



5603 38TH AVE NW
GIG HARBOR, WA 98335

T: 253 - 857 - 5544

F: 253 - 857 - 9088

frontdesk@peninsulanaturalhealth.com

CONFIDENTIAL NEW PATIENT FORM

LEGAL NAME	AGE	DATE OF BIRTH	
GENDER	PREFERRED NAME	PERSONAL PRONOUN OPTIONAL - <i>example - he/she/they</i>	
EMPLOYER	OCCUPATION		
STREET ADDRESS	CITY	STATE	ZIP
HOME/CELL PHONE-1	ALTERNATE PHONE-2	EMAIL ADDRESS	

EMERGENCY CONTACT NAME	PHONE	RELATIONSHIP
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PLEASE CIRCLE: single married partnered divorced widowed separated

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

1. _____
2. _____
3. _____

PRIMARY CARE PROVIDER, 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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature: _____ Date of Birth: _____ Date: _____

OVER THE COUNTER MEDICATIONS AND SUPPLMENTS:

NAME OF MEDICATION

DOSE + FORM

FREQUENCY

PAST MEDICAL HISTORY & SURGICAL HISTORY:

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

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 AND RECREATIONAL DRUG USE: please circle - (Never/Former/Current): If former or current, list how many cigarettes per day for how many years. Please specify what recreational drug you participate in and the amount.

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 ANY PROTECTION 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_____
AGE_____
DELIVERIES_____
COMPLICATIONS_____
MISCARRIAGES_____
ABORTIONS_____
COMPLICATIONS**Patient Signature:** _____**Date of Birth:** _____**Date:** _____

PLEASE CIRCLE OR CHECK EACH ISSUE THAT HAS APPLIED IN THE PAST TWO WEEKS ONLY:

DERMATOLOGIC/ INTEGUMENTARY

Rashes/ Hives
Hair Loss
Dry Skin
Itching
New Mole (s)
Skin Sores/ Lumps

Nose:

Nasal Congestion
Nose Bleeds
Sneezing
Snoring

Eyes:

Changes In Vision
Loss Of Vision
Blurred Vision
Dry Eye
Double Vision

Ears/ Neck:

Difficulty Hearing
Hearing Loss
Ear Pain/ Earache
Ringing in the Ears
Neck Pain
Neck Lumps

Urinary:

Painful Urination
Blood in Urine
Urinary Hesitancy
Difficulty Initiating Stream
Urine Dribbling/ Leaking
Increased/ Decreased Urinary Frequency
Nighttime Urination
Difficulty Controlling Urge to Urinate

Genital/ Reproductive:

Changes in Libido
Pain During Intercourse
Difficulty Achieving Erection
Difficulty Maintaining Erection
Difficulty Reaching Orgasm
Heavy Bleeding During Period
Spotting Between Periods
Excessive Pain with Menses'

Musculoskeletal:

Joint Pain
Muscle Pain
Back Pain
Muscle Cramps/ Weakness
Decreased Strength

Respiratory:

Trouble Breathing
Cough
Coughing Up Blood
Wheezing

Mouth and Throat:

Mouth Sores
Painful/ Trouble Swallowing
Gum Bleeding
Hoarseness
Change in Voice Quality

Hematologic/ Lymphatic:

Easy Bruising
Difficulty Stopping Bleeding
Blood Disorders
Blood Clots

Constitutional:

Fever
Night Sweats
Chills
Cold Intolerance
Fatigue
Weight Gain
Weight Loss
Increased Thirst
Daytime Sleepiness
Increased Hunger

Psychiatric:

Changes in Mood
Depression
Sadness Interfering w/ Function
Anxiety
Nervousness
Suicidal Thoughts
Hopelessness/ Worthlessness
Delusions/ Hallucinations
Postmenopausal Vaginal Bleeding
Hot Flashes

Neurological:

Headaches/ Migraines
Vertigo
Lightheadedness/ Fainting
Tingling
Tremor
Lack of Coordination
Weakness
Memory Loss

Breast:

Breast Lumps
Breast Pain
Nipple Discharge

Cardiovascular:

Chest Pain
High Blood Pressure
Shortness of Breath
Palpitations
Edema
Varicose Veins

Gastrointestinal:

Abdominal Pain
Rectal Pain
Nausea
Vomiting
Vomiting Blood
Excessive Flatulence
< 1 bowel movement per day
Difficulty Holding Bowel Movements
Clay Colored Stool
Greasy Stool
Tarry Stool

Patient Signature:

Date of Birth:

Date:



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FAMILY HISTORY & ALLERGENS

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FAMILY HISTORY - Check appropriate box

AGE AT DEATH (IF APPLICABLE)	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)								

PLEASE LIST ANY ALLERGIES YOU MAY HAVE AND INCLUDE REACTIONS

FOOD/DRUG/ENVIRONMENTAL

REACTION

Patient Signature:

Date:

By signing below, I acknowledge I have read, understand, and agree to the following policies:

OFFICE POLICIES AND PROCEDURES

Insurance & Financial Responsibility:

- PNHC will bill contracted insurance companies as a **courtesy**; however, I am ultimately responsible for **knowing my insurance benefits, exclusions, and coverage** for naturopathic services.
- **Medicare A/B does not cover naturopathic care.**
- I am responsible for all **copays, coinsurance, deductibles, uncovered services**, and any balances not paid by insurance.
- I agree to **pay my copay at the time of service** and all outstanding balances **within 30 days** of receiving a statement.
- I will provide **accurate and current insurance information** at the time of each visit. If not, I understand that I am responsible for resulting charges.
- If I do **not** have naturopathic coverage, I agree with the **courtesy rates** listed below:
 - **First Office Visit:** \$250–\$310
 - **Return Visit:** \$185–\$230 (extended visit)
 - **Wellness Exam:** \$210

Contracted Insurance Plans

(Current as of today and subject to change without notice)

- Regence
- Premiera
- LifeWise
- First Choice
- BlueCross/BlueShield
- PacificSource

Physical Exams & Split Visit Policy

- Physical exams are **preventive visits only**, and DO cover medication refills, ongoing conditions, but DO NOT cover new concerns.
- Physical exams include:
 - Review of health and family history
 - Basic screening exams (heart, abdomen, eyes, etc.)
 - Annual questionnaires (PHQ-9, GAD-7)
 - Labs as needed
 - If **new concerns** are addressed during the physical exam, **additional charges may apply, such a split visit. Split visits** (physical + office visit) may result in **additional billing** (e.g., copay, deductible, coinsurance).

Messaging, Forms & Administrative Fees

- **Extensive messaging or email communication** with a provider that is not at the request of the provider (beyond basic follow-up or coordination) may be **billed as a clinical service** and submitted to insurance or charged directly to the patient.
- Completion of **FMLA, school, or work forms** outside of an office visit may incur a **form completion fee**, billed directly to the patient. Rates vary depending on form complexity.

Cancellations & Missed Appointments

- **First Office Visit:** Cancellations must be made **48 hours in advance** to avoid a **\$250 fee**.
- **Return Visits:** Cancellations must be made **24 hours in advance** to avoid a **\$185 fee**.
- Exceptions due to emergencies are at the discretion of the Medical Director.
- Appointment reminders are sent via **text, email, phone call** and are sent **multiple times** prior to the appointment.

Patient Signature: _____

Date of Birth: _____

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
GIG HARBOR, WA 98335
frontdesk@peninsulanaturalhealth.com

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 – 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