Nurturing Optimal Wellness

The Holistic Medical Practice of Nancy Russell, M.D.
5140 N. Antioch, Kansas City, MO 64119-2523
(816) 453-5545

Welcome to Nurturing Optimal Wellness where we combine integrative and functional medicine under the direction of Nancy Russell, M.D. Holistic principles guide our direction in your path to optimal wellness. Our goals include: getting to know you, one on one, as an individual; striving to get at the root of issues, not just treating symptoms; and having you partnership with us as the treatment plan is established.

We look forward to your first visit. Please allow three to three and a half hours for your initial visit. Also included is a practice brochure. We encourage you to visit our web site, www.nancyrussellmd.com and sign up for our newsletter.

The process of getting to know you begins with the completion of the new patient forms. They are also included in this email. We ask that you complete the "fill in the blank forms" **in black ink**. Please fill these out before you arrive at the office and bring them with you for your first visit.

If you have any questions, please call our office at 816-453-5545. Detailed directions can be found on the back of this letter.

The staff at Nurturing Optimal Wellness is looking forward to meeting you.

DIRECTIONS TO NURTURING OPTIMAL WELLNESS

Address: 5140 NE Antioch Rd
Kansas City, MO 64119

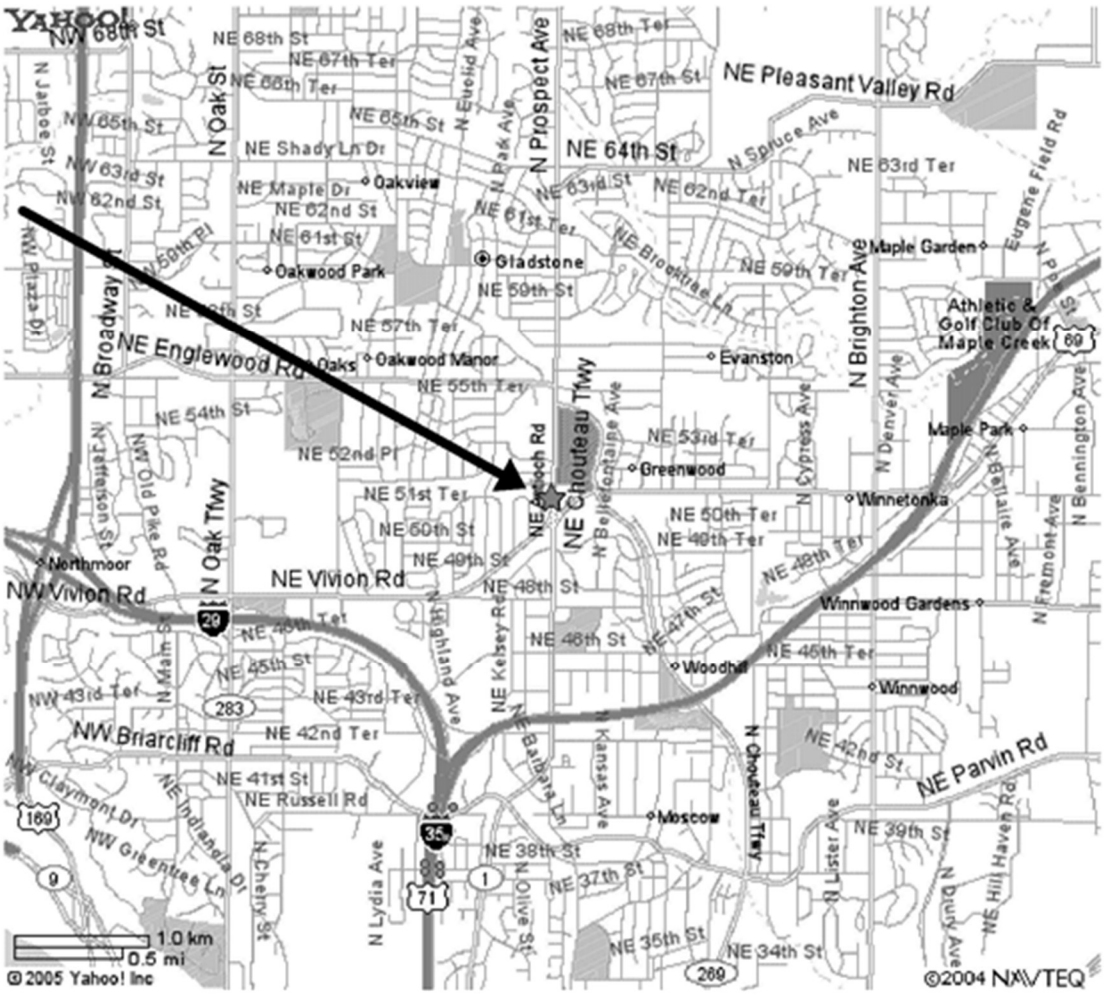
Telephone: 816-453-5545

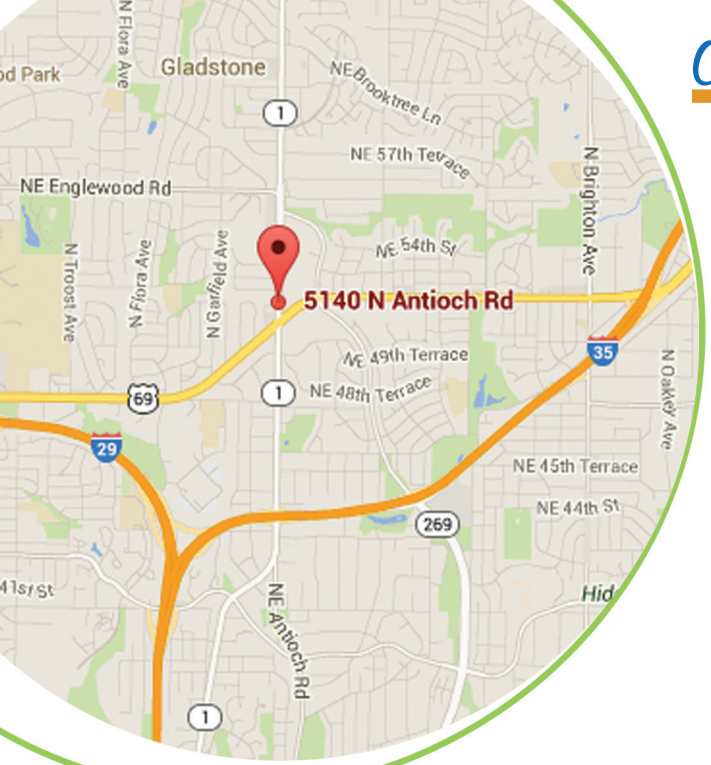
We are located approximately 1 mile north of the intersection of N. Antioch and I-35, 1.5 blocks North of Vivion Rd. on the West side of the street.

Our building is located BEHIND and up the hill from Firestone Tire Store and directly across from Walgreens.

You cannot see our building from Antioch Rd.

Our driveway is a little hard to see. There is no sign! It is located **directly to the North of Firestone's parking lot**. It has been painted **Red** at the bottom of the drive with large **white numbers "5140"**. Our entrance is the middle glass door at the middle of the building.





Office Location

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How To Contact Us

To learn more about Dr. Russell and to pursue the healthcare you deserve, you can visit her website at www.nancyrussellmd.com or contact the practice at (816) 453-5545 or (800) 276-3844.

mind - body - spirit NOW

Nurturing Optimal Wellness

5140 N. Antioch Road | Kansas City, MO 64119

mind - body - spirit NOW

Nurturing Optimal Wellness

Pursuing Healthcare You Deserve

Caring For Your Body, Mind and Spirit

Nancy Russell, MD

816-453-5545
800-276-3844

5140 N. Antioch Road
Kansas City, MO 64119

nancyrussellmd.com

Our Approach

Dr. Russell is trained as an Internal Medicine physician, is a founding member of the American Board of Holistic Medicine, and is board certified in Holistic-Integrative Medicine. She is also trained through the Institute of Functional Medicine.

Dr. Russell connects to each patient on a deeper level and establishes a partnership with them. Building trust through that relationship, Dr. Russell takes the time to get to know each patient as an individual and always strives to find the root cause of medical conditions. She guides her patients through the healing process by engaging all aspects of their mind, body and spirit, while also encouraging them to take responsibility for their own health.

The N.O.W. Difference

With years of experience and a belief that the "body uses symptoms to communicate its needs," Dr. Russell blends traditional and functional medicine in her holistic practice. The human body has a tremendous ability to heal itself and Dr. Russell seeks ways to listen to it rather than simply mask symptoms or work against it. Aided by her talented office team, Dr. Russell supports and nurtures each patient in entirety (mind, body, and spirit) on their path to optimal wellness in a safe, encouraging environment. You will feel that your voice has been heard when you visit her office.

www.nancyrussellmd.com

TREATING HEALTH CARE CONCERNS SUCH AS:

- Natural Hormones
- Digestive Imbalance
- Chronic Fatigue
- Fibromyalgia
- Thyroid Issues
- Brain Health
- Chronic Pain

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Patient Financial Responsibility

1. I understand that Nurturing Optimal Wellness (NOW) is out-of-network for all insurance companies, and that it is my responsibility to submit claim forms to my insurance company.

2. I understand that payment in full is due at the time services are rendered. NOW accepts all major credit cards, as well as cash, personal checks or Care Credit.

3. If I have Medicare, I understand that Nancy Russell MD has opted-out of Medicare, and I agree to not submit any statements to Medicare for reimbursement.

Acknowledgement:

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____

Parent, Guardian or Power of Attorney Signature for Minor or Dependent:

_____ Date: _____

Nurturing Optimal Wellness

Nancy Russell, MD

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Patient Email Consent

Please read carefully. This form discusses the risks of using email to share personal health information.

Please consider the following risks before requesting or transmitting personal health information by unsecure email:

- Email messages sent or received by NOW are **not** encrypted and may not be secure.
- Third parties may therefore be able to intercept, read, alter, forward or use personal health information transmitted by email, without authorization or detection by you or NOW.
- An unsecure email message may be accidentally or intentionally forwarded to unintended recipients.
- Employers and internet service providers generally have the right to inspect and review any email message transmitted, received, or stored using their systems.
- Information shared by email may be printed, copied, and stored by any recipient in multiple locations.
- Copies of email messages containing personal health information may be kept, for example on backup servers or hard drives, long after the "original" message is deleted by both the sender and the recipient.
- Documents may be forged and identities may be stolen to take advantage of these vulnerabilities.
- Your personal health information in NOW's records may include information relating to prescriptions and medications, communicable diseases, physical impairments, chronic conditions, genetics, behavioral and mental health services, alcohol and drug abuse or addiction, billing and payments, and other information related to your medical care and condition.
- NOW is not responsible for any unauthorized access to or use of your personal health information that results from any unencrypted transmission that you authorize.

PERMISSION TO ALLOW COMMUNICATIONS BY UNENCRYPTED EMAIL:
I understand the risks involved when personal health information is transmitted via unencrypted email, and hereby give NOW permission to use unsecured email to communicate with me regarding the following classes of personal health information (check all that apply):

- ☐ Appointment Scheduling
- ☐ Medical Care, Test Results and Services
- ☐ Insurance and billing information
- ☐ Other: _____

_____ _____
Signature Date

_____ _____
Print Name Email Address

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PATIENT INFORMATION

Name: _____ Name you prefer to be called: _____
(Last) (First) (Middle)
Birth Date: ____/____/_____ SS# _____-_____-_____ Sex: _____ Marital Status: _____
Street Address: _____ Apt#: _____ Home Phone: (____) _____
City: _____ State: _____ Zip: _____ Cell Phone: (____) _____
Employer: _____ Work Phone: (____) _____ Ext: _____
Spouse's Name: _____ E-mail Address: _____

PERSON RESPONSIBLE FOR ACCOUNT – THAT PERSON MUST BE PRESENT TO SIGN!!!!

Please complete the section below, if someone other than the patient is responsible for the payment of services.

Name: _____ Relationship to Patient: _____
Street Address: _____ Apt#: _____ Date of Birth: _____ Home Phone: (____) _____
City: _____ State: _____ Zip: _____ Cell Phone: (____) _____
SS#: _____-_____-_____ Employer: _____ Work Phone: (_____) _____

PREFERRED METHOD OF PAYMENT

CASH ( ) CHECK (_____) CREDIT CARD (_____) CARE CREDIT (_____)

INSURANCE INFORMATION

Policy Holders Name: _____ Date of Birth: _____
Policy Holders ID#:_____ Group # _____ Insured's Relationship to Patient: _____
Insurance Company Name: _____
Please list any additional insurance on the back of this form, including all information as listed above.

HOW DID YOU HEAR ABOUT OUR OFFICE OR WHO REFERRED YOU?

Name: _____ Relationship: _____Phone: (_____) _____
Address: _____ City: _____ State: _____ Zip: _____

AUTHORIZATION

I grant authority, with my permission, to the doctor to perform necessary tests, for the establishment of my health profile and for the diagnosis of disease. I also grant authority, with my permission, to the doctor to provide treatment for any diagnosed illness that she and I deem necessary.

I understand that I am responsible for fees, at the time of service, for all in-house services (regardless of insurance payments). I also understand that I will be responsible for any portion of the doctors fee for hospital visits that my insurance does not cover.

I agree to pay finance charges of 1.5% per month (an Annual Rate of 18%) on any unpaid balance, after 90 days as well as collection fee cost and/or a reasonable attorney's fees if any delinquent balance is placed with an agency or attorney for collection or suit.

I hereby authorize the release of any information relating to my medical treatment and/or medical insurance claims to my insurance carrier.

Authorized Signature: _____ Date: _____

Parent of Minor or Guarantor: _____ Date: _____

Relationship to Patient: _____ Date: _____

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PATIENT MEDICAL/FAMILY HISTORY

Name _____ **Date** _____

Please circle any of the following illnesses YOU have had:

Diabetes Mellitus	**Arthritis**	**Fibromyalgia**	**Autoimmune Disorder**	**AIDS**
High Blood Pressure	**Asthma**	**Heart Trouble**	**COVID 19**	
Cancer	**Thyroid Disorders**	**Kidney Disease**	**Sexually Transmitted Infection(s) (STI)**	

SURGERIES:	**Operations**	**Date**	**Doctor**	**Hospital**
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

MEDICAL HOSPITALIZATIONS:	**Illness**	**Date**	**Doctor**	**Hospital**
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

ALLERGIES TO MEDICINE & REACTION: _____
_____
_____

SOCIAL HISTORY

Marital Status: ***Please Circle*** **Single Partner Married Widowed Divorced**

Occupation _____ **How Long?** _____

HABITS:

Do you use tobacco now? _____ **In the Past?** _____ **Type/Daily Amount?** _____ **How Long?** _____
Do you use alcoholic beverages? _____ **Type?** _____ **Weekly Amount?** _____ **How Long?** _____
Hobbies: _____
Exercise regularly (other than work-related)? _____ **Type of Exercise?** _____

(Continued on back)

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PATIENT MEDICAL/FAMILY HISTORY

Name _____ **Date** _____ **Page 2**

Please check the immunizations you have had and date if known:

MMR _____ **Polio (oral)** _____ **TDap** _____ **COVID-19 (Manufacturer)**_____
Pneumovx (pneumonia vaccine) _____ **Influenza (flu shot)** _____ **Other** _____

_____

FAMILY HISTORY

	Living	Age or Age at Death	Present Health or Cause of Death
Father	**Yes**___ **No** ___	_____	_____
Mother	**Yes** ___ **No** ___	_____	_____
Spouse	**Yes** ___ **No** ___	_____	_____

Brothers **Number Living** _____ **Their Health:** _____
Number Deceased _____ **Cause of Death:** _____
Sisters **Number Living** _____ **Their Health:** _____
Number Deceased ____ **Cause of Death:** _____
Children Living _____ **Their Ages and Health:**_____
Children Deceased _____ **Cause of Death and Child's Age:** _____

DO ANY OF THE FOLLOWING DISEASES RUN IN YOUR FAMILY?

Heart Disease/Stroke	_____	**Relationship to You:** _____
Thyroid Disorders	_____	**Relationship to You:** _____
Diabetes Mellitus	_____	**Relationship to You:** _____
Osteoporosis	_____	**Relationship to You:** _____
Cancer of Breast	_____	**Relationship to You:** _____
Cancer of Colon	_____	**Relationship to You:** _____
Cancer (Other)	_____	**Relationship to You:** _____

ANY OTHER PERTINENT INFORMATION REGARDING YOUR HEALTH OR THE HEALTH OF A FAMILY MEMBER: _____

_____

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Name: _____ **Date:** _____

Please rank your most troubling symptoms by level of concern to you.

PROBLEM	ONSET	FREQUENCY	SEVERITY
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

When was the last time you were in really good health? _____

What preceded your health decline? (Factors that may have triggered your change in health status) _____

_____

_____

What has happened to you / your family as a consequence of your illness? _____

_____

_____

What do you hope to receive in your visit?/What are your future health-related goals? _____

_____

_____

Do you see yourself in good health again in the future? Yes_____No_____Describe _____

_____

_____

(PLEASE FILL OUT BACK IF APPLICABLE)

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Name _____ **Date** _____

Preventive History

When have you last had:

_____Eye Exam
_____Dental Exam
_____Dermatology Exam
_____Male Annual Exam
_____Female Annual Exam
_____Mammogram
_____Dexa (Bone) Scan
_____Colonoscopy / Cologuard
_____EKG
_____Pap Smear
_____Prostate Exam
_____Other Test (please list)
_____Other Test (please list)

Please list any abnormal findings:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Alternative Therapies

Have you previously tried complementary, integrative or alternative medicine therapies? ☐ Y ☐ N

If yes, please fill out chart below.

Name of Therapy:	**Condition**	**Frequency and Duration of Use:**	**Improvement Seen?**	**Still Using Therapy?**
			☐Yes ☐No	☐Yes ☐No
			☐Yes ☐No	☐Yes ☐No
			☐Yes ☐No	☐Yes ☐No
			☐Yes ☐No	☐Yes ☐No

Please list the names of the other integrative providers you have seen:_____

_____

_____

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REVIEW OF SYSTEMS

Name _____ Date _____

*****ON EACH OF THE FOLLOWING QUESTIONS – IF YOUR ANSWER IS "YES" PLEASE MARK A "C" FOR CURRENT SYMPTOMS OR CONDITIONS AND A "P" FOR PAST ONES.*****

HAVE YOU EVER HAD	YES	NO
Chronic Headaches		
Problems with vision		
Glaucoma or Cataracts		
Decreased hearing		
Nose bleeds		
Sinus trouble		
Hoarseness		
Trouble swallowing		
Teeth or gum problems		

Dry cough		
Productive cough		
Lung disease – asthma, bronchitis or emphysema		

Chest pain with exercise		
Enlarged heart or heart failure		
Ankle swelling		
Heart palpitations		
High cholesterol or triglycerides		
High blood pressure		
Heart attack		

Change in bowel habits		
Constipation		
Diarrhea or blood in stool		
Indigestion, heartburn or gas		
Yellow jaundice or hepatitis		
Ulcers (stomach or duodenal)		
Hiatal hernia		
Gall stones		
Hemorrhoids		
Stomach x-ray (upper GI)		
Colon x-ray (lower GI)		
Colonoscopy or Procto		

Infections of kidneys or bladder		
Blood or protein in urine		
Kidney stones		
Trouble starting or holding urine		

HAVE YOU EVER HAD	YES	NO
Kidney x-rays (IVP)		
Problems with sexual desire or function		
Low Back pain		
Disc trouble		
Joint trouble		
Phlebitis or blood clots		
Leg pain with exercise		
Osteoporosis		

Unconsciousness from head injury		
Paralysis or stroke		
Dizziness (lightheadedness)		
Dizziness (room spins around)		
Convulsions or epilepsy		

Under active or overactive thyroid		
Thyroid goiter, nodule or tumor		
Hypoglycemia (low blood sugar)		
Diabetes Mellitus		

Skin cancers		
Cancer or blood disorder		
Chronic skin disease or rash		

Are you frequently ill?		
Do you have difficulty falling asleep or staying asleep?		
Are you considered a nervous person?		
Are you easily upset or irritated?		
Do you often cry?		
Do you feel unhappy or depressed?		

Please continue on the back of this page

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REVIEW OF SYSTEMS

WOMEN ONLY

	YES	NO
Breast lumps, tumors or discharge		
Hot flashes or vaginal dryness		
Surgery on your female organs		
Have you ever taken female hormones or birth control pills		

Age at beginning of menstruation
Age at end of menstruation
Irregular periods
Number of pregnancies
Number of miscarriages
Number of children born alive
Number of abortions
Last PAP smear date
Abnormal PAP smear
Last Mammogram (breast x-ray)
Birth Control Method

CURRENT MEDICATIONS

Supplements

(other side)

Patient Name: _____ Date:_____

Start Date	Medication	Dose, Quantity & Time of Day Taken		

Date	Allergy or Sensitivity	Reaction

CURRENT SUPPLEMENTS

Medications

(other side)

Patient Name: _____ Date:_____

Start Date	Medication	Dose, Quantity & Time of Day Taken		

Date	Allergy or Sensitivity	Reaction