NextMD Patient Portal:

Your secure, online connection to Vera Whole Health

NextMD, Vera Whole Health's secure email system, enables you to connect with your doctor through a convenient, safe, and secure environment. With NextMD, you can:

- Communicate directly with your provider from the privacy of home
- Request appointments electronically
- Request your lab results over secure email

How do I get started?

Great news! You are already enrolled. The only remaining step is to confirm your identity and set up your account.

1. Your enrollment token is a secret number assigned especially to you, which allows you to set up your account. This token number will be valid in 5 business days. You will find this number in the attached letter. Please note that it expires 30 days.
2. The attached letter outlines the setup features of your account in detail. You will also receive an email from us which contains the same information as the attached letter, in electronic form. If you do not see it in your inbox, please check your spam folder.
3. Once you have completed setting up your account, you may begin communicating with your provider immediately.

Questions? Concerns?

We appreciate your feedback - call your clinic's front desk anytime!

Vera Whole Health Coaching Overview

Whole Health Coaching Description
A Whole Health Coach facilitates the process of behavior change and helps you move closer to your wellness vision by co-creating a personalized and strategic action plan. You can expect your coach to listen with curiosity and empathy, ask powerful questions and hold you accountable to your commitments. Through coaching, you are empowered to initiate change and set personally motivating session goals to address a variety of concerns, such as stress, exercise, nutrition, sleep or work-life balance. Throughout the process, your coach will work beside you as a collaborative partner on your journey, helping draw out of you what you already know, believe, and desire.

Whole Health Coaching Process
Coaching is a collaborative process that requires active and invested participation. To get the maximum benefit from coaching, you are encouraged to come to each coaching session prepared with a topic for discussion. You determine what to share during these sessions, and your coach will respect those boundaries. You can expect your coach to be honest and direct and offer challenges.

Successful Health Coaching is largely dependent on your willingness to define and accept goals, try new approaches and take action outside of the coaching session. You determine the goals and outcomes, and you have the ultimate responsibility for the choices, plans, timing, and actions you take.

While your coach works collaboratively with your Vera provider to support you, coaching services are not medical advice, nor do they replace services such as those provided by Registered Dietitians, Personal Trainers, Behavioral Health Therapists, Physical Therapists, Medical Doctors, Nurse Practitioners, Chiropractors or any other health professional.

Structure of Coaching:

- Session length: 30 minutes
- Location: May be done in-person or over the phone (not while driving)
- Frequency: Varies from weekly, bi-weekly, monthly, etc.
- Duration: From 3 to 12 sessions
- Cost to you: No cost to you

Notice of Privacy Practices Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Vera Whole Health.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

X_____

Printed name of Patient

X_____

Printed name of legally authorized individual signature if signed on behalf of the patient

X_____

Relationship (parent, legal guardian, personal representative)

X_____

Patient or legally authorized individual signature Date Time

Vera Whole Health WA, PC

Consent to Services

I, (print name)_____, authorize Vera Whole Health WA, PC to provide me with services it performs. Among those services include:

- Administration and performance of all relevant diagnoses and treatments;
- Performance of such procedures as may be deemed necessary or advisable in my treatment;
- Administration of prescribed medication;
- Performance of diagnostic procedures/tests and cultures;
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.

I fully understand that this information is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made, treatment recommendations including alternatives to treatment have been discussed, and possible risks have been addressed.

I certify that I have read and fully understand this consent, have had the opportunity to ask questions about it, and voluntarily agree to its contents.

_____ _____

Printed Patient Name *Date of Birth*

_____

Parent/Legal Guardian Name if Patient under 18 years old

_____ _____

Patient Signature (or Parent/Legal Guardian if Patient is under 18 years old) *Date of Signature*

ONCE SIGNED, PLEASE RETURN BY HAND-DELIVERY OR MAIL (PREFERRED METHODS). IF SENT VIA FAX OR E-MAIL, PLEASE ENCRYPT TO ENSURE YOUR INFORMATION IS SECURE.

Patient DOB: _____

vera
WHOLE HEALTH

PATIENT E-MAIL/TEXT MESSAGE AUTHORIZATION FORM

Vera Whole Health (Vera) has the ability to communicate with you, reminding you of your appointments, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information . Please refer to our Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters

I,_____, authorize Vera to contact me at the following email address and/or cell phone number:

☐ E-mail: _____

☐ Cell phone number: _____

Vera will use reasonable means to protect the security and confidentiality of information sent and received. However, because of the risks outlined below, Vera cannot guarantee the security and confidentiality of electronic communications:

Risks:

1) I understand that if Vera contacts me by e-mail or text, the most likely risk to my personal health information is that information intended for me could be intercepted without the knowledge of either myself or Vera.

1) Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties

2) I also understand that there is a risk that my e-mail account could be hacked, and that email sent to me could be monitored, intercepted, read, and/or altered before it reaches my e-mail in-box.

3) Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the Physician or the patient.

4) Even after the sender and recipient have deleted copies of electronic communications, back-up copies may exist on a computer system.

5) Electronic communications maybe disclosed in accordance with a duty to report or a courtorder.

Acknowledgement and Agreement:

1. I consent to receive text messages from Vera at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change.

2. I understand that communications with Vera may not be encrypted and there is a risk of messages being read by a third party. Despite this, I agree to communicate with Vera, its Providers, and Vera staff with a full understanding of that risk.

3. I have read and understand the risks associated with e-mail/text communications, and I understand there may be additional risks not described here.

4. I understand that Vera cannot control who reads my e-mail or text messages, while in route or when delivered to my e-mail account or phone.

5. I hold Vera harmless from any liability for sending my protected health information by e-mail or text message, or for any unintentional misdirection of e-mail or text messages to someone other than me.

6. I understand that I may revoke this authorization at any time.

Name of Patient	Date of Birth
Signature of Patient or Legal Representative	Date
Printed Name of Patient's Legal Representative	Relationship to Patient

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WHOLE HEALTH

Clinic Use Only			
Height		Tot. Chol.	
Weight		HDL	
HgA1c		LDL	
Glucose		Trig	

Health Summary

Demographic Information	
Full Name:	Date of Birth:
Primary Care Provider:	Occupation:
Relationship Status:	
Children: ☐ I have none ☐ I have children, ages:	
What concerns or goals would you like to address in today's visit?	

What other healthcare providers do you see for your care? (☐ check if you have none)	
Name:	Specialty:
Name:	Specialty:
Name:	Specialty:

Have you ever been diagnosed or treated for any of the following? (☐ check if you have none)

☐ Acid Reflux Disease	☐ Chronic Back Pain	☐ High Blood Pressure	☐ Seizure Disorder
☐ Acne	☐ Chronic Kidney Disease	☐ High Cholesterol	☐ Sleep Apnea
☐ Allergies	☐ COPD/Emphysema	☐ HIV/AIDS	☐ Stroke
☐ Anemia	☐ Crohn's Disease	☐ Liver Disease	☐ Substance Abuse
☐ Anxiety	☐ Depression	☐ Migraines	☐ Thyroid Disorder
☐ Arthritis	☐ Diabetes	☐ Overweight	☐ Ulcerative Colitis
☐ Asthma	☐ Erectile Dysfunction	☐ Peripheral Vascular Disease	☐ Urinary Incontinence
☐ Atrial Fibrillation	☐ Heart Attack/Disease	☐ Prediabetes	☐ Vitamin D Deficiency
☐ Cancer:_____	☐ Heart Failure	☐ Rheumatoid Arthritis	☐ _____

Please list all pills or medicines you take – Please bring all medicines to your visit. (☐ check if you have none)

Name of Medication	Dosage	When and how often do you take it?

Do you use any medical equipment (Ex: cane, hearing aid, home oxygen, etc.)?
☐ No ☐ Yes, I use:

Allergies to Medications (☐ check if you have none)

Medication	Reaction

Surgeries and Hospitalizations (☐ check if you have none)

Year	Surgery or hospitalization reason

Patient Name _____ Date of Birth _____

Family History – Please list all medical problems in your family, including cause of death if appropriate
☐ I don't have a family history to share
Mother:
Father:
Sibling:
Sibling:
Other family members:

Review of Systems: Mark the symptoms you have had in *the past **30** days and want to discuss today*

Constitutional	**Head and Throat**	**Lungs and Heart**	**Gastrointestinal**
• Chills ☐ • Fatigue ☐ • Fever ☐ • Night Sweats ☐ • Weight Gain ☐ • Weight Loss ☐	• Ear Pain ☐ • Eye Discharge ☐ • Eye Pain ☐ • Hearing Loss ☐ • Sinus Pressure ☐ • Sore Throat ☐ • Vision Changes ☐ • Snoring ☐	• Cough ☐ • Shortness of Breath ☐ • Wheezing ☐ • Difficulty Breathing ☐ • Chest Pain ☐ • Swelling of Hands or Feet ☐ • Palpitations ☐ • Fainting ☐	• Abdominal Pain ☐ • Blood in Stool ☐ • Change in Stool ☐ • Constipation ☐ • Diarrhea ☐ • Nausea ☐ • Vomiting ☐ • Heartburn ☐ • Change in Appetite ☐
Reproductive: Female	**Reproductive: Male**	**Urinary**	**Skin**
• Hot Flashes ☐ • Menstrual Pain ☐ • Irregular Periods ☐ • Vaginal Discharge ☐ • Vaginal Itch ☐ • Pain with Sex ☐ • Decreased Libido ☐ • Sexual Dysfunction ☐ • Breast Discharge ☐ • Breast Lumps ☐ • Breast Pain ☐	• Decreased Libido ☐ • Erectile Dysfunction ☐ • Masses ☐ • Penile Discharge ☐ • Scrotum/Testicular Pain ☐ • Sexual Dysfunction ☐	• Painful Urination ☐ • Blood in Urine ☐ • Frequent Urination ☐ • Urinary Incontinence ☐ • Nighttime Urination ☐ • Flank Pain ☐ • Slow Stream ☐	• Acne ☐ • Itching ☐ • Change in Mole ☐ • Rash ☐ • Skin Masses or Lumps ☐ • Hair Loss ☐ • Skin Lesion ☐
Musculoskeletal	**Mental Health**	**Metabolic/Endocrine**	**Neurologic**
• Joint Pain ☐ • Muscle Weakness ☐ • Neck Pain ☐ • Joint Stiffness ☐ • Back Pain ☐ • Joint Deformity ☐	• Anxiety ☐ • Depression ☐ • Difficulty Sleeping ☐	• Cold Intolerance ☐ • Heat Intolerance ☐ • Extreme Thirst ☐ • Extreme Hunger ☐	• Dizziness ☐ • Numbness/Tingling ☐ • Extremity Weakness ☐ • Headache ☐ • Memory Loss ☐ • Seizures ☐ • Tremors ☐ • Change in Gait ☐ • Increased Falls ☐
	Hematologic/Lymph	**Environmental**	
	• Easy Bleeding ☐ • Easy Bruising ☐ • Swollen Lymph Nodes ☐	• Contact Allergy ☐ • Environmental Allergy ☐ • Food Allergy ☐ • Seasonal Allergy ☐	

Patient Name _____ Date of Birth _____

General Health

In general, would you say your health is: ☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

How would you describe the condition of your mouth and teeth – including false teeth or dentures:
☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

In general, how satisfied are you with your life? ☐Very Satisfied ☐Satisfied ☐Dissatisfied ☐Very Dissatisfied

How often do you find yourself confused by health information like what your medical provider tells you?
☐Usually ☐Sometimes ☐Rarely

Do you have a:
- Medical power of attorney? ☐Yes ☐No
- Living will/advanced directives? ☐Yes ☐No

How interested are you in making changes to improve your health?
☐Very interested ☐Somewhat interested ☐Not interested

If interested, what health change do you want to make? _____

Wellness

Average hours of sleep per night? _____ **Do you feel rested when you awaken?** ☐Yes ☐No

Average hours of physical activity per week? _____ Type(s) of activity: _____

How often do you eat fruits or vegetables? ☐Every meal ☐With most meals ☐Once a day ☐Less than once a day

How often do you consume foods or drinks that are high in added sugar? (Ex: soda, sweetened drinks, desserts, etc.)
☐3+ times a day ☐1-2 times a day ☐A few times a week ☐Less than once a week

How often do you eat fried or highly processed foods? (Ex: fast food, bacon, potato chips, etc.)
☐3+ times a day ☐1-2 times a day ☐A few times a week ☐Less than once a week

Do you consume caffeine? ☐Yes ☐No **If yes, how much per day?** _____

Behavioral Health

Do you have significant stress with any of the following?
☐Work ☐Finances ☐Legal Issues ☐Housing ☐Family Concerns ☐Relationships ☐Other: _____ ☐N/A

How often do you get the social and emotional support you need? ☐Usually ☐Sometimes ☐Rarely

Are religious or spiritual beliefs or practices something that you use for support? ☐Usually ☐Sometimes ☐Rarely

Think about the <u>last 2 weeks</u> as you answer the following questions:

How often have you had little or no interest in daily activities?
☐Not at all ☐Several days ☐More than half the days ☐Nearly every day

How often have you been bothered by feeling down, depressed, or hopeless?
☐Not at all ☐Several days ☐More than half the days ☐Nearly every day

How often have you felt nervous, anxious, or on edge?
☐Not at all ☐Several days ☐More than half the days ☐Nearly every day

How often were you not able to stop worrying or control your worry?
☐Not at all ☐Several days ☐More than half the days ☐Nearly every day

Tobacco Use

What tobacco or vapor products have you used?
☐Cigarettes ☐Chew ☐Vapor/e-cigarettes ☐Other_____ ☐None

If you've ever smoked cigarettes, answer the following:(otherwise, skip to next section)
How many cigarettes per day? _____ Number of years used: _____ If you stopped, when did you quit? _____

Alcohol and Drug Use

How often do you have a drink containing alcohol?

Patient Name _____ Date of Birth _____

☐ Never ☐Monthly or less ☐2-4 times a month ☐2-3 times a week ☐4 or more times a week

How many drinks containing alcohol do you have on a typical day when you were drinking in the past year?

☐1-2 ☐3-4 ☐5-6 ☐7-9 ☐ 10 or more ☐I don't drink

How often do you have four or more (six or more for males) drinks on one occasion in the past year?

☐ Never ☐Less than monthly ☐ Monthly ☐ Weekly ☐Daily or almost daily

Have you ever had a problem with alcohol or binge drinking in the past? ☐Yes ☐No

Have you ever used recreational drugs?

☐No history of use ☐ Use or have used: Type(s): _____ Frequency of use: _____

Sexual History

Are you sexually active? ☐Yes ☐Formerly ☐No

How many sexual partners have you had in the past 3 months? _____

Have you had sex with: ☐Men ☐Women ☐Both

Do you use birth control? ☐Always ☐Sometimes ☐No

If so, what types? ☐Condoms ☐N/A

☐Other: _____

Do you desire to start or change contraception?

☐ No ☐Yes

Safety

How often do you need help with eating, grooming, dressing, toileting, or walking?	☐Often ☐Sometimes ☐Never
How often do you need help with cooking, banking, transportation, or housekeeping?	☐Often ☐Sometimes ☐Never
Do you ever drive after drinking or ride with a driver who has been drinking?	☐Often ☐Sometimes ☐Never
Do you fasten your seat belt when you are in a car?	☐Always ☐Sometimes ☐Never
Does anyone in your life hurt you or make you feel unsafe in any way?	☐Yes ☐I don't know ☐No
Are your firearms unloaded and locked away?	☐Yes ☐No ☐Don't have guns

Screenings - Please include date or year if known

☐Dental Exam	☐ Hepatitis C screening	☐HIV Screening
Colon Cancer Screening	☐Colonoscopy: _____ ☐ Stool Based test (FIT, stool card): _____	☐Sigmoidoscopy: _____ ☐CT Colonography: _____

Immunizations - Please include date or year if known

☐Pneumonia Vaccine	☐Tetanus Shot	☐HPV Vaccine
☐Shingles Vaccine	☐ Flu Shot (within the year)	☐MMR

Women's Health – Please include date or year if known

1st day of last period _____

Pap Smear ☐ Never	Chlamydia/Gonorrhea test ☐ Never	Mammogram ☐ Never	DEXA/Bone Density Scan ☐Never

Do you have any concerns about your periods or menopause? □ No □ Yes: Describe_____

Patient Signature: _____ Today's Date: _____

Date of Birth: _____