



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



## PATIENT PROFILE & HEALTH HISTORY QUESTIONNAIRE

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



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

<u>Name of Drug/Supplement</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Start Date/Year</u>	<u>Prescribed By</u>	<u>Reason</u>

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

<b>Dietary</b>	How would you describe your nutritional intake:				
	<input type="checkbox"/> Regular	<input type="checkbox"/> Diabetic	<input type="checkbox"/> High Protein	<input type="checkbox"/> Low Carbohydrate	
	<input type="checkbox"/> Vegetarian	<input type="checkbox"/> Vegan	<input type="checkbox"/> Low Fat	<input type="checkbox"/> Low Sodium	
	<input type="checkbox"/> Weight Reduction	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Lactose Free	<input type="checkbox"/> 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?			
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Soda	<input type="checkbox"/> Other
	Number of cups/cans per day?				
<b>Alcohol</b>	Do you drink alcohol?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	How many drinks per week?				
<b>Tobacco</b>	Current or past tobacco use?				<input type="checkbox"/> Yes <input type="checkbox"/> 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



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### 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
- Sexually-transmitted Diseases
- HIV/AIDS
- 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:

\_\_\_\_\_



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**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**



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## 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 HIPAA. 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

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## 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

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