PENINSULA NATURAL HEALTH CENTER

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

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

GENDER _____ PREFFERED NAME _____ PREFFERED PRONOUNS - *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

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?

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 USE A CONTRACEPTIVE? ☐ yes ☐ no _____ IF YES, WHAT TYPE?

ANY ADDITIONAL INFORMATION YOU WISH TO ADD? _____

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

5603 38TH AVE NW
GIG HARBOR, WA 98335

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

PATIENT FINANCIAL RESPONSIBILTY AGREEMENT

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 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
- › Pacific Source
- › LifeWise
- › Kaiser
- › BlueCross/BlueShield
- › First Choice

› First Office Visit rate: $265.00-$205.00
› Return Office Visit rate: $140.00 - $185 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

_____ _____
PRINTED NAME RELATIONSHIP IF OTHER THAN PATIENT

PENINSULA NATURAL HEALTH CENTER

5603 38TH AVE NW
GIG HARBOR, WA 98335

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

PATIENT REPRESENTATIVE IDENTIFICATION FORM

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, 200 .

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: 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 ___/___/___

5603 38TH AVE NW
GIG HARBOR, WA 98335

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

NOTICE OF PRIVACY PRACTICES

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 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

5603 38TH AVE NW
GIG HARBOR, WA 98335

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

NO SHOW & LATE CANCELLATION POLICY

PATIENT NAME _____ DATE OF BIRTH _____

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 **48 hours** prior to their scheduled time for a First Office Visit, when they knowingly are unable to make their appointment to avoid a $100 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 $50 fee.
- 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.

PATIENT SIGNATURE _____ DATE ___/___/___

PENINSULA NATURAL HEALTH CENTER

5603 38TH AVE NW
GIG HARBOR, WA 98335

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

REVIEW OF SYSTEMS PAGE 1

PATIENT NAME _____ DATE OF BIRTH _____

PLEASE CIRCLE OR CHECK EACH BULLET POINT THAT APPLIES TO YOU

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/ear ache 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

PENINSULA NATURAL HEALTH CENTER

5603 38TH AVE NW
GIG HARBOR, WA 98335

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

REVIEW OF SYSTEMS PAGE 2

PLEASE CIRCLE OR CHECK EACH BULLET POINT THAT APPLIES TO YOU

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 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	**Psychiatric cont.** Sleep disturbance Suicidal thoughts Hopelessness Worthlessness Delusions Hallucinations	

PATIENT SIGNATURE

/ /
DATE

PENINSULA NATURAL HEALTH CENTER

5603 38TH AVE NW
GIG HARBOR, WA 98335

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

FAMILY HISTORY & ALLERGINS

FAMILY HISTORY - Check appropriate box

	MOTHER	FATHER	CHILDREN	MATERNAL GRANDPARENTS	PATERNAL GRANDPARENTS	SIBLINGS
allergies						
alcoholism						
anemia						
asthma						
bleeding tendency						
blindness						
cancer						
depression						
diabetes						
epilepsy						
heart disease						
hearing loss						
high blood pressure						
hypoglycemia						
kidney disease						
mental illness						
nervous/mental disorder						
stroke						
tuberculosis						

OTHER - PLEASE SPECIFY FAMILY MEMBER

DO YOU REACT TO POLLENS?

TO FOODS? (what type?)

PLEASE LIST ANY DRUG ALLERGIES YOU MAY HAVE AND INCLUDE REACTIONS TO THOSE DRUGS

DRUG REACTION

PATIENT SIGNATURE

DATE / /