

Federal Way Naturopathy REGISTRATION FORM

(Please Print)

Today's date:		PCP:	
PATIENT INFORMATION			
Patient's last name:		First:	Middle initial: <input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Marital status			
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):	Birth date: / /
Age:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:		Social Security #:	Home phone : ()
City:	State:	ZIP Code:	Cell phone: ()
Occupation:	Employer:		Employer phone: ()
<input type="checkbox"/> Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> African <input type="checkbox"/> African American <input type="checkbox"/> Other _____			
Chose clinic because/was referred to clinic by:			
Other family members seen here:			
E-mail Address:		Would you like to receive our e-newsletter? <input type="checkbox"/> Yes <input type="checkbox"/> No	
INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
It is recommended that you contact your insurance company to verify coverage for Naturopathic physicians and services. Your policy may not cover claims made by this office.			
Person responsible for bill:		Address (if different):	Home phone: ()
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Birth / /		
Occupation:	Employer:	Employer address:	Employer phone: ()
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Referral needed from PCP?		
Name of primary insurance	Group number	ID number	Co-payment: \$
Subscriber's name:		Subscriber's S.S. #:	Birth date:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone : ()	Work phone : ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Federal Way Naturopathy or insurance company to release any information required to process my claims.			
Patient/Guardian signature		Date	

FEDERAL WAY  **NATUROPATHY**
SYSTEMS REVIEW

TO BE COMPLETED BY PATIENT	CIRCLE ABNORMAL FINDINGS				DESCRIBE HERE	
	HEAD	1	Acne	2	Dizziness	
		3	Fainting	4	Loss of Hair	
	EYES	5	Vision	6	Pain	
		7	Glasses	8	Floaters	
	EARS	9	Ache	10	Discharge	
		11	Hearing	12	ringing	
	NOSE	13	Discharge	14	Congestion	
		15	Sinus	16	Inflammation	
	MOUTH	17	Teeth	18	Gums	
THROAT	19	Soreness	20	Hoarseness		
	21	Swallowing Problem	22	Infections		
CHEST	23	Pain	24	Cough		
	25	Sputum	26	Blood in Mucus		
HEART	27	Pain	28	Short of breath		
	29	Postural Breathing Problem	30	Pale Blue Skin Color		
GASTROINTESTINAL	31	Pain	32	Nausea		
	33	Appetite	34	Belching		
	35	Vomiting	36	Bowel Habits		
GENITOURINARY	37	Dysuria	38	Nighttime Urination		
	39	Frequency	40	Blood in Urine		
	41	Urgency	42	Incontinence		
	43	Obstruction	44	Other		
MENSTRUAL	45	Last Menstrual Cycle	46	Onset		
	47	Cycle	48	Pain		
	49	Amount	50	Menopause		
	51	Duration	52	Other		
MARITAL	53	Children	54	Abortion		
	55	Miscarriage	56	Sterility		
BONES, JOINTS & EXTREMITIES	57	Arthritis	58	Backache		
	59	Varicose	60	Nerve pain		
	61	Inflamed vein	62	Edema		
	63	Deformity	64	Other		
GENERAL	65	Fatigue	66	Fever		
	67	Chills	68	Weight Loss/Gain		

TO BE COMPLETED BY DR.	H2O	ABO		
	LAST COMPLETE PHYSICAL	MAMMO	BLOOD WORK	EKG
	ANTIBIOTIC USE	IMMUNIZATIONS		
	SEATBELTS	DENTISTRY		
	BREAKFAST			
	LUNCH			
	DINNER			
	SNACK			
	PATIENT NAME	DATE		

CONFIDENTIAL PATIENT HEALTH RECORD

PERSONAL HISTORY

Name: _____ Age: _____ Date of Birth: _____ Sex: Female Male

How would you prefer to be addressed in our office: _____ Profession: _____

Address: _____ City: _____ State/Zip: _____

Residence Telephone: _____ Business Telephone _____

Please check one: Single Married Widowed Separated Divorced

Number of Children: _____ Referred to this office by: _____

CURRENT HEALTH CONDITION

PROBLEM

DURATION

1.

2.

3.

4.

5.

6.

What, if any, treatment have you tried?

Has anything recently changed or become worse?

What questions do you have that you would like answered?

Are you currently being treated by a physician Yes No

Physician

Condition

MEDICATION AND SUPPLEMENTS

Please include all of your prescription medications, non-prescription medication (aspirin, antacids, laxatives, antihistamine), vitamins, minerals, herbs, etc.

ALLERGIES

Such as medication, pollens, foods, etc.

HOSPITALIZATIONS, SURGERIES OR SERIOUS INJURIES

Date and reason for each hospitalization.

PERSONAL HEALTH HABITS

Height: _____ Current Weight: _____ lbs 1 year Ago: _____ Maximum Weight: _____

Smoker: Yes No Years Smoked: _____ Amount per day: _____ Year Stopped: _____

Alcohol Use: Yes No Type: _____ Frequency: _____

Recreational Drug Use: Yes No Type: _____ Frequency: _____

Coffee/lattes: Yes No Cups/day _____ Tea: Yes No Soft Drinks Yes No

Diet: *Any food groups you avoid?* Yes No Describe: _____

Regular exercise: Yes No Type: _____ Duration: _____ Frequency: _____

Average Hours of sleep per night: _____ Do you wake during the night? Yes No If yes how often? _____

MEDICAL HISTORY

Please ✓ check only those conditions that pertain to YOU personally

<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Allergies	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer
<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Colitis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ear Problems	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Edema
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Eye Problems	<input type="checkbox"/> Fatigue, chronic	<input type="checkbox"/> Fever	<input type="checkbox"/> Hayfever	<input type="checkbox"/> Headaches
<input type="checkbox"/> Heart Disorders	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Joint Problems	<input type="checkbox"/> Indigestion
<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Parasites	<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Bladder/ Urinary Problems	<input type="checkbox"/> Blood Pressure Problems/Stroke	<input type="checkbox"/> Gum/Teeth problems	<input type="checkbox"/> Frequent Colds, Flu, Sore Throat	<input type="checkbox"/> Gall Bladder or Liver Problems	<input type="checkbox"/> Head injury or other Serious Injury
<input type="checkbox"/> Female Gynecological Problems	<input type="checkbox"/> Occupational Exposure to Toxic Substances	<input type="checkbox"/> Psychological difficulties, Suicidal thoughts, or Depression	<input type="checkbox"/> Sexually Transmitted Infections (Herpes, Chlamydia, Gonorrhea)	<input type="checkbox"/>	<input type="checkbox"/> Other: _____ _____

FAMILY MEDICAL HISTORY

Please ✓ check any disease which you or a family member have had

Relative	Living	Deceased	Arthritis	Asthma	Cancer	Diabetes	Epilepsy	Glaucoma	Gout	Heart Disease or Stroke	High Blood Pressure	Hypothyroidism	Kidney Disease	Neurological Disease	Stomach Ulcer	Periodontal Disease	Tuberculosis	Artero-sclerosis	Obesity		
You																					
Father																					
Mother																					
Brothers																					
Sisters																					
Spouse																					
Children																					
Grandparents																					

Patient Name: _____

Date: _____

Financial Policy

The policy of Federal Way Naturopathy is to collect all payments or insurance information at the time services are rendered. For your convenience, we accept cash, check, Visa or MasterCard. We will bill all insurance companies that we are contracted with.

Health insurance is a contract between the patient and their insurance carrier. Your policy may not cover claims made by this office, and some services provided by the physicians may be covered by different plan benefits. Claims may not be resubmitted with different codes if they have been denied for lack of coverage.

Preventive office visits

Well-child exams, annual gynecological exams, and routine physicals are coded differently from standard office visits, and are based on the age of the patient and whether you are a new or established patient. Legally we are not permitted to resubmit claims with a new diagnosis or office code if the claim was accurately submitted as a preventive care visit and denied by your insurance company. If there are additional concerns brought up at these preventive office visits, there will be an additional brief office visit fee.

It is your responsibility to know the limits and exclusions to your insurance coverage.

It is the patient's responsibility to provide the most current insurance information to our office at the time services are rendered. A rebilling charge of **\$5.00** will be added if claims need to be resubmitted to the correct insurance company.

All dispensary products will be paid for at the time of pickup. If products are mailed, a Visa or MasterCard number will be required for billing. Shipping and handling charges will be added to the bill.

All checks returned for non-sufficient funds will result in a **\$25.00** service charge to be collected at the next visit, or within 30 days (whichever comes first).

A **\$5.00** rebilling fee will be charged each month on any outstanding balances. If no payment is received on an account after 90 days, the account will be sent to the collection agency.

Phone visits are charged at a rate of **\$13.00** for each 5 minutes and are not billable to insurance. A phone visit is only for the use of established patients.

A fee of **\$15.00** will be charged for letter requests for military, work or personal reasons.

A fee of **\$50.00** will be charged for a non-emergent page to the physician.

An itemized receipt is provided to the patient at each visit or dispensary purchase. A fee of **\$23.00** will be charged for the searching and handling of financial records, receipts or reports for the purpose of HSA, FSA reimbursement, taxes or other financial purposes.

A fee of \$25.00 will be charged for cancellations made less than 24 hours from your scheduled appointment.

A no show fee of \$50.00 will be assessed for patients that fail to show up for a scheduled appointment.

- I understand and agree that my health insurance is an arrangement between my insurance carrier and myself; that all services furnished to me are charged directly to me and that I am personally responsible for payment of all services.
- I authorize treatment and agree to pay all charges at the time of service. Charges shown on statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing.
- It is agreed that payment will not be delayed or withheld because of any insurance coverage or pendency of the claims thereon. *A copy of this agreement is as valid as the original. I also agree to pay for any missed appointments that were not canceled or rescheduled at least 24 hours in advance.*

Signature _____ Date _____

Print Name _____



900 South 336th St
Federal Way, WA 98003
253-942-3301 253-237-0606

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form will be retained in your medical record

By my signature below, I _____,
Acknowledge that I received a copy of the Privacy practices for Federal Way Naturopathy.

I hereby designate the following individual(s) to receive communications from Federal Way Naturopathy that may include health information about me:

Signature of patient (or personal representative)

Date

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

I authorized Federal Way Naturopathy to leave voice mail messages concerning, my health information(i.e. lab results, appointment instructions, etc.) at the following number:

Phone _____ Patients initials _____