5603 38TH AVE NW
GIG HARBOR, WA 98335

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

CONFIDENTAL NEW PATIENT FORM

LEGAL NAME (last, first, m.) _____ AGE _____ DATE OF BIRTH ___/___/___

GENDER _____ PREFFERED NAME _____ PERSONAL PRONOUN OPTIONAL - *example - he/she/they* _____

EMPLOYER _____ OCCUPATION _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

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

EMAIL ADDRESS _____ REFERRED BY _____

ARE YOU ENROLLED IN INSURANCE THROUGH A FAMILY MEMBER? ◯YES ◯NO

ARE YOU ENROLLED IN MEDICARE? ◯YES ◯NO

IF YES - PLEASE PROVIDE THE FOLLOWING INFORMATION: _____ NAME (last, first, m.) ___/___/___ DATE OF BIRTH

_____ ( ) _____ _____

EMERGENCY CONTACT NAME HOME PHONE RELATIONSHIP TO PATIENT

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

What brings you in today? Please list in order of importance:

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

PRIMARY CARE PROVIDER AND CLINIC NAME: _____
(If wishing to establish Primary Care at Peninsula Natural Health, please indicate.)

DATE OF LAST ANNUAL EXAM: _____

SPECIALISTS AND CLINIC NAME(S): _____

_____

PREFERRED PHARMACY (NAME AND LOCATION): _____

MEDICATIONS:

NAME OF MEDICATION DOSE + FORM FREQUENCY

_____

_____

_____

_____

SUPPLEMENTS:

NAME OF SUPPLEMENT (AND BRAND) DOSE + FORM FREQUENCY

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY:

Please list any medical conditions you have been diagnosed with (past or current) and include approximate year of diagnosis:

_____

_____

_____

SURGICAL HISTORY: Please list any surgeries you have had and dates:

_____

_____

SOCIAL HISTORY:

WHAT DOES A TYPICAL DIET LOOK LIKE: _____

PHYSICAL ACTIVITY: _____

ENVIRONMENTAL EXPOSURES: chemicals, metals, fumes, etc. you are repeatedly exposed to, or which you were repeatedly exposed to in the past (include dates):

_____

TOBACCO USE: please circle - (Never/Former/Current): If former or current, list how many cigarettes per day for how many years:

_____

DO YOU USE RECREATIONAL DRUGS? IF YES PLEASE SPECIFY:

_____

ALCOHOL USE: please circle - (Never/Monthly or less/2-4 times per month/2-3 times per week/4+ times per week)

Note the number of each item you drink per week: **Glass of wine ____ Cans/bottles of beer___ Shots of liquor___**

SEXUALLY ACTIVE: (YES/NO) PARTNERS? (MALE/FEMALE/BOTH) OTHER: _____

DO YOU USE ANYTHING TO PREVENT PREGNANCY? IF SO WHAT TYPE: _____

WHAT STRESS REDUCING ACTIVITIES DO YOU DO REGULARLY: _____

IF APPLICABLE:

LAST MAMMOGRAM (YEAR AND RESULT): _____

ANY ABNORMAL PAPS (YEAR RESULT): _____

____/____/____	____/____/____	_____	_____	_____
DATE OF LAST PAP	DATE OF LAST PERIOD	DURATION	# OF CHILDREN	AGES

_____	_____	_____
DELIVERIES	COMPLICATIONS	MISCARRIAGES
_____	_____	
ABORTIONS	COMPLICATIONS	

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FAMILY HISTORY & ALLERGENS

FAMILY HISTORY - Check appropriate box

AGE AT DEATH (IF APPLICALBLE)								
	MOTHER	FATHER	CHILDREN	MATERNAL GRANDMA	MATERNAL GRANDPA	PATERNAL GRANDMA	PATERNAL GRANDPA	SIBLINGS
ALLERGIES								
ADDICTION								
ASTHMA								
BLEEDING OR CLOTTING DISORDER								
DIABETES								
EPILEPSY								
HEART ATTACK								
HIGH CHOLESTEROL								
KIDNEY DISEASE								
STROKE								
ANEMIA (PLEASE SPECIFY TYPE)								
AUTOIMMUNE CONDITON (PLEASE SPECIFY)								
CANCER (PLEASE SPECIFY + AGE AT DIAGNOSIS)								
GENETIC CONDITON (PLEASE SPECIFY)								
OTHER HEART DISEASE (PLEASE SPECIFY)								
MENTAL HEALTH CONDITION (PLEASE SPECIFY)								

OTHER - PLEASE SPECIFY FAMILY MEMBER:

_____

_____

PLEASE LIST ANY <u>ALLERGIES</u> YOU MAY HAVE AND INCLUDE REACTIONS

FOOD/DRUG/ENVIORNMENTAL REACTION

_____

_____

_____

ANY ADDITIONAL INFORMATION YOU WISH TO ADD? _____

_____

_____

_____ _____ / _____ / _____

PATIENT SIGNATURE DATE

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REVIEW OF SYSTEMS PAGE 1

PATIENT NAME _____ DATE OF BIRTH _____

*PLEASE CIRCLE OR CHECK EACH BULLET POINT THAT APPLIES TO YOU IN THE LAST **TWO WEEKS***

Constitutional Fever Night sweats Chills Cold intolerance Fatigue Daytime sleepiness Weight gain Weight loss Increased thirst Increased hunger Lack of appetite	**Eyes** Change in vision Loss of vision Blurred vision Double vision Eye redness Eye pain Tearing Pus Discharge	**Ears/Neck** Difficulty hearing Hearing loss Ear pain/earache Ear drainage Ringing in the ears Neck pain Neck stiffness Neck lumps Neck swelling
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	**Respiratory** Trouble breathing Cough Productive cough (mucus) Coughing up blood Wheezing
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	**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 Bloody Stool	**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
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	**Urinary cont.** Minimal urine volume Nighttime urination Difficulty controlling urge to urinate Trouble holding urine Leaking or dribbling urine with cough	**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 Menopausal Symptoms

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REVIEW OF SYSTEMS PAGE 2

*PLEASE CIRCLE OR CHECK EACH BULLET POINT THAT APPLIES TO YOU IN THE LAST **TWO WEEKS***

Genital/reproductive cont. Heavy bleeding during period Bleeding between periods Excess pain with menses Irregular menses Postmenopausal Postmenopausal vaginal bleeding Hot flashes Genital discharge	**Breast** Breast lumps Breast pain Nipple discharge	**Hematologic/Lymphatic** Easy bruising Difficulty stopping blood flow Lymph node enlargement Lymph node tenderness
Dermatologic/Integumentary 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** Joint pain Joint swelling 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	**Psychiatric cont.** Sleep disturbance Suicidal thoughts Hopelessness Worthlessness Delusions Hallucinations	

PATIENT SIGNATURE

DATE / /

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NO SHOW & LATE CANCELLATION POLICY

PATIENT NAME _____ DATE OF BIRTH _____

This policy has been established to provide the highest level of service to all our patients. It has been proven that consistent attendance provides 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 48 hours prior to their scheduled time for a First Office Visit, when they are unable to make their appointment to avoid a $250 fee.**

- **Patients must call at least 24 hours prior to their scheduled time for return office visits, when they knowingly are unable to make their appointment to avoid a $185 fee.**

- We do understand that emergencies arise and that it may not be possible to give such 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 with copies of their scheduled appointments.

PATIENT SIGNATURE _____ DATE ___/___/___

PATIENT REPRESENTATIVE IDENTIFICATION FORM

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PATIENT NAME _____ DATE OF BIRTH ___/___/___

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, 2001.

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

NAME _____ RELATIONSHIP TO PATIENT _____

NAME _____ RELATIONSHIP TO PATIENT _____

NAME _____ RELATIONSHIP TO PATIENT _____

NAME _____ RELATIONSHIP TO PATIENT _____

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

NAME _____ RELATIONSHIP TO PATIENT _____

PHONE _____ EMAIL _____

NAME _____ RELATIONSHIP TO PATIENT _____

PHONE _____ EMAIL _____

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: 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 ___/___/___

NOTICE OF PRIVACY PRACTICES

5603 38TH AVE NW
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PATIENT NAME _____ DATE OF BIRTH ___/___/___

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 Natural Health Center 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.

HIPPA 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 the 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

EMAIL CONTACT RELEASE

I grant Peninsula Natural Health Center permission to contact me via this email:_____

I understand that this correspondence could contain personal health information (PHI). This correspondence will be used to provide care on patients' behalf and will come from kareo.com for electronic health records and correspondence with my physician. Emails from Square Retail for pharmacy/supplement receipts and notification on specials and newsletters from PNHC staff.

PNHC agrees to protect our patients' PHI in accordance with the HIPPA and will only share PHI with patients and their authorized representatives. Emails are never shared for other purposes other than patient care and direct contact with PNHC.

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)

Peninsula Natural Health Center

ACKNOWLEDGMENT AND AGREEMENT Peninsula Natural Health Center (PNHC) will use reasonable means to protect the privacy of the patient's health information. However, because of the risks outlined above, PNHC cannot guarantee that e-mail will be confidential. Additionally, PNHC will not be liable in the event that you or anyone else inappropriately uses or accesses your e-mail. PNHC will not be liable for improper disclosure of your health information that is not caused by PNHC intentional misconduct. By signing this form, I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communications of e-mail between PNHC and me, and consent to the conditions outlined herein, as well as any other instructions that PNHC may impose to communicate with me by e-mail. Any questions I may have had were answered. I understand that this consent is valid until I revoke the consent as outlined above, except to the extent that a person who is to make a communication has already acted in reliance upon this authorization.

Please select an option below:

OPTION 1 – ALLOW UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to PNHC to send me personal health information via unencrypted email regarding patient_____

Patient name

_____

Signature Date Please clearly print ONE email address
(Parent or guardian if patient is a minor)

OPTION 2 – DO NOT ALLOW UNENCRYPTED EMAIL - ENCRYPTED EMAIL ONLY

I do not wish to receive personal health information via email for patient_____

Patient name

_____ _____ _____

Signature Date Please clearly print ONE email address
(Parent or guardian if patient is a minor)

ENCRYPTED EMAILS COME FROM PROOFPOINT ESSENTIALS

If you do not release your email from quarantine within 14 days it will automatically delete.

5603 38TH AVENUE NW – GIG HARBOR – WA- 98335
253-857-5544P 253-857-9088F
WWW.PENINSULANATURALHEALTH.COM
FRONTDESK@PENINSULANATURALHEALTH.COM –PATIENT CARE
BILLING@PENINSULANATURALHEALTH.COM – BILLING QUESTIONS

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PNHC PHYSICAL/ WELLNESS EXAM POLICY

Physical Examination:

- A preventative visit only (done yearly).
- Billing for lab tests is separate from the billing from our clinic. You may receive bills from LabCorp depending on tests performed.
- Does not include Monitoring or diagnosing a specific medical condition or an ongoing health issue (Ex: Medication refills or a new health issue that has occurred.

Physical examination typically includes:

- Review of health history and family history.
- Various physical exams (eyes, heart, abdomen, ears, mouth, etc) to screen for abnormalities.
- Annual patient health questionnaires (PHQ-9, GAD 7).
- Possible examination of genitalia and rectum (Paps, Breast exams).
- Some lab testing at the discretion of the physician.

Addressing a new concern:

- Is not a part of a preventative examination.
- **If added with the physical exam, additional charges may incur****
- May result in rescheduling the physical exam as a typical appointment.

Insurance or self-pay will be billed depending on the service you received:

- We must bill according to the type of visit that appears in your medical record.
- You will be responsible for payment if you are self-paying or if your insurance refuses to pay for the visit. The providers nor clinic can change any codes billed.

Split visit billing:

- **If multiple concerns need to be addressed in addition to the physical exam, your insurance or you yourself will be charged for a physical exam and an office visit. This may require full payment, a copay, coinsurance, or deductible for these additional services which will be billed.

By signing below, I also understand the following:

- This exam does not include treatment of new or existing health problems.
- I understand that if any additional services are provided during this visit, they will be billed separately and may require full payments, copay, coinsurance, or deductible.

BY SIGNING BELOW I AGREE TO UNDERSTANDING THE ABOVE INFORMATION.

PATIENT SIGNATURE _____ DATE OF BIRTH _____ DATE _____

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PATIENT FINANCIAL RESPONSIBILTY AGREEMENT

T: 253 - 857 - 5544
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I, _____have read, initialed and understand the following:

_____Peninsula Natural Health Center (PNHC) provides Naturopathic Medical Care.

_____PNHC is required to bill insurance plans we are contracted with.

_____Medicare A/B does not cover or reimburse naturopathic services.

_____I agree to be responsible for any uncovered portions of my bill, coinsurance and copay.

_____I understand that PNHC is not responsible to understand my policy benefits or exclusions and that billing my insurance company is a courtesy.

_____I understand it is my responsibility to update and provide PNHC with current medical insurance information at time of service, and costs incurred as a result will be my responsibility.

_____I agree to pay my co-pay at the time of service and previous balance with-in 30 days of receipt of statement.

PNHC is currently contracted with the following insurance companies:
(These may change without notice)

- Regence
- Premera
- LifeWise
- First Choice
- BlueCross/BlueShield
- Pacific Source

- B-Shot Injection: $30
- Wellness Exam: $210
- First Office Visit rate: $250-$310
- Return Office Visit rate: $185.00 - $230 for extended visit

_____I agree to the courtesy rates above if I do not have Naturopathic Coverage.

BY SIGNING BELOW I AGREE TO UNDERSTANDING THE ABOVE INFORMATION.

_____ _____/_____/_____

PATIENT SIGNATURE OR LEGALLY AUTHORIZED INDIVIDUAL DATE