Northwest Center for Natural Medicine

Patient: _____ DOB: _____ Date: _____

Present Health Concern: Please list your most important health concerns in the order of significance

1.	2.	3.
4.	5.	6.

What goals do you have for your visit at the clinic today?
Primary goal: _____
Secondary goal: _____

Have you been to a naturopathic physician before? **YES/NO** If yes, whom: _____

List name of doctors you are currently seeing and for what reason:

1. _____
2. _____
3. _____

Please list medications and dosage you are currently taking: Use separate sheet if needed

Medication	Dosage	Purpose

Please list any vitamins, minerals, herbs or homeopathic remedies that you are currently taking:

Drug allergies: _____
Food allergies: _____
Environmental allergies (ex: grass/pollen):_____

PERSONAL HABITS:
Tobacco **YES/NO** how often: _____
Alcohol **YES/NO** how often: _____
Recreational drugs **YES/NO** type of drug: _____how often: _____

Exercise regularly **YES/NO** type of exercise: _____ how often: _____

PAST HISTORY:
How many births: _____ Complications: **YES/NO** if yes, what: _____
Immunizations: _____
Childhood illnesses/sickness: _____

DOS: _____

HOSPITALIZATIONS:

REASON:	DATE:

SERIOUS ILLNESSES/INJURIES:

DATE OF LAST EXAMS:

Physical exam: _____ Blood test: _____ Pap smear: _____
Prostate exam: _____ Mammogram: _____ Stool test: _____

Do you give self breast exams? **YES/NO** if yes, how often: _____

SOCIAL HISTORY:

Please circle: Single Married Divorced Widowed Significant Other

Children: **YES/NO** how many: _____ Ages: _____

LIFESTYLE PROFILE

24 hour diet recall: Please list what you had to eat in the last 24 hours:

Breakfast	
Lunch	
Dinner	
Snacks	

List average amounts per day of the following:

Water	
Alcohol	
Caffeine	
Other beverages	
Other beverages	

Hours of work a day: _____ Hours of sleep a night: _____
Relaxation: What do you do to relax? _____ How often: _____

CONSTITUTIONAL PROFILE

Energy Level: Low 1 2 3 4 5 6 7 8 9 10 High

DOS:_____

FAMILY HISTORY: Did any of your family members have? If yes, indicate whom:

- ☐ Alcoholism _____
- ☐ Allergies _____
- ☐ Alzheimer's_____
- ☐ Hepatitis_____
- ☐ High Blood Pressure _____
- ☐ Kidney Disease _____
- ☐ Mental Illness _____
- ☐ Stroke _____
- ☐ Tuberculosis _____
- ☐ Epilepsy _____
- ☐ Heart Disease _____
- ☐ Anemia_____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Eczema _____
- ☐ Other _____

SYMPTOMS: Check symptoms you currently have or had in the past year

GENERAL
- ☐ Fatigue
- ☐ Fever/Chills
- ☐ Weakness
- ☐ Sweating/Night sweats
- ☐ Hair/Nail changes
- ☐ Mood changes
- ☐ Depression
- ☐ Headache
- ☐ Sleeping problems
- ☐ Fainting
- ☐ Antibiotic history

EENT
- ☐ Eye discharge
- ☐ Sinusitis
- ☐ Nasal Discharge
- ☐ Postnasal drip
- ☐ Nose bleeds
- ☐ Mouth sores
- ☐ Bleeding gums
- ☐ Blurring vision
- ☐ Double vision
- ☐ Eye pain

SKIN
- ☐ Bruises
- ☐ Hives
- ☐ Itching
- ☐ Rashes
- ☐ Change in moles
- ☐ Scars
- ☐ Sores not healing

GASTRO-INTESTIONAL
- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Hemorrhoids
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

GENITOURINARY
- ☐ Urinary Tract Infection
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Night urination
- ☐ Urgency
- ☐ Lack of bladder control
- ☐ Blood in urine

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling ankles
- ☐ Varicose veins
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Coughing

WOMEN
- ☐ Breast masses
- ☐ Nipple discharge
- ☐ Menstrual
  - Length_____
  - Duration_____
- ☐ Spotting
- ☐ Irregular cycle
- ☐ Painful periods
- ☐ PMS
- ☐ Abnormal pap
- ☐ Abnormal discharge

MEN
- ☐ Breast masses/lumps
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other _____

CONDITONS: Check any of the following you had with approximate dates

- ☐ AIDS _____
- ☐ Alcoholism _____
- ☐ Anemia _____
- ☐ Anorexia _____
- ☐ Appendicitis _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Barrett's Esophagus_____
- ☐ Bleeding disorders _____
- ☐ Breast lump_____
- ☐ Bronchitis _____
- ☐ Bulimia _____
- ☐ Cancer _____
- ☐ Cataracts_____
- ☐ Chemical dependency____
- ☐ Chicken Pox _____
- ☐ Colitis_____
- ☐ Crohn's disease _____
- ☐ Diabetes_____
- ☐ Edema _____
- ☐ Emphysema _____
- ☐ Epilepsy _____
- ☐ Glaucoma _____
- ☐ Goiter _____
- ☐ Gout _____
- ☐ Heart Disease _____
- ☐ Hepatitis _____
- ☐ Hernia _____
- ☐ Herpes _____
- ☐ High Cholesterol _____
- ☐ HIV positive _____
- ☐ Hysterectomy_____
- ☐ Kidney disease_____
- ☐ Liver disease _____
- ☐ Measles _____
- ☐ Migraine _____
- ☐ Miscarriage _____
- ☐ Mononucleosis_____
- ☐ Multiple Sclerosis_____
- ☐ Mumps_____
- ☐ Pacemaker_____
- ☐ Pneumonia _____
- ☐ Polio _____
- ☐ Prostate issues _____
- ☐ Psychiatric care _____
- ☐ Rheumatic fever_____
- ☐ Scarlet fever _____
- ☐ Stroke_____
- ☐ Suicide attempt_____
- ☐ Thyroid issues_____
- ☐ Tonsillitis _____
- ☐ Tuberculosis _____
- ☐ Typhoid fever_____
- ☐ Ulcers_____
- ☐ Vaginal infection _____
- ☐ Venereal disease _____

Any additional information or comments: _____

_____

_____

_____

_____

Reviewed by: _____ Date:_____

PATIENT INFORMATION

PATIENT INFO: PLEASE PRINT

Patient Name: _____ DOB: _____

Social Security#: _____ Sex: F or M Marital Status: _____

Address: _____ City/Zip: _____

Home phone: _____ Cell/Alternate number: _____

What phone number do you prefer we call? _____

Employment Status: Employed Non-Employed Student Retired

Employer: _____ Work number: _____

Occupation: _____

How did you hear about us? _____

Email Address: _____

Drug Allergies: _____

Spouse and/or Legal Guardian

Name: _____ Relationship: _____

Address: _____ City/Zip: _____

DOB: _____ Employer: _____

Work number: _____ Alternate number: _____

Emergency Contact (someone not living with you)

Name: _____ Relationship: _____

Address: _____ City/Zip: _____

Home phone: _____ Alternate number: _____

Insurance:

- ❒ No insurance to bill (cash paying patient)
- ❒ If you have insurance with Naturopathic coverage; please give insurance card to receptionist to copy. ****Make sure you verified your benefits with your insurance, see insurance form to assist you****

Northwest Center for Natural Medicine

Office Policies

Supplements:

1. We will not bill your insurance for supplements. You are required to purchase supplements before receiving. Feel free to submit to your insurance for possible refund. We do accept: Cash, Check, Visa, MasterCard and Discover.

2. You may return supplements for office credit if unopened and purchased last 60 days and not expired.

Health Savings Accounts:

1. We can only fill out forms for prescription products that were purchased and prescribed by Northwest Center for Natural Medicine. This will need to be verified by receipt and/or your treatment plan from the provider. You should keep track of your treatment plans and receipts to attach with to your forms when you submit them to us.
2. Due to the large amount of requests for these, we will need 2-3 business days to complete forms.

Injections:

We will not bill insurance for injections given in office. If you receive and agree with having a Vitamin B shot these will be due at time of service. Injections range from $11.00 to $20.00.

Lab Services:

If we are unable to bill insurance for Urinalysis dipstick and performed in our office; the cost is due at the time of service. Urinalysis dipstick test are $15.00.

We will refer patients to an outside laboratory for blood draw and cytology services. If you plan to bill Medicare for your lab work, we are unable to order since we are not contracted with Medicare. **It is the patient's responsibility to find out what their preferred out patient laboratory is with their insurance**. We typically send our patients to Quest Diagnostic.

No Show/Cancel Policy:

We require a 24 hour notice for any cancels or reschedules. We do understand that emergencies do happen and will handle those case by case. There will be a $35.00 fee billed to you directly without proper notice given to our office.

Three people are hurt when there is a no-show or last minute cancel/reschedule

1. The professional who set aside their time
2. The other patients that could have been seen
3. The patient that doesn't receive the help they need

I understand and agree to the above policies

Patient signature: _____ Date: _____

Northwest Center for Natural Medicine

Financial Payment Policy and Assignment of Benefits

Thank you for choosing us as your health care provider. The provision of care rendered to you will result in a bill for our services. The following is a statement of our Financial Payment Policy, which we requested you read and sign prior to your treatment. All patients must complete our Information & Insurance Form, provide a current insurance card and a valid photo ID issued by a local, state or federal agency before seeing the provider.

REGARDING INSURANCE

If we are the participating provider, all co-payments and deductibles are due at the time of service.

As a courtesy we will bill your insurance carrier for you. Your insurance policy is a contract agreement between you and your insurance company. We are not a party to that contract. If you do not inform us of any specific requirements or guidelines in your contract and your provider subsequently orders services that are not covered; we, or the selected facility will bill you directly for those charges. Your insurance company determines the amount you are responsible to pay based on your plan policy with them. These amounts will be shown on the Explanation of Benefits you will receive from your insurance company.

If your insurance has not paid your account within 45 days, the account automatically becomes your responsibility and will become due immediately. Please be aware that some of the services provided may be non-covered services or not considered reasonable and necessary under your policy, but deemed to be in your best interest by your provider.

PRIVATE PATIENTS

Private Pay patients are entitled to a discounted cash price when paid in full payment at the time of service.

A minor's parent(s) or guardian(s) are responsible for full payment. For unaccompanied minors, non-emergency treatments will be denied unless a valid medical power-of-attorney and an approved method of payment accompany the patient at the time of service.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE, UNLESS WE ARE BILLING YOUR INSURANCE FOR YOU. WE ACCEPT CASH, CHECK, OR CREDIT CARD. IF YOUR ACCOUNT IS SENT TO COLLECTIONS FOR LACK OF PAYMENT, YOU WILL BE DISCHARGED FROM PRACTICE UNTIL YOUR ACCOUNT IS A ZERO BALANCE.

Please remember that when you receive our statement, you already received quality health care from our provider. Prompt payment upon statement is greatly appreciated. Delinquent accounts after 90 days will be sent to collections.

Thank you for understanding our Financial Payment Policy. Please let us know if you have any questions or concerns.

I have received the Financial Payment Policy

X_____ Date:_____

(Signature of Patient or Responsible Party)

I, the undersigned authorized the release of any information relating to all claims for benefits submitted on behalf of myself and/or any dependents. I further expressly acknowledge that my signature on this document authorizes the provider of medical services to submit claim for benefit for services rendered to my insurance company, without obtaining my signature on each and every claim to be submitted for myself and/or dependents. I hereby authorize payment of all insurance, payable to me to be paid directly to provider. This authorization shall remain in effect until revoked by me in writing.

X_____ Date: _____

(Signature of Patient or Responsible Party)

Northwest Center for Natural Medicine

CONSENT of SERVICES

I authorize the doctors of Northwest Center for Natural Medicine to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Naturopathic Medicine

Common diagnostic procedures: e.g. venipuncture, Pap smears radiography, laboratory and x-ray.

Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation and intramuscular vitamin injections.

Botanic medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, plasters or suppositories.

Homeopathic medicine: the use of highly diluted quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.

Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, balancing of work and social activities.

Minor office procedures: wound dressing, ear cleansing

Psychological counseling

Contraception

Immunization

I recognize the potential risks and benefits of these procedures as described below:

Potential benefits: restoration of health and the body's maximum capacity for function, relief of pain and symptoms of disease, assistance in injury and disease recovery and prevention of disease or its progression.

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures.

ACUPUNTURE

Acupuncture: insertion of special sterilized needles through the skin into underlying tissues at specific points on the surface of the body.

Cupping: a technique to relieve symptoms in which cups made of glass or other materials are placed on the skin with a vacuum created by heat or suction.

Gua Sha: a rubbing on an area of the body with a blunt, round instrument.

Herbs: may be prescribed in the form of pills, powders, tinctures, pastes, plasters or other forms such as raw herbs to be cooked. Cooked herbs may be given to take internally or externally as a wash. Herbal formulas may include shell, mineral or animal materials.

Moxa: indirect burning on an acu-points using stick, string or ball moxa to relieve symptoms.

Tuina: an ancient massage used to treat a wide variety of common disharmonies.

Dietary Advice: based on traditional Chinese Medical Theory.

I recognize the potential risks and benefits of these acupuncture procedures as described below:

Potential benefits: drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem and the strengthening of the constitution.

Potential risks: discomfort, pain, infection or blistering at the site of acupuncture procedures, temporary discoloration of the skin, nausea, loose bowel movement, abdominal cramping and aggravation of symptoms existing prior to the acupuncture treatment.

Notice to pregnant women: all female patients must alert the doctor if they know or suspect that they are pregnant, as some of the therapies could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the Northwest Center for Natural Medicine or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or myself or unless it is required by law. I understand that I may look at my medical record at any time and can request of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential. I understand that any question I have will be answered by my practitioner to the best of his/her ability.

Signature: _____ Dated: _____

Signature of patient representative or Guardian: _____

Northwest Center for Natural Medicine

HIPPA

Acknowledgement and Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this acknowledgement. A copy can be reviewed in our waiting room. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting a request.

By signing this form, you acknowledge receipt of our notice regarding use and disclosure of protected health information about you for treatment, payment and health care operations as described in the notice.

❒ Yes ❒ No I authorize NW Center for Natural Medicine to call my home and leave a message.

❒ Yes ❒ No I authorize NW Center for Natural Medicine to call my work and leave a message.

Please list anyone whom you want to have verbal and/or physical access to your health care information. This information will remain in place until you direct NW Center for Natural Medicine otherwise.

Name: **Relationship:**

_____

_____

_____

_____

Patient name: _____ DOB: _____

Patient/Representative Signature: _____Date: _____