_\_\_\_

**I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE, I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES ON THIS ACCOUNT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. I UNDERSTAND AND AGREE THAT I WILL PAY A FEE FOR THE DOCTOR'S TIME IF I FAIL TO CANCEL OR RESCHEDULE AN APPOINTMENT WITH LESS THAN 24 HOURS NOTICE.**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Print Name \_\_\_\_\_

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**CONTEXT OF CARE REVIEW**

What do you know about our **approach**?

What *three* **expectations** do you have from *this* visit to the clinic?

What *long term* expectations do you have from working with our clinic?

What is your present level of **commitment** to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.

0%    0        1        2        3        4        5        6        7        8        9        10      100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe **support** your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are **non-beneficial** to your health?

What potential **obstacles** do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely and consistently **support** you with the beneficial lifestyle changes you will be making?

What do you **love to do**?

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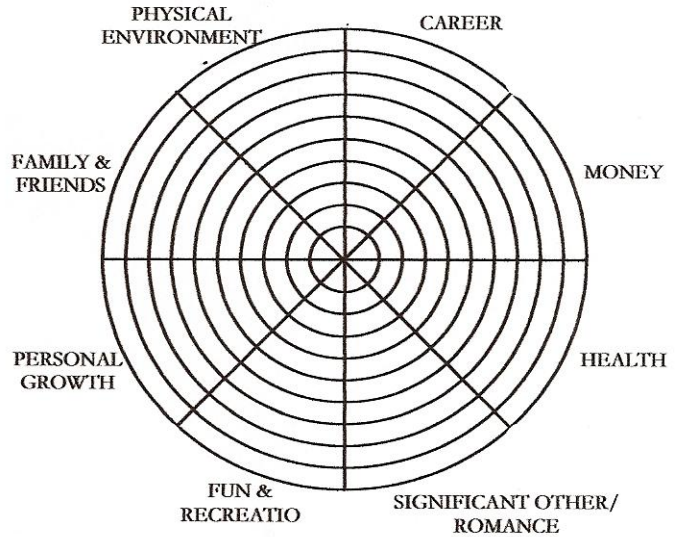
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**WHEEL OF BALANCE**

Wellness is a balance of many factors. Using this circle, shade your level of satisfaction on each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, **starting from the center point radiating outward.**



Are you currently receiving healthcare? Yes / No

If yes, where and from whom? \_\_\_\_\_

If no, when and where did you last receive medical or health care? \_\_\_\_\_

\_\_\_\_\_

What was the reason? \_\_\_\_\_

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

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Do you have any known contagious diseases at this time? Yes / No

If yes, what? \_\_\_\_\_





Print Name \_\_\_\_\_

**PATIENT FEES**

**Cost of services:** Initial intake visit (approx. 1 hour): \$285.00. Follow-up visits are typically 15 minutes to 1 hour (\$55.00-\$130.00). Please ask for specific prices before receiving treatment.

Note: Prices for products and services are subject to change without notice. For a complete listing of our current prices please see our website or ask our receptionist for a price list.

Dr. Tina Marcantel will do **phone consultations for established patients** under special circumstances when an office visit may not be deemed necessary or possible. Fees are dependent on the length of the consultation.

To better monitor the progress of our patients we encourage the use of e-mail correspondence. This **free service** is provided to allow patients to send **brief** updates to Dr. Marcantel regarding symptoms or to seek clarification about treatment. These *e-mail updates are not meant to take the place of an office visit or a phone consultation*; they are a way to help the patient and Dr. Marcantel make the most efficient use of your time together to ensure that you are receiving the best possible treatment we can offer.

**CANCELLATION CHARGE**

If an appointment is cancelled or rescheduled with a minimum of 24 hours notice, no charge is incurred by the patient.

**We do not double book our schedule and your scheduled clinic visit is reserved for you and the doctor.**

Cancellations made with less than 24 hours notice may be subject to cancellation fees.

**INSURANCE BILLING**

**Full payment is due at the time of service.** As an **additional free service** to our patients, Dr. Marcantel's staff will submit billing claims for reimbursement to most insurance companies. Submission of a claim does not guarantee reimbursement and is subject to your individual health plan benefits. We do not offer prequalification of coverage for patients. Please contact your insurance provider directly with questions about covered services. All insurance reimbursements received by our office will be credited to the patient's account or directly reimbursed to the patient.

**Please note: Medicare does not cover Naturopathic Physicians and we are unable to bill Medicare for services.**

**DISPENSARY**

The clinic maintains a dispensary for your convenience and to ensure that patients may obtain quality products. You may purchase similar or like products elsewhere. If you experience undesirable and out-of-ordinary symptoms after taking a product purchased at our dispensary, please call and let the doctor know immediately. **Unopened** products purchased at the clinic may be returned within 14 days for refund.

**INFORMED CONSENT**

Your signature below verifies the understanding of the information above and also gives Dr. Tina Marcantel, an Arizona state licensed naturopathic physician, consent for naturopathic treatment for you or the minor for whom you are legally in charge.

PATIENT'S/GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

NAME OF MINOR \_\_\_\_\_ RELATION TO MINOR \_\_\_\_\_

*Dr. Marcantel is committed to providing quality health care. We provide you with an individualized plan because we consider each person a unique individual with unique health needs. Thank you for joining our health team. We look forward to coaching, supporting, and providing you with alternative and integrated health approaches to health care.*