Dr. Rebecca Gustavson ND

Believing in the healing power of nature. . .

Dr. Rebecca Gustavson ND
707-523-8028
www.GatewayHealing.Org
drg@gatewayhealing.org

New Patient Packet - Please keep this top sheet for your information.

Dear New Patient,

Welcome to the office of Dr. Gustavson. We are looking forward to partnering with you to improve your health. Enclosed you will find several forms. Each of these is important for your initial consultation. **Please complete the forms before your appointment and bring them with you on the day of your appointment. Waiting until your scheduled appointment time to fill out the forms will result in having less time with the doctor. Allow at least 2.5 hours for your initial appointment. Important: Please bring a copy of your most recent lab work with you.**

ENCLOSED FORMS:
- Fee Schedule
- Informed Patient Consent
- The Health History Questionnaire; very important in evaluating your health needs.
- Emergency Contact Sheet

FOR INITIAL VIST, YOU MUST BE FASTING FOR AT LEAST 4 HOURS. PLEASE DRINK PLENTY OF WATER AND TAKE ALL OF YOUR REGULAR MEDICATIONS AND SUPPLEMENTS ON THE DAY OF YOUR APPOINTMENT. NO COFFEE OR OTHER BEVERAGES. YOU MAY BRING A SNACK TO EAT. DRESS IN LOOSE CLOTHING. THIS IS IMPORTANT FOR THE DOCTOR TO BE ABLE TO MOVE YOU AROUND DURING CERTAIN MUSCLE TESTS.

Please be considerate if it is necessary to cancel your appointment and give us 48 hours notice so we may reschedule the time with another patient. We reserve the right to charge for missed appointments without sufficient notice. If you have any questions do not hesitate to call us at (707) 523-8028.

To your good health,

Dr. Rebecca Gustavson ND

APPOINTMENT DATE/TIME:
- **Fast for 4 hours before appointment, no gum**
- **Bring completed paperwork**
- **Bring most recent lab work**
- **Bing a pad of paper to take notes**
- **Bring a snack if you would like**
- **Drink plenty of water prior to appointment**
- **Dress in loose clothing that you can move**

FEE SCHEDULE

The first visit with Dr. Gustavson is billed as an extended comprehensive visit at the customary rate of $295.00. Dr. Gustavson routinely spends between 90 to 120 minutes with each new patient, reviewing history, medications and symptoms. Appointment time is somewhat determined by the depth and complexity of each individual's history and symptoms. During the evaluation, Dr. Gustavson will perform a live blood analysis, and a bio-field assessment along with a physical exam. A treatment strategy will be set up for you and be given on your follow up visit.

A follow up visit is typically scheduled within the next 2-3 weeks. Follow up visits are generally an hour. After that, visits are scheduled based on the needs of the individual.

Dr. Gustavson ND is not part of any Medicare, PPO, HMO, IPA or IPP group.

BASIC FEES

Initial Visit …….. $ 295.00
Follow-up Visit 1 hour……$135.00
Follow-up fee in addition to treatments..……$ 65.00

All other therapies have separate fee amounts and are not included in the Initial Visit or Follow up Prices.
At our discretion, a $135.00 deposit may be required at the time the appointment is made in order to reserve your Initial Visit time slot. This will be applied to your visit at the time of checkout. If you are unable to keep the appointment, **a 48 hour cancellation notice is required,** at which time your deposit will be refunded minus a $20 service charge.

ADDITIONAL INFORMATION

1. Please note, that we need labs before any IV treatment:
    1. CBC (complete blood count)
    2. CMP (comprehensive metabolic panel)
    3. UA with microscopic (urinalysis)
    4. Please do not eat for 6 hours and be well hydrated before the blood tests.
    5. These labs need to be less than one month old for cancer patients and less than six months old for non cancer patients. Your main stream primary care doctor hopefully can order these for you if you have lab insurance coverage.
3. The following Labs / Tests are desirable.
    1. For Lyme or Mold patients a CD57 lab report from Labcorp is desirable.
    2. Please note Labs/Tests ordered by Dr. Gustavson ND will not be covered by insurance.

Thank you for taking the time to read these instructions.

For any questions, please call us at 707-523-8028.

INFORMED PATIENT CONSENT FOR DIAGNOSIS AND TREATMENT

An Agreement for Naturopathic Medicine with Dr. Gustavson ND

Consent: I hereby request and consent to the performance of naturopathic treatments and other procedures within the scope of the practice of naturopathic medicine on me (or on the patient named below, for I am legally responsible) by the naturopathic doctor named above and/or other licensed naturopathic doctor or technician who or in the future treat me while employed by, working or associated with or serving as back-up for the naturopathic doctor named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I voluntarily consent to outpatient care provided by doctors, nurses and staff at 3863 Montgomery Dr. Santa Rosa 95405, encompassing routine diagnostic procedures, examination and medical treatment including but not limited to; routine laboratory work (such as blood, urine and imaging studies), intravenous therapies, injections, botanical medicine, nutrition, acupuncture, therapeutic adjustments, bio-field testing, rife-frequencies, frequency specific microcurrent, and prescribed medications.

I consent that there will be times when the Naturopathic Doctor will perform therapeutic adjustments without doing imaging.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including their designees as is necessary in the medical staff's judgment.

I understand that not ALL of the treatment suggestions provided are accepted by the United States FDA and therefore should not be taken as such.

Type of Care: I understand that this medical practice uses some diagnostic and treatment methods that are variously known as, but not limited to: Naturopathy, homeopathy, environmental, complementary, alternative, integrated or nutritional medicine. I agree to treatment using, but not limited to: nutritional counseling, lifestyle, vitamin and mineral therapies, botanical medicine (herbs), homeopathy, medical intuitive counseling, bio-field assessment, applied kinesiology, Rife, energy medicine (reiki, acupuncture, cranio-sacral) flower essences and essential oil, hypnotherapy, ozone therapy, chelation therapy, hydrogen peroxide therapy, light and ultraviolet light therapy, naturopathic manipulation, frequency specific microcurrent, aesthetic, hormones, pharmaceuticals, prolozone, 5-star, intravenous and injection therapies.

I understand that herbs, remedies and supplements should be consumed according to the instructions provided orally and in writing. I will immediately notify the doctor listed below of any unanticipated or unpleasant effects associated with the herb, remedies or supplements.

I have been informed that naturopathic medicine is a generally safe method of treatment, but that it may have some side effects, such as a healing crisis which could cause fatigue, nausea, muscle soreness, headache, etc. The herbs, remedies and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe, although some may be toxic in large doses. I understand that some herbs and supplements may

be inappropriate during pregnancy or breastfeeding. **I will notify the naturopathic doctor who is caring for me if I am or become pregnant or am currently breastfeeding.**

I do not expect the naturopathic doctor to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the naturopathic doctor to exercise judgment during the course of treatment which the naturopathic doctor thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of naturopathic medicine and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____

Patient Signature (Or Patient Representative) Date

_____

Indicate Relationship if signing for patient Naturopathic Doctor: Rebecca Gustavson, ND

Dr. Rebecca Gustavson ND

Believing in the healing power of nature…

HEALTH HISTORY QUESTIONNAIRE

The information on this form shall become part of the patient's medical record and will be kept in strict confidence as in any doctor patient relationship. Bring this questionnaire (completely filled out), and all your current drugs, supplements, drug store medications and all labs from the past 6 months to your history/physical visit with Dr. Gustavson.

Name_____Age_____Date of Birth_____
Street Address_____
City_____State_____Zip_____
Phone: _____Work Phone: _____
E-mail:_____

Please check the box below to receive full access to Full Script. We will need both your email and cell phone number to sign you up. The second box is if you would like to receive integrative medical information.

☐ I would like to have access to Full Script (online nutraceutical store for specialized supplements).

☐ I would like to have Dr. G's monthly Naturopathic Medical Articles sent to me.

Occupation (if retired what was your occupation)?_____
_____
_____

I AM TROUBLED WITH THE FOLLOWING SYMPTOMS OR PROBLEMS:

_____
_____

I HAVE THE FOLLOWING ILLNESSES / DIAGNOSES:

_____
_____

I HAVE THE FOLLOWING ALLERGIES: (medications, foods, seasonal etc.)

_____
_____

I AM TAKING THE FOLLOWING MEDICATIONS: (please include dose, how long you have been taking and reason for taking)

_____
_____
_____
_____
_____

I AM TAKING THE FOLLOWING SUPPLEMENTS: (please include dose, how long you have been taking and reason for taking)

_____
_____
_____
_____

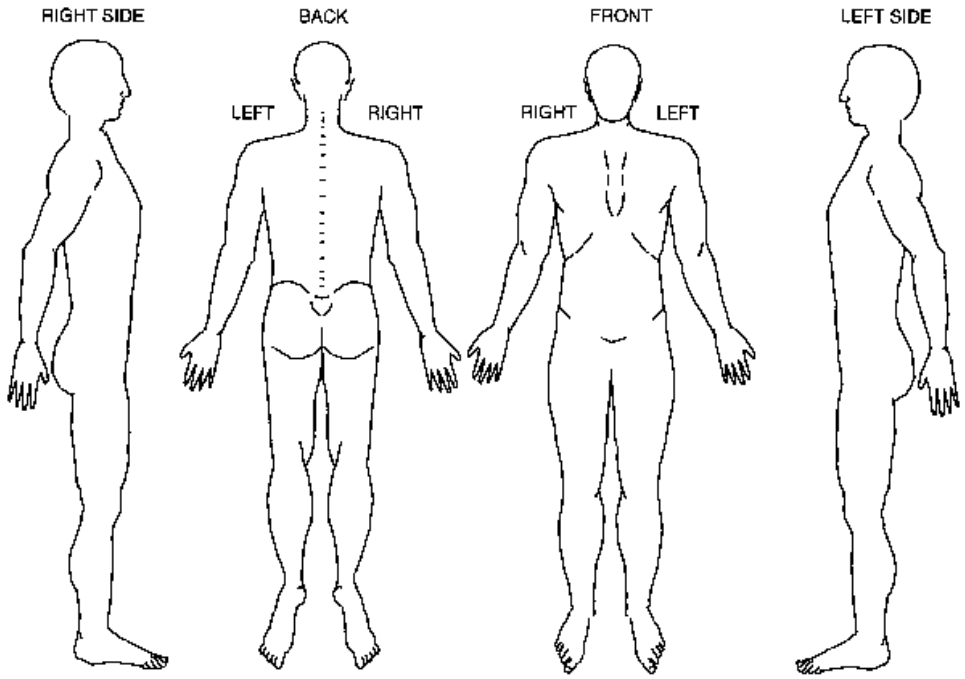
PLEASE CIRCLE ALL THAT APPLY:

- **General**: weight change, fever/chills, weakness, fatigue, sweats/night sweats
- **Skin**: changes in hair/nails, dryness, itching, rashes
- **Head**: head ache, trauma, dizziness, lightheadedness
- **Eyes**: vision changes/ new glasses, blurring, floaters, double vision, pain, discharge, cataracts
- **Nose**: sinusitis, discharge, postnasal drip, congestion, bloody nose
- **Mouth/throat**: sore throats, bleeding gums, hoarseness, changes in taste, dentures
- **Pulmonary**: asthma, bronchitis, COPD, difficult or labored breathing, wheezing, shortens of breath: with exertion / without exertion, coughing up blood, chest pain, chronic cough, sputum

- **Breasts**: masses, pain, discharge, color changes, texture changes
- **C/V**: palpitation, pain, breathless while lying down, murmurs, hypertension, cyanosis, edema, claudication
- **GI**: appetite change, pain, indigestion, jaundice, hernia, blood in stool, constipation, anal discomfort, difficulty swallowing, hemorrhoids, nausea/vomiting/diarrhea *(stool frequency, shape, color?)*
- **Genitourinary**: pain, discomfort or burning when urinating, excessive urinating at night, blood / mucus/ cloudy urine, frequency, urgency, incontinence
- **Sexual history**: history of syphilis, gonorrhea, sores/discharge, chlamydia, impotence, testicular pain/swelling, herpes, *(contraceptive use?)*
- **Female menses**: abnormal cycle / duration / amount, spotting, dysmenorrhea, menopause, *(Gravida number of pregnancies ____ /para number of live births____ / abortions__)*
- **Endocrine**: patient denies goiter, tremor, hormone therapy, heat/cold intolerance, glycouria/diabetes
- **Allergic**: asthma, hives, eczema, hay fever
- **Bones, joints, muscles**: trauma, swelling, pain, arthritis
- **Blood/lymph**: anemia, bleeding tendency, transfusion, lymph enlargement/pain
- **Neuro**: fainting, convulsions, sensations, gait problems/incoordination, speech changes, paralysis, weakness
- **Psych**: memory loss, mood, insomnia, sleep pattern changes, anxiety, depression, phobias

PAIN CHART

ON THE BODY DIAGRAM BELOW PLACE AN **X** ON AREAS OF PAIN. NEXT TO THE X WRITE A NUMBER FROM **1 – 10**. 1 IS THE LOWEST AND 10 WOULD BE THE HIGHEST AMOUNT OF PAIN YOU FEEL IN THE AREA.



IN GENERAL IS THE PAIN: (please circle all that apply or answer)
Worse in the: morning, daytime, nighttime.
Better with movement / worse with movement.
Does the pain keep you awake: yes / no.
How long have you had the pain?_____
Please describe: (stabbing, burning, constant etc.): _____

LIST HERE ANYTHING ELSE ABOUT YOURSELF, MEDICALLY OR OTHERWISE, THAT THE DOCTOR SHOULD KNOW:

_____

_____

READ CAREFULLY AND SIGN BELOW INDICATING THAT YOU HAVE READ THIS STATEMENT:

IT IS THE FIRM POSITION OF DR. REBECCA GUSTAVSON ND, THAT THE BODY HAS THE INHERENT ABILITY TO HEAL ITSELF AND, THAT AT BEST, THE MOST A DOCTOR CAN DO IS TO SET UP THE CIRCUMSTANCES BY WHICH THE BODY HEALS ITSELF. MOREOVER, SINCE HEALING COMES FROM WITHIN, THE PATIENT MUST ULTIMATELY TAKE RESPONSIBILITY FOR HIS OR HER OWN HEALTH.

Sign here indicating that the patient has read the above statement:_____

Dr. Gustavson ND Revised 6-20

EMERGENCY CONTACT SHEET

When filling out this form it is important to print clearly. In case of an emergency we will notify the following people that you have named below. In the off chance that 911 is activated we will make a copy of this form and hand it to the emergency responders. PLEASE INITIAL _____

PATIENT INFORMATION

PRINT FULL NAME DOB AGE

ALLERGIES:

ADDRESS

HOME PHONE CELL PHONE

WORK PHONE E-MAIL ADDRESS

IN CASE OF EMERGENCY PLEASE NOTIFY

NAME (primary contact)

PHONE

ADDRESS

RELATIONSHIP

NAME (secondary contact)

PHONE

ADDRESS

RELATIONSHIP

I am authorizing the medical office of Dr. Rebecca Gustavson ND to contact the above written emergency contacts.
I am authorizing the release of this form along with any pertinent medical information to be released to emergency responders.

SIGNATURE OF PATIENT DATE