**How Do I Check My Insurance Benefits Worksheet?**

Many insurance companies now require a referral or pre-authorization. Here are questions you can ask your insurance company to determine benefits, eligibility, and if a referral or pre-authorization is required for your visit.

1. Do I have Naturopathic coverage? Yes \_\_\_\_ No \_\_\_\_
2. Do I need a referral from my family doctor to get naturopathic care? Yes \_\_\_\_ No \_\_\_\_
3. What are my benefits for Naturopathic services?

Co-Pay/Co-Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year Max # of Visits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

It is always helpful to obtain the name of the representative you spoke with.

I spoke with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note: Medical coverage is determined by your insurance company when a claim is received and processed. Benefits quoted by your insurance company are not a guarantee of payment and may be rejected or paid at a different rate. This is not a guarantee of payment; charges may still be the patient’s responsibility. Medicare and Medicare supplemental insurance benefits typically do not cover Naturopathic care. Please call Medicare or your secondary insurance if you have any questions.

**This package must be filled out completely prior to your appointment. We do not double book patients.**

**We have many locations. Please reconfirm the location of your appointment.**

1. Northwest Natural Health – Main Office

6135 Seaview Ave. NW Ste. 300

Seattle, WA 98107-2628

1. Northwest Natural Health @ Swedish First Hill Campus

1221 Madison Street – 5th Floor AR517

Seattle, WA 98104

1. Northwest Natural Health @ Northwest Medical Specialties(Puyallup)

2920 South Meridian Ste. 100

Puyallup, WA 98373

1. Northwest Natural Health @ Swedish Issaquah Campus

751 NE Blakely Drive, Suite 1090

Issaquah, WA 98029

1. Northwest Natural Health @ Northwest Medical Specialties (Tacoma)

1624 South I Street

Tacoma, WA 98405

1. Northwest Natural Health @ Northwest Medical Specialties (Bonney Lake)

9230 Sky Island Dr., Suite 310

Bonney Lake, WA 98391

1. Northwest Natural Health @ Swedish Edmonds Campus

21605 76th Ave. W., Suite 200

Edmonds, WA 98026

NOTE: Starred (\*) information is required

\*Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*DOB \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ \*􀂅 M 􀂅 F

\*Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*State\_\_\_\_\_\_\_\_\_\_\*ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*Social Security\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Emergency contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*How did you hear about us?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*History (check all that apply):**

\_\_\_\_\_\_\_ 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Females Only:** Age at onset of menstruation: \_\_\_\_\_\_\_ Last menstrual cycle:\_\_\_\_\_\_\_\_\_\_\_\_\_ Number. of Live Births: \_\_\_\_

**\*Surgeries, Hospitalizations or other treatments** (Use a separate sheet if needed)

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Month/Year Reason

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Month/Year Reason

**\*List all medications** Include prescriptions, OTC medicines, and all supplements. Use a separate sheet if needed

Name of Drug/Supplement Dosage Frequency Started Month/Year Prescribed By\_ Reason

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

**\*Known allergies or sensitivities** (foods, chemicals, pollens, etc.) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Are you following a specific diet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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 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.

**Late Cancellation/No Show Policy and Associated Fees:**

I understand that my appointment time is reserved exclusively for me, that 24-hour notice is required for cancellation and that my credit or debit card will be charged for no-show or late cancellation as follows:

·      First Office Visit: $240

·      Extended Return Office Calls: $160

·      Return Office Calls  (30 minutes):   $120

·      Missed IV Therapy Appointment: $170

\**Please Note:* *Insurance will not cover missed appointment fees.*

**Payments:**

I understand that co-pays are due at time of service and that I am financially responsible for all charges that are not paid by insurance. Co-pays not collected at time of service will be charged to my Credit or Debit Card on file.

Interest at the current rate in use by the clinic will be charged to my Credit or Debit Card on file for balances more than 30 days old.

**Extended distance consultations - Telephone and Telehealth**

Telephone and telehealth consultations are utilized for patients who cannot appear in person. They are normally coordinated with the patient’s local healthcare providers. Most insurance companies do not cover telephone consultations.

I understand any costs for an extended distance consultation not covered by insurance is my responsibility and authorize Northwest Natural Health Specialty Care clinic to charge my credit or debit card at time of service.

**Insurance:**

\*Name of responsible party, if a minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Relationship to patient: ( )Self ( )Spouse/Partner ( )Child ( )Parent ( ) Other \_\_\_\_\_\_\_\_\_\_

\*Address (if different from patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*State: \_\_\_\_\_\_\_\_\_\_\_ \*Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Subscriber’s employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Primary Insurance Company:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Patient name as it appears on ID card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Member #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Phone # on card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Please include alpha prefix, if applicable)**

\*Subscriber name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Subscriber Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Secondary Insurance Company:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Patient name as it appears on ID card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Member #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Phone # on card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Please include alpha prefix, if applicable)**

\*Subscriber name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Subscriber Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current provider list.**

Please provide the names of all current healthcare providers including your primary care.

**\*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 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Specialty Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\*Facility or Clinic Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Nurse or contact **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\*Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*State \_\_\_\_\_\_\_\_\_\_\_ \*Zip code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Phone **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\***Fax **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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 the FDA does not check 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 treat our patients the same, regardless of where supplements are purchased. The supplements provided by our clinic pharmacy have been tested for safety and label accuracy. 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 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. 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.**

**Telehealth**If this visit is conducted is conducted remotely, I give my permission for the use of electronic, internet visit and confirm I am physically located in a state where the treating doctor is licensed.

**Authorization for release and submission of protected health records.**

I authorize Northwest Natural Health Specialty Care Clinic to receive my health records and also to provide records to my other healthcare providers for the purpose of providing healthcare subject to the following limitations:

\*All medical records except (check all that you wish to exclude):

( ) Drug or alcohol abuse ( ) Sexually transmitted disease ( ) HIV/AIDS Mental health disorders ( ) Other \_\_\_\_\_\_\_\_\_\_\_\_

\*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

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.

If dated separately, this authorization will expire one year from that date**.**

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 the practice.

I have also been informed of and/or given the rights to review and secure a copy of our 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.

I certify that by signing this form I have read and understand the information above and authorize Northwest Natural Health Specialty Care Clinic to proceed with my care as provided herein.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Signature of Patient, Parent, Guardian or Personal Representative \*Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Please Print Name of Patient, Parent, Guardian or Personal Representative \*Date