5603 38TH AVE NW
GIG HARBOR, WA 98335

T: 253 - 857 - 5544
F: 253 - 857 - 9088
frontdesk@peninsula**natural**health.com

CONFIDENTIAL NEW PATIENT FORM

NAME (last, first, m.) ____________ AGE ______ DATE OF BIRTH ___/___/___

☐ male ☐ female EMPLOYER ____________ OCCUPATION ____________

STREET ADDRESS ____________ CITY ______ STATE ______ ZIP ______

HOME/CELL PHONE-1 (   ) ______ ALTERNATE PHONE-2 (   ) ______ SOCIAL SECURITY NUMBER ______

EMAIL ADDRESS ____________ REFERRED BY ____________ DATE ___/___/___

INSURANCE COMPANY (primary) ____________ POLICY NUMBER ____________

INSURANCE COMPANY (secondary) ____________ POLICY NUMBER ____________

NAME OF INSURED ____________ INSURED'S DATE OF BIRTH ______ RELATIONSHIP TO PATIENT ______

EMPLOYER ____________ EFFECTIVE DATE OF INSURANCE ____________

EMERGENCY CONTACT NAME ____________ HOME PHONE (   ) ______ RELATIONSHIP TO PATIENT ______

PLEASE CHECK THE APPROPRIATE BOX: ☐ single ☐ married ☐ partnered ☐ divorced ☐ widowed ☐ separated

Please list any current symptoms you may have in order of importance:

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

SURGERIES (year/type) ____________

SERIOUS ILLNESS AND/OR ACCIDENTS (year/cause) ____________

MEDICATIONS: (please list all supplements, prescriptions and non-prescription drugs)

NAME OF MEDICATION	TAKEN HOW OFTEN?	WHEN DID YOU START/STOP TAKING IT?

Other medications you have taken in the last 5 years: ____________

HABITS:

	NEVER	RARELY	OCCASIONALLY	
Coffee:				Weekly/Daily Amount:
Black Tea:				Weekly/Daily Amount:
Tobacco:				Weekly/Daily Amount:
Alcohol:				Weekly/Daily Amount:
Laxatives:				Weekly/Daily Amount:
Aspirin:				Weekly/Daily Amount:
Drugs:				Weekly/Daily Amount:
Other:				Weekly/Daily Amount:

NAME/LOCATION/DATE OF LAST DOCTOR VISITED

OTHER PRACTITIONERS SEEN

DO YOU EAT A SPECIAL DIET?

WORK hours/week | SLEEP hours/week | GENERAL QUALITY OF SLEEP

EXERCISE hours/week | TYPE OF EXERCISE | Are you willing to change your living habits to improve your health?

/ /

DATE OF LAST COMPLETE CHECKUP | PRACTITIONER

PLEASE LIST chemicals, metals, dusts or fumes you are repeatedly exposed to, or which you were repeatedly exposed to in the past

(please include dates):

DO YOU REACT TO POLLENS? | TO FOODS? (what type?)

DO YOU USE A CONTRACEPTIVE? ☐ yes ☐ no | IF YES, WHAT TYPE?

IF ANY FAMILY MEMBERS HAVE HAD THE FOLLOWING, PLEASE CHECK:

☐ allergies ☐ bleeding tendency ☐ diabetes ☐ hearing loss ☐ kidney disease
☐ alcoholism ☐ blindness ☐ epilepsy ☐ high blood pressure ☐ nervous/mental disorder
☐ asthma ☐ cancer ☐ heart disease ☐ hypoglycemia ☐ tuberculosis

OTHER (please describe)

LIVING SITUATION: ☐ alone ☐ family ☐ with a partner ☐ group | FOR HOW LONG?

WHAT STRESS-REDUCING ACTIVITIES DO YOU DO REGULARLY?

DO YOU HAVE ANY OTHER PROBLEMS YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR?

FOR WOMEN:

/ / | / /

DATE OF LAST PAP | DATE OF LAST PERIOD | DURATION | # OF CHILDREN | AGES

DELIVERIES | COMPLICATIONS | MISCARRIAGES

ABORTIONS | COMPLICATIONS

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself, and that I am ultimately responsible for any expenses incurred at Peninsula Natural Health Center.
I authorize the doctor to examine and treat my condition(s), which may include diagnostic tests deemed necessary for my care, medication and therapy.

/ /

PATIENT SIGNATURE | DATE

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Patient Financial Responsibility Agreement

Please read and acknowledge your receipt and understanding of the following service billings and your financial responsibility.

› First Office Visit Cash (courtesy) rate: $210.00-$170.00
› Return Office Visit (courtesy) rate: $105.00 (typical), $150 for extended visit
› Insurance First Office Visit Maximum Charge: $290.00*
› Insurance Return Office Visit Maximum Charge: $205.00*

*Charges billed to insurance companies may vary depending on the specific treatment provided during each visit. Contracted rates may also vary from one insurance company to another.

If Peninsula Natural Heath Center is contracted with your health insurance company, we are **legally obligated** to bill your insurance for your visits. We can only offer the cash courtesy rate if you do not have health insurance, you have been denied coverage, we are out of network with your insurance company or you do not have naturopathic benefits within your individual plan.

We are currently contracted with the following insurance companies for Naturopath: (These may change without notice.)

› Regence
› Premera
› First Choice
› LifeWise
› Kaiser
›
› BlueCross BlueShield

You have an obligation to pay the charges that are not covered by your insurance carrier. You are ultimately financially responsible for all services provided. Therefore, it is recommended that you familiarize yourself with your policy benefits. **In addition to the above, please note that we request notice of cancellation 24 hours prior to your scheduled visit. Repeated cancellations or missed appointments may result in billings for the appointment, for which you are financially responsible.**

By signing below, I acknowledge the receipt of the above information.

____ __________/_____/_____
PATIENT SIGNATURE OR LEGALLY AUTHORIZED INDIVIDUAL DATE

____________________________________ ________________________
PRINTED NAME RELATIONSHIP IF OTHER THAN PATIENT

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PATIENT REPRESENTATIVE IDENTIFICATION FORM

PATIENT NAME ______________________ DATE OF BIRTH ____ / ____ / ____

OFFICE USE ONLY:

CHART # ____________

By law, the HIPPA Privacy Rule prohibits Peninsula Natural Health Center from disclosing your Protected Health Information (PHI) to anyone without your authorization, except for treatment, payment and health care operations. This rule became effective April 14th, 2003.

Please list the names of all person(s) that you wish to have access to your Protected Health Information (PHI):

NAME	RELATIONSHIP TO PATIENT

Please list the name of the person(s) with whom we can discuss your bill:

NAME	RELATIONSHIP TO PATIENT

If applicable, please list the name of your legal representative.

NAME	RELATIONSHIP TO PATIENT

Check one: By what authority is this person your legal representative?

☐ NEXT OF KIN ☐ GUARDIAN ☐ GENERAL POWER OF ATTORNEY ☐ HEALTH CARE POWER OF ATTORNEY

PLEASE NOTE: In order for us to disclose your Protected Health Information (PHI) the above representatives must be able to provide two (2) of the three (3) identifiers listed below:

› PATIENT'S SOCIAL SECURITY NUMBER
› PATIENT'S DATE OF BIRTH
› PATIENT'S ZIP CODE

PATIENT SIGNATURE ______________________ DATE ____ / ____ / ____

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Peninsula Naturopathic Clinic respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatments, health information from other providers, and billing and payment information related to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of use and disclosures of protected health information for treatment, payment and health care operations:

TREATMENT

- Information obtained by a medical assistant, physician or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

PAYMENT

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnosis, procedures performed or recommended care.

HEALTH CARE OPERATIONS

- We will use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
  - › Medical quality review by your health plan
  - › Accounting, legal, risk management and insurance services
  - › Audit functions, including fraud and abuse detection and compliance programs

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide to you. You may ask to see and copy that record. You may ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or requires us to do so. You may see your record or get more information about it by contacting a Peninsula Natural Health Center staff member. 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.

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

____ ________ / ________ / ________

SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED INDIVIDUAL | DATE

____ ____________________________

PRINTED NAME | RELATIONSHIP (if other than the patient)

No-Show/Late Cancellation Policy

This policy has been established to provide the highest level of service to all of our patients. It has been proven that consistent attendance provides for the greatest opportunity for success. By providing us notice of a cancellation, we may be able to accommodate other patients with your appointment slot.

• Patients must call at least 24-hours prior to their scheduled time, when they knowingly are unable to make their appointment. Cancellations within 24-hours of appointment will be considered a late cancellation.

• All Patients agree to pay a $100.00 fee for not cancelling 24 hrs. in advance

• We do understand that emergencies arise and that it may not be possible to give such a notice. Exceptions to the No-Show/Late Cancellation Policy will be determined by the Medical Director.

• Patients will receive text and e-mail reminders of appointment dates/times the workday prior to scheduled appointment (unless patient chooses otherwise). Patients will always be provided copies of their scheduled appointments.

Name:____________________________________

Signature: _________________________________Date:_____________________________________

Please circle each bullet point that applies to you.

Constitutional	**Eyes**	**Ears**
• Fever • Night sweats • Chills • Cold intolerance • Fatigue • Daytime sleepiness • Weight gain • Weight loss • Increased thirst • Increased hunger • Lack of appetite	• Change in vision • Loss of vision • Blurred vision • Double vision • Eye redness • Eye pain • Tearing • Pus Discharge	• Difficulty hearing • Hearing loss • Ear pain/ear ache • Ear drainage • Ringing in the ears
Nose • Nasal congestion • Nasal discharge • Nose bleeds • Sneezing • Snoring	**Mouth/Throat/Voice** • Lip sores • Mouth sores • Tongue sores • Trouble swallowing • Painful swallowing • Gum bleeding • Hoarse voice • Change in voice quality	**Neck** • Neck pain • Neck stiffness • Neck lumps • Neck swelling
Respiratory • Trouble breathing • Cough • Productive cough (mucus) • Coughing up blood • Wheezing	**Cardiovascular** • Chest pain • Palpitations • Shortness of breath at rest • Shortness of breath with activity • Shortness of breath lying down • Shortness of breath and coughing during sleep • Leg edema • Varicose veins	**Breast** • Breast lumps • Breast pain • Nipple discharge
Gastrointestinal • Abdominal pain • Rectal pain • Nausea • Vomiting • Vomiting blood • Farting frequently • Decrease in bowel movements • Less than 1 bowel movement per day or straining with movements	**Urinary** • Painful urination • Blood in urine • Urinary hesitancy • Difficulty initiating urine stream • Difficulty maintaining urine stream • Urine dribbling • Increased urinary frequency • Decreased urinary frequency • Excessive urine volume	**Genital/Reproductive** • Changes in libido • Problems with sexual function • Pain during sex • Difficult achieving erection • Difficulty maintaining erection • Difficulty reaching orgasm • Currently having menstrual cycles •

Please circle each bullet point that applies to you.

Gastrointestinal cont. • Increased frequency of bowel movements • More than 3 bowel movements per day or loose stools • Difficulty holding bowel movements • Clay-colored stools • Greasy stools • Tarry stools	Urinary cont. • Minimal urine volume • Nighttime urination • Difficulty controlling urge to urinate • Trouble holding urine • Leaking or dribbling urine with cough	Genital/reproductive cont. • Heavy bleeding during period • Bleeding between periods • Excess pain with menses • Irregular menses • Postmenopausal • Postmenopausal vaginal bleeding • Hot flashes • Genital discharge
Dermatologic/Integumentary • Change in hair texture • Change in skin texture • Change in nail appearance • Dry hair • Brittle hair • Hair loss • Dry skin • Itching • Hives • Rash • Bruising • New mole(s) • Skin sores • Skin lumps	**Musculoskeletal** • Muscle pain • Back pain • Tender points • Muscle cramps • Muscle weakness • Decreased muscle strength • Paralysis of arms or legs • Difficulty walking • Limp	**Neurological** • Headaches • Vertigo • Lightheadedness • Fainting • Blackout(s) • Numbness • Tingling • Tremor • Lack of coordination • Weakness • Difficulty speaking • Memory loss • Difficulty concentrating
Psychiatric • Change in mood • Depression • Sadness interfering with function • Anxiety • Nervousness • Sleep disturbance • Suicidal thoughts • Hopelessness • Worthlessness • Delusions • Hallucinations	**Hematologic/Lymphatic** • Easy bruising • Difficulty stopping blood flow • Lymph node enlargement • Lymph node tenderness	

Please list any drug allergies you may have and include reactions those drug(s):

1. ____
2. ____
3. ____