Northwest Natural Health®
A Specialty Care Clinic

# REGISTRATION INSTRUCTIONS

It is important that you check-in 15-20 minutes prior to your scheduled appointment with your completed intake forms.

- **Patient Profile & Health History**
  These forms should be filled out completely, signed and dated. It provides important health and legal information needed your appointment.

- **Financial Responsibility & Insurance Information**
  At check-in, please provide receptionist with your insurance card and WDL or picture ID, if applicable.

  If you have insurance, it is advised you call our main clinic prior to your scheduled appointment at (206) 784-9111 or Toll Free: (888) 706-6667. We will attempt to verify if Naturopathic services are a covered benefit on your policy and also if a referral from your primary care provider is a requirement.

  Payment or copayments are due at time of service unless other arrangements have been made.
  Northwest Natural Health® Clinic accepts; cash, personal checks, MasterCard, Visa, American Express and Discover.

  If you need to be billed for your healthcare services, the staff at our main clinic will be happy to help establish a convenient payment plan through an in-office payment plan or monthly auto pay with your credit or debit card.

  We require 24-hours advance notice for changing or canceling appointments. We charge ($50) if an appointment is not kept as scheduled. Please help us serve you better by keeping scheduled appointments.

- **Authorization to Release Healthcare Information**
  This form allows us to discuss and/or release your personal health information to you. When applicable, this form also allows us to request or release pertinent records and test results to or from your other health care provider(s), and provide regular progress reports for coordination of your care. This form needs to be signed if you want records requested or released to anyone other than your referring physician.

- **Provider List**
  Include the names of your current health care provider(s), so we can provide them with regular progress reports, if applicable. Please fill in the provider contact information as completely as possible, including phone and fax numbers. We request you include your primary care provider, even if that practitioner is not actively involved during your medical specialist treatments.

- **Nutritional Supplement Information**
  Review, sign and date form, even if you do not make purchases from our clinic. This form provides important health and legal information about the supplements our physicians may prescribe, including our return policy.

Thank you for choosing Northwest Natural Health®.
We appreciate the opportunity to participate in your care.

6135 Seaview Avenue NW Suite 300 - Seattle, WA 98107
Main Office: (206) 784-9111 Toll Free: (888) 706-6667 Fax: (206) 784-7444
www.nwnaturalhealth.com
For scheduling at our MultiCare (Tacoma) location please call: (253) 403-7677

Northwest Natural Health®
A Specialty Care Clinic

# PATIENT PROFILE & HEALTH HISTORY QUESTIONAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

**NAME:** _____ **DOB:** _____/_____/_____ ☐ M ☐ F

**ADDRESS:** _____ **HOME PHONE:** _____

**CITY:** _____ **STATE:**_____ **ZIP:**_____ **CELL PHONE:** _____

**SOCIAL SECURITY #:**_____ **OCCUPATION:** _____ **HOW LONG:** _____

**EMPLOYER:** _____ **WORK PHONE:** _____

**EMERGENCY CONTACT:** _____ **RELATIONSHIP:** _____

**ADDRESS:** _____ **PHONE** _____

**EMAIL:** _____ ***(to keep you updated on clinic news & health related topics.)***

**HOW DID YOU HEAR ABOUT US?** _____

**PLEASE LIST YOUR HEALTH CONCERNS IN ORDER OF IMPORTANCE:**

**1.** _____ **2.** _____ **3.** _____ **4.** _____

**FAMILY HISTORY & ILLNESSES YOU HAVE OR BEEN TREATED FOR (check all that apply):**

**Please mark: X = Self S = Sibling P = Mother or Father GP = Grandparent**

| | | |
|---|---|---|
| _____ **ADD/ADHD** | _____ **Alcohol or Substance Abuse** | _____ **Allergies** |
| _____ **Anemia** | _____ **Arthritis** | _____ **Asthma** |
| _____ **Blood Clots** | _____ **Cancer** | _____ **Colitis or Bowel disorder** |
| _____ **Depression** | _____ **Diabetes** | _____ **Eating Disorder** |
| _____ **Glaucoma** | _____ **Gynecological Problems** | _____ **Gout** |
| _____ **Heart Disease** | _____ **Hepatitis or Liver disease** | _____ **Hemophilia or Bleeding Disorder** |
| _____ **High Cholesterol** | _____ **High Blood Pressure** | _____ **HIV/AIDS** |
| _____ **Hypoglycemia** | _____ **Indigestion / Gerd** | _____ **Multiple Sclerosis (MS)** |
| _____ **STD** | _____ **Seizures/Epilepsy** | _____ **Psychological / Mental Illness** |
| _____ **Stroke** | _____ **Skin Condition / Rash** | _____ **Thyroid Disease** |
| _____ **Tuberculosis** | _____ **Vertigo / Dizziness** | _____ **Other** _____ |

**List any other medical condition(s) not specified:** _____

**Females Only:**

Age at onset of menstruation: _____ Last menstrual cycle:_____ No. of Live Births: ____

History of Breast lumps: ☐ Yes ☐ No Birth control pills? ☐ Yes ☐ No Menopausal: ☐ Yes ☐ No

**Males Only:**

Prostate exam or PSA test within the last year? ☐ Yes ☐ No Last PSA count: _____

## SURGERIES, HOSPITALIZATIONS OR OTHER TREATMENT:

_____ _____
Month/Year Reason

_____ _____
Month/Year Reason

Northwest Natural Health®
A Specialty Care Clinic

**LIST ALL MEDICATIONS:** (Include prescriptions, over-the-counter medications, vitamins, supplements, herbal remedies, etc. continue on back if needed)

| Name of Drug/Supplement | Dosage | Frequency | Start Date/Year | Prescribed By | Reason |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**KNOWN ALLERGIES OR SENSITIVITIES (foods, chemicals, pollens, etc.):** _____

_____

| | | | | | |
|---|---|---|---|---|---|
| **Dietary** | How would you describe your nutritional intake: | | | | |
| | ☐ Regular | ☐ Diabetic | ☐ High Protein | ☐ Low Carbohydrate | |
| | ☐ Vegetarian | ☐ Vegan | ☐ Low Fat | ☐ Low Sodium | |
| | ☐ Weight Reduction | ☐ Weight Gain | ☐ Lactose Free | ☐ Gluten Free | |
| | Number of meals in an average day: | | Number of snacks in an average day: | | |
| | Number of meals you eat out daily? | | Number of meals you eat out weekly? | | |
| **Caffeine** | ☐ None | ☐ Coffee | ☐ Tea | ☐ Soda | ☐ Other |
| | Number of cups/cans per day? | | | | |
| **Alcohol** | Do you drink alcohol? | | | ☐ Yes | ☐ No |
| | How many drinks per week? | | | | |
| **Tobacco** | Current or past tobacco use? | | | ☐ Yes | ☐ No |
| | Type(s): | # per day: | # of years: | Year quit: | |

***Medicare, Medicare supplemental and Medicaid insurance benefits do not cover** Naturopathic consultations. Please call Medicare or your secondary insurance if you have any questions.

Medical coverage is determined by your insurance company when a claim is received and processed. Claims may be rejected or paid at a different rate based on claim review, current coverage information and eligibility. We are unable to bill tertiary insurance claims. Benefits quoted by your insurance company are not a guarantee of payment. Depending on coverage at the time services are rendered, charges may still be the patient's responsibility. In those situations, Northwest Natural Health® Clinic will be more than willing to work with you.

## Financial Agreement

I acknowledge that payment is due at time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges. If applicable, I authorize the release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Northwest Natural Health® Clinic.

**CERTIFICATION: The above information is true to the best of my knowledge.**

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative | Relationship to Patient

_____ _____
Please Print Name of Patient, Parent, Guardian or Personal Representative | Date

Northwest Natural Health®
A Specialty Care Clinic

# AUTHORIZATION FOR RELEASE OF RECORDS

Patient Name: _____ Date of Birth: ____/____/____

Information to be released FROM or *TO*:

Northwest Natural Health® Specialty Care Clinic
6135 Seaview Ave NW # 300, Seattle, WA 98107
Phone (206) 784-9111 Fax (206) 784-7444

Information to be released FROM or *TO*: _____

_____

_____

☐ Most recent 2 years of pertinent information (treatment and diagnostic reports)
☐ Any and all medical records
☐ Lab Reports
☐ Other specific information:

_____

_____

_____

**Purpose for which disclosure is being made:** (Please check one of the following)

☐Healthcare ☐Insurance ☐Lab ☐Personal ☐Legal ☐Other: _____

**Patient Authorization:**

I understand that my records may contain information requiring special consent for disclosure. My initials below specifically authorize the release of healthcare information relating to the testing, diagnosis and /or treatment for:

☐ Drug or Alcohol Abuse
☐ HIV/AIDS
☐ Sexually-transmitted Diseases
☐ Mental Health or Psychiatric Disorders

**My Rights:**

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I understand that I may revoke this authorization in writing. I understand that the revocation will not apply to information that has already been used or released in response to this authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and that the information may no longer be protected by privacy laws. **Copy fees may apply.**

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative | Relationship to Patient

_____ _____
Please Print Name of Patient, Parent, Guardian or Personal Representative | Date

If dated, this authorization will expire one year from the date or event resulting in expiration of authorization as indicated**:**

_____

Northwest Natural Health®
A Specialty Care Clinic

## PATIENT CURRENT PROVIDER LIST

Include the names of your current health care provider(s) including your primary care provider, even if that practitioner is not actively involved during your medical specialist treatments. We will provide them with regular progress reports, when applicable.

**Referral Source**: _____ ☐ Physician ☐ Nurse ☐ Other

**Primary Care Physician:** _____
Facility or Clinic Name: _____ Nurse or contact: _____
Address: _____
City: _____ State: _____ Zip code: _____
Phone: _____ Fax: _____
**Specialty Care Physician:** _____
Facility or Clinic Name: _____ Nurse or contact: _____
Address: _____
City: _____ State: _____ Zip code: _____
Phone: _____ Fax: _____
**Specialty Care Physician:** _____
Facility or Clinic Name: _____ Nurse or contact: _____
Address: _____
City: _____ State: _____ Zip code: _____
Phone: _____ Fax: _____

## INSURANCE

**It is your responsibility to notify us of any changes to your coverage, so that we may update our records and verify new coverage if necessary. Failure to do so can result in denied claims.**

Patient name as it appears on ID card: _____ DOB: ____/____/____ ☐ M ☐ F
Name of responsible party, if a minor: _____
Relationship to patient: ☐Self ☐Spouse/Partner ☐Child ☐Parent
Address (if different from patient): _____
City: _____ State: _____ Zip code: _____
Home Phone: _____ Work: _____ Cell: _____

**Primary Insurance Company:** _____
Phone #: _____ Address: _____
Member #:_____ Group#:_____ Co-pay_____
**(Please include alpha prefix, if applicable)**
Subscriber name: _____ Subscriber Birth date: _____
Subscriber's Employer: _____

**Secondary Insurance Company:** _____
Phone #: _____ Address: _____
Member #:_____ Group#:_____ Co-pay_____
Subscriber name: _____ Subscriber Birth date: _____
Subscriber's Employer: _____

**We are unable to bill tertiary insurance claims**

Northwest Natural Health®
A Specialty Care Clinic

# Patient Consent for Use and Disclosure of Protected Health Information

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Northwest Natural Health® Specialty Care Clinic to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and/or given the rights to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the use and disclosures of my protected health information, and my rights under HIPPA. I understand that Northwest Natural Health® Clinic reserves the right to change the terms of this notice from time to time and that I may contact them at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that Northwest Natural Health® Clinic is not required to agree to these request restrictions. However, if they do agree, Northwest Natural Health® Clinic is then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected. If I do not sign this consent, or later revoke it, Northwest Natural Health® Clinic may decline to provide treatment to me.

This form will be retained in my patient records.

| _____ | _____ |
|---|---|
| Signature of Patient, Parent, Guardian or Personal Representative | Relationship to Patient |
| _____ | _____ |
| Please Print Name of Patient, Parent, Guardian or Personal Representative | Date |

Northwest Natural Health® Specialty Care Clinic
6135 Seaview Avenue NW Suite 300
Seattle, WA 98107
Phone: (206) 784-9111 Fax: (206) 784-7444
www.nwnaturalhealth.com

Northwest Natural Health®
A Specialty Care Clinic

# NUTRITIONAL SUPPLEMENTS

## Notice to Patients

The label accuracy and microbial screening of the nutritional supplements you use can affect your response to treatment and safety. For this reason, we recommend only specific products, brands and production batches that have been screened. Quality control is a very serious problem with supplements and there are literally no FDA rules for microbial safety.

The supplements we recommend are manufactured by a number of different companies and may be available in some hospital pharmacies, from our Seattle (Ballard) main clinic and in some cases, on the internet or from retail sources.

You are free to purchase supplements from whomever you wish. We will treat patients the same, regardless of where you purchase supplements. If you purchase from our clinic, we only stock batches that have provided safety and label accuracy, by independent reports. Our clinic does not charge sales tax for prescribed products and we can ship phone orders via UPS.

If you would like to shop around, you can obtain a list of verified batch numbers and alternate suppliers from our website for individual prescribed products by following the directions on the bottom of the patient Instruction form or alternatively by phoning our clinic dispensary. Our staff will gladly provide the full product information for each item in your individual plan to be certain that you get the correct product.

Bartell Drug pharmacists can provide Safe and Sound® products only. All Safe & Sound® batches are independently assayed and approved so there is no need to verify batch numbers.

Some of our specialized products are low-microbial Safe and Sound® brand, manufactured by Advanced Health Concepts LLC, a company founded and owned by Dr. Labriola.

**For safety reasons, we cannot accept or resell returned supplements.**

Feel free to contact our office if you have any questions about this or any other Northwest Natural Health® Specialty Care Clinic policy.

| _____ | _____ |
|---|---|
| Signature of Patient, Parent, Guardian or Personal Representative | Relationship to Patient |
| _____ | _____ |
| Please Print Name of Patient, Parent, Guardian or Personal Representative | Date |

Northwest Natural Health® Specialty Care Clinic
6135 Seaview Avenue NW Suite 300
Seattle, WA 98107
Phone: (206) 784-9111 Fax: (206) 784-7444
www.nwnaturalhealth.com