Northwest Center for Natural Medicine

Patient: ______________________________ DOB: ________________ Date: ___________

Present Health Concern: Please list your most important health concerns in the order of significance

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

What goals do you have for your visit at the clinic today?
Primary goal: ____
Secondary goal: ____

Have you been to a naturopathic physician before? **YES/NO** If yes, whom: ____________________

List name of doctors you are currently seeing and for what reason:

1. ____
2. ____
3. ____

Please list medications and dosage you are currently taking: Use separate sheet if needed

Medication	Dosage	Purpose

Please list any vitamins, minerals, herbs or homeopathic remedies that you are currently taking:

Drug allergies: ____
Food allergies: ____
Environmental allergies (ex: grass/pollen):_____________________________

PERSONAL HABITS:
Tobacco **YES/NO** how often: _________
Alcohol **YES/NO** how often: _________
Recreational drugs **YES/NO** type of drug: ____________________how often: _________

Exercise regularly **YES/NO** type of exercise: __________________ how often: _________

PAST HISTORY:
How many births: _________ Complications: **YES/NO** if yes, what: ________________
Immunizations: __________________________
Childhood illnesses/sickness: ______________________________________

DOS: ___________________

HOSPITALIZATIONS:

REASON:	DATE:

SERIOUS ILLNESSES/INJURIES:

DATE OF LAST EXAMS:

Physical exam: ____________ Blood test: _________ Pap smear: _________

Prostate exam: ____________ Mammogram: ______ Stool test: __________

Do you give self breast exams? **YES/NO** if yes, how often: ________________

SOCIAL HISTORY:

Please circle: Single Married Divorced Widowed Significant Other

Children: **YES/NO** how many: _________ Ages: ________________________________

LIFESTYLE PROFILE

24 hour diet recall: Please list what you had to eat in the last 24 hours:

Breakfast	
Lunch	
Dinner	
Snacks	

List average amounts per day of the following:

Water	
Alcohol	
Caffeine	
Other beverages	
Other beverages	

Hours of work a day: _____________ Hours of sleep a night: ____________

Relaxation: What do you do to relax? _________________________ How often: _____________

CONSTITUTIONAL PROFILE

Energy Level: Low 1 2 3 4 5 6 7 8 9 10 High

DOS:____________________

FAMILY HISTORY: Did any of your family members have? If yes, indicate whom:

- € Alcoholism ____________________
- € Allergies ______________________
- € Alzheimer's____________________
- € Hepatitis_______________________
- € High Blood Pressure _____________
- € Kidney Disease _________________
- € Mental Illness __________________
- € Stroke _________________________
- € Tuberculosis ___________________
- € Epilepsy __________________________
- € Heart Disease ______________________
- € Anemia____________________________
- € Arthritis ___________________________
- € Asthma ___________________________
- € Cancer ____________________________
- € Diabetes ___________________________
- € Eczema ____________________________
- € Other _____________________________

SYMPTOMS: Check symptoms you currently have or had in the past year

GENERAL

€ Fatigue
€ Fever/Chills
€ Weakness
€ Sweating/Night sweats
€ Hair/Nail changes
€ Mood changes
€ Depression
€ Headache
€ Sleeping problems
€ Fainting
€ Antibiotic history

EENT

€ Eye discharge
€ Sinusitis
€ Nasal Discharge
€ Postnasal drip
€ Nose bleeds
€ Mouth sores
€ Bleeding gums
€ Blurring vision
€ Double vision
€ Eye pain

SKIN

€ Bruises
€ Hives
€ Itching
€ Rashes
€ Change in moles
€ Scars
€ Sores not healing

GASTRO-INTESTIONAL

€ Poor appetite
€ Bloating
€ Bowel changes
€ Constipation
€ Diarrhea
€ Excessive hunger
€ Excessive thirst
€ Gas
€ Indigestion
€ Nausea
€ Rectal Bleeding
€ Hemorrhoids
€ Stomach pain
€ Vomiting
€ Vomiting blood

GENITOURINARY

€ Urinary Tract Infection
€ Frequent urination
€ Painful urination
€ Night urination
€ Urgency
€ Lack of bladder control
€ Blood in urine

CARDIOVASCULAR

€ Chest pain
€ High blood pressure
€ Low blood pressure
€ Irregular heart beat
€ Poor circulation
€ Rapid heart beat
€ Swelling ankles
€ Varicose veins
€ Shortness of breath
€ Wheezing
€ Coughing

WOMEN

€ Breast masses
€ Nipple discharge
€ Menstrual
Length_______
Duration_____
€ Spotting
€ Irregular cycle
€ Painful periods
€ PMS
€ Abnormal pap
€ Abnormal discharge

MEN

€ Breast masses/lumps
€ Erection difficulties
€ Lump in testicles
€ Penis discharge
€ Sore on penis
€ Other __________________

CONDITONS: Check any of the following you had with approximate dates

AIDS ____
Alcoholism ____
Anemia ____
Anorexia ____
Appendicitis ____
Arthritis ____
Asthma ____
Barrett's Esophagus ____
Bleeding disorders ____
Breast lump ____
Bronchitis ____
Bulimia ____
Cancer ____
Cataracts ____
Chemical dependency ____
Chicken Pox ____
Colitis ____
Crohn's disease ____
Diabetes ____
Edema ____
Emphysema ____
Epilepsy ____
Glaucoma ____
Goiter ____
Gout ____

Heart Disease ____
Hepatitis ____
Hernia ____
Herpes ____
High Cholesterol ____
HIV positive ____
Hysterectomy ____
Kidney disease ____
Liver disease ____
Measles ____
Migraine ____
Miscarriage ____
Mononucleosis ____
Multiple Sclerosis ____
Mumps ____

Pacemaker ____
Pneumonia ____
Polio ____
Prostate issues ____
Psychiatric care ____
Rheumatic fever ____
Scarlet fever ____

Stroke ____
Suicide attempt ____
Thyroid issues ____
Tonsillitis ____
Tuberculosis ____
Typhoid fever ____

Ulcers ____
Vaginal infection ____
Venereal disease ____

Any additional information or comments: ____

____

____

____

____

Reviewed by: ____ Date: ____

PATIENT INFORMATION

PATIENT INFO: PLEASE PRINT

Patient Name: ____DOB: ________________

Social Security#: _________________________ Sex: F or M Marital Status:__________

Address: ____ City/Zip: ___________________

Home phone: ___________________________ Cell/Alternate number: _______________________

What phone number do you prefer we call?____

Employment Status: Employed Non-Employed Student Retired

Employer: ____ Work number: ____________________

Occupation: ____

How did you hear about us? ____

Email Address: ____

Drug Allergies: ____

Spouse and/or Legal Guardian

Name: ____Relationship: _______________

Address: ____ City/Zip: ___________________

DOB: _________________ Employer: ____

Work number: ________________________________ Alternate number: ______________________

Emergency Contact (someone not living with you)

Name: ____ Relationship: _______________

Address: ____ City/Zip: ___________________

Home phone: _________________________________ Alternate number: ______________________

Insurance:

- ❒ No insurance to bill (cash paying patient)
- ❒ If you have insurance with Naturopathic coverage; please give insurance card to receptionist to copy. ****Make sure you verified your benefits with your insurance, see insurance form to assist you****

Northwest Center for Natural Medicine

Office Policies

Supplements:

1. We will not bill your insurance for supplements. You are required to purchase supplements before receiving. Feel free to submit to your insurance for possible refund. We do accept: Cash, Check, Visa, MasterCard and Discover.

2. You may return supplements for office credit if unopened and purchased last 60 days and not expired.

Health Savings Accounts:

1. We can only fill out forms for prescription products that were purchased and prescribed by Northwest Center for Natural Medicine. This will need to be verified by receipt and/or your treatment plan from the provider. You should keep track of your treatment plans and receipts to attach with to your forms when you submit them to us.
2. Due to the large amount of requests for these, we will need 2-3 business days to complete forms.

Injections:

We will not bill insurance for injections given in office. If you receive and agree with having a Vitamin B shot these will be due at time of service. Injections range from $11.00 to $20.00.

Lab Services:

If we are unable to bill insurance for Urinalysis dipstick and performed in our office; the cost is due at the time of service. Urinalysis dipstick test are $15.00.

We will refer patients to an outside laboratory for blood draw and cytology services. If you plan to bill Medicare for your lab work, we are unable to order since we are not contracted with Medicare. **It is the patient's responsibility to find out what their preferred out patient laboratory is with their insurance**. We typically send our patients to Quest Diagnostic.

No Show/Cancel Policy:

We require a 24 hour notice for any cancels or reschedules. We do understand that emergencies do happen and will handle those case by case. There will be a $35.00 fee billed to you directly without proper notice given to our office.

Three people are hurt when there is a no-show or last minute cancel/reschedule

1. The professional who set aside their time
2. The other patients that could have been seen
3. The patient that doesn't receive the help they need

I understand and agree to the above policies

Patient signature: ______________________________ Date: __________

Northwest Center for Natural Medicine

Financial Payment Policy and Assignment of Benefits

Thank you for choosing us as your health care provider. The provision of care rendered to you will result in a bill for our services. The following is a statement of our Financial Payment Policy, which we requested you read and sign prior to your treatment. All patients must complete our Information & Insurance Form, provide a current insurance card and a valid photo ID issued by a local, state or federal agency before seeing the provider.

REGARDING INSURANCE

If we are the participating provider**, all CO-PAYMENTS are due at the time of service**. If we have to bill you for your co-payment there will be a $7.00 service charge.

As a courtesy we will bill your insurance carrier for you. Your insurance policy is a contract agreement between you and your insurance company. We are not a party to that contract. If you do not inform us of any specific requirements or guidelines in your contract and your provider subsequently orders services that are not covered; we, or the selected facility will bill you directly for those charges. Your insurance company determines the amount you are responsible to pay based on your plan policy with them. These amounts will be shown on the Explanation of Benefits you will receive from your insurance company.

If your insurance has not paid your account within 45 days, the account automatically becomes your responsibility and will become due immediately. Please be aware that some of the services provided may be non-covered services or not considered reasonable and necessary under your policy, but deemed to be in your best interest by your provider.

PRIVATE PATIENTS

We **DO NOT** accept Medicare or any supplements to Medicare. You will be a considered a self-paying patient. If you do have a secondary insurance that is an individual plan; we can bill Medicare which will deny the claim since we are not contracted with Medicare; then we can bill your secondary insurance.

Private Pay patients are entitled to a discounted cash price when paid in full payment **at the time of service**.

A minor's parent(s) or guardian(s) are responsible for full payment. For unaccompanied minors, non-emergency treatments will be denied unless a valid medical power-of-attorney and an approved method of payment accompany the patient at the time of service.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE, UNLESS WE ARE BILLING YOUR INSURANCE FOR YOU. WE ACCEPT CASH, CHECK, OR CREDIT CARD. IF YOUR ACCOUNT IS SENT TO COLLECTIONS FOR LACK OF PAYMENT, YOU WILL BE DISCHARGED FROM PRACTICE UNTIL YOUR ACCOUNT IS A ZERO BALANCE.

Please remember that when you receive our statement, you already received quality health care from our provider. Prompt payment upon statement is greatly appreciated. Delinquent accounts after 90 days will be sent to collections.
Thank you for understanding our Financial Payment Policy. Please let us know if you have any questions or concerns.

I have received the Financial Payment Policy

X____ Date:________________________

(Signature of Patient or Responsible Party)

I, the undersigned authorized the release of any information relating to all claims for benefits submitted on behalf of myself and/or any dependents. I further expressly acknowledge that my signature on this document authorizes the provider of medical services to submit claim for benefit for services rendered to my insurance company, without obtaining my signature on each and every claim to be submitted for myself and/or dependents. I hereby authorize payment of all insurance, payable to me to be paid directly to provider. This authorization shall remain in effect until revoked by me in writing.

X____ Date: ________________________

(Signature of Patient or Responsible Party)

Northwest Center for Natural Medicine

CONSENT of SERVICES

I authorize, **under my discretion**, the doctors of Northwest Center for Natural Medicine to perform the following specific procedures as my provider and I find necessary to facilitate my diagnosis and treatment:

Naturopathic Medicine

Common diagnostic procedures: e.g. venipuncture, Pap smears radiography, laboratory and x-ray.

Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation and intramuscular vitamin injections.

Botanic medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, plasters or suppositories.

Homeopathic medicine: the use of highly diluted quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.

Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, balancing of work and social activities.

Minor office procedures: wound dressing, ear cleansing

Psychological counseling

Contraception

Immunization

HcG diet

I recognize the potential risks and benefits of these procedures as described below:

Potential benefits: restoration of health and the body's maximum capacity for function, relief of pain and symptoms of disease, assistance in injury and disease recovery and prevention of disease or its progression.

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures.

ACUPUNTURE

Acupuncture: insertion of special sterilized needles through the skin into underlying tissues at specific points on the surface of the body.

Cupping: a technique to relieve symptoms in which cups made of glass or other materials are placed on the skin with a vacuum created by heat or suction.

Gua Sha: a rubbing on an area of the body with a blunt, round instrument.

Herbs: may be prescribed in the form of pills, powders, tinctures, pastes, plasters or other forms such as raw herbs to be cooked. Cooked herbs may be given to take internally or externally as a wash. Herbal formulas may include shell, mineral or animal materials.

Moxa: indirect burning on an acu-points using stick, string or ball moxa to relieve symptoms.

Tuina: an ancient massage used to treat a wide variety of common disharmonies.

Dietary Advice: based on traditional Chinese Medical Theory.

I recognize the potential risks and benefits of these acupuncture procedures as described below:

Potential benefits: drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem and the strengthening of the constitution.

Potential risks: discomfort, pain, burn, infection or blistering at the site of acupuncture procedures, minor bruising, broken needle, needle sickness, temporary discoloration of the skin, nausea, loose bowel movement, abdominal cramping and aggravation of symptoms existing prior to the acupuncture treatment.

Notice to pace maker patients and/or bleeding disorders: Patients with severe bleeding disorders or pace makers should inform practitioners prior to any treatment.

Notice to pregnant women: all female patients must alert the doctor if they know or suspect that they are pregnant, as some of the therapies could present a risk to the pregnancy.

Dr. Steven Plaza ND, LAc and Dr. Cheryl Plaza ND, LAc

Both graduating from Bastyr University   Kenmore, WA

Dr. Steve Plaza 1994-1998

Dr. Cheryl Plaza 1995-1999

Dr. Steve Plaza Acupuncture License WA-AC00000627

Dr. Cheryl Plaza Acupuncture License WA-AC00000696

With this knowledge, I voluntarily consent to the above procedures, **<u>under my discretion</u>** realizing that no guarantees have been given to me by the Northwest Center for Natural Medicine or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or myself or unless it is required by law. I understand that I may look at my medical record at any time and can request of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential. I understand that any question I have will be answered by my practitioner to the best of his/her ability.

Signature: ____ Dated: ____________________

Signature of patient representative or Guardian: ____

Northwest Center for Natural Medicine

HIPPA

Acknowledgement and Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this acknowledgement. **A copy can be reviewed in our waiting room**. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting a request.

By signing this form, you acknowledge receipt of our notice regarding use and disclosure of protected health information about you for treatment, payment and health care operations as described in the notice.

❒ Yes ❒ No I authorize NW Center for Natural Medicine to call my **HOME** and leave a message.

❒ Yes ❒ No I authorize NW Center for Natural Medicine to call my **CELL** and leave a message.

❒ Yes ❒ No I authorize NW Center for Natural Medicine to call my **WORK** and leave a message.

Please list anyone whom you want to have verbal and/or physical access to your health care information. This information will remain in place until you direct NW Center for Natural Medicine otherwise.

Name: **Relationship:**

____

____

____

____

Patient name: ____ DOB: ____________

Patient/Representative Signature: ________________________________Date: _______

Northwest Center for Natural Medicine

Insurance Benefit/Eligibility Coverage

This form needs to be filled out before your appointment. Please call the number on the back of your insurance card. This will help you and our office understand your benefit coverage relating to Naturopathic/Acupuncture Care. This will also prevent future financial surprises. Also on the back of this form is some additional information to hopefully help you understand your insurance.

We **DO NOT** accept Medicare or any supplements to Medicare. You will be a considered a self-paying patient. If you do have a secondary insurance that is an individual plan; we can bill Medicare which will deny the claim since we are not contracted with Medicare; then we can bill your secondary insurance.

- **Your first visit will be billed as a First time Evaluation/Consultation CPT code 99203 or 99204 under the provider's Naturopathic License no matter if you are here for Acupuncture or Naturopathic medicine. The provider is a licensed naturopathic doctor and a licensed acupuncturist. The provider will need to know your complete medical history before performing acupuncture if this is what you're interested in. If you know that you *DO NOT* have naturopathic benefits please call the office and/or let us know to make changes to your appointment. Any questions please contact our office.**
- **SELF PAY: 1st consultation/Naturopathic visit is approximately billed $170.00- $245.00, if you have no insurance or no benefits we give a discounted rate at time of service. Your follow-up Naturopathic and/or Acupuncture visits after your initial consultation will be at a discounted rate also. You may inquire about our discounted rates with our office. This is for self paying patients ONLY!!!! We do accept: cash, check, Visa, MasterCard and Discover.**

Insurance: ____

Rep spoken to: ______________________________ Date: ______________

1. Is Naturopathic Medicine/Care covered under your plan? ❒ YES ❒NO
   a. If **YES**, is there a dollar amount limit? _________ Visit limit: ___________ Co-Pay? ______
   If you need Dr's license number or TAX ID number to verify benefits please contact our office
3. Does your plan cover your first visit/consult with this CPT code, 99203/99204? ❒ YES ❒NO
4. Is Acupuncture covered: ❒ YES ❒ NO
   a. If **YES**, is there a dollar amount limit? _________ Visit limit: ___________ Co-Pay?______
   b. If **YES**, is it only covered under certain diagnosis? ______________________
   ****if your insurance is Group Health, Group Health does not cover Dr. Plaza for Acupuncture. If you have an "Options" plan verify that you have Out-of-Network. Dr. Plaza can perform acupuncture as an out-of-network provider if you have those benefits. ****
5. Do you have deductible: ❒ YES ❒ NO Amount: ____________________
6. If yes, has your deductible been met? YES NO How much have you met: __________

I have verified the above information with my insurance company and/or know my benefits.

Patient signature: ______________________________________ Date: ____________

INSURANCE COVERAGE AND NATURAL MEDICINE

In WA State, we are very lucky to have some insurance coverage for natural ("alternative" or "complementary") medicines. This is because of a law called the "Every Category of Provider Law" that was introduced by a champion of natural medicine, Debra Senn, when she was Attorney General in Washington. This law states that insurance companies who operate out of Washington State must offer insurance coverage for alternative care providers as well as for conventional medical providers.

There are some exceptions to the law, of course. If an insurance company does business in WA but is not based here they do not have to comply. If your employer has headquarters outside of WA State they may not have to comply. Some insurance companies from other states do insure businesses in WA State and offer alternative medicine coverage, as long as the provider is licensed in the state of WA where they provide care. Other out of state insurers do not offer coverage for any alternative care of they only cover certain types of providers, for example, they may only allow acupuncture or massage but not naturopathic medicine.

If an employer creates and buys "self-insured plans" from an insurance company then they are expected from the every category of Provider law. Several large corporations chose to "self-insure" and have limited access to alternative providers in their insurance packages.

Some insurances companies offer plans to employers that limit on how much money the insured can spend on alternative care. Other insurances plans limit how many visits you may make to a type of provider (for example only 12 acupuncture visits). Another thing that might occur is a separate deductible for alternative medicine.

To better understand your insurance benefits, some insurance terms and experiences you should familiarize yourself with include:

In-Network: this term refers to providers of medical service (doctors, clinics, hospitals, laboratories) that are signed up with the insurance company. There is generally an application and approval process. The providers are then termed "in-network" or "preferred providers" by the insurance companies. The preferred providers generally agree to accept lower rates of reimbursement decided upon by the insurance companies.

Out-of Network: This means that a provider such as a doctor or lab is not a preferred provider with your plan. Coverage depends upon your individual plan and may range from zero to partial. Some plans will provide significant coverage once you pay an out-of network deductible, i.e. a certain amount of the initial out-of-network doctors' bills.

Annual Deductible: Many plans have this feature, which means that every calendar year you must apply a certain initial portion of your medical bills before in the insurance company will cover anything. In some plans the deductible is certain initial portion of your medical bills before the insurance company will cover anything. Some plans the deductible is small, requiring you to pay the first $100-500 of each year's medical. Catastrophic plans have higher deductibles such as $1,000-5,000 yearly. Once your yearly deductible is paid then the insurance company will begin paying for some or all of your medical bills. When the calendar year is up, you are responsible for the annual deductible again for the New Year.

Some insurance companies have several individual plans. Just because you and a friend might have the same insurance, doesn't mean you will have the same benefits/eligibility. Always, call and verify with your insurance company.

FIRST OFFICE EVALUATION REMINDER

OR VISIT LONGER THAN 3 YEARS

Please bring the following:

1. **All information in this packet must be completed.**
2. **Current insurance card(s) at every appointment and insurance authorization (if required)**
3. **Co-payments are due at the time of service. If you co-pay amount is not on your card please check with your insurance company.**
4. **Due to provider and staff allergies, we request no perfume or cologne.**
5. **Please bring medications or supplements with you to first appointment.**
6. **If you have labs or radiology reports, please bring to your first appointment.**
7. **Photo identification will be requested at each appointment to comply with the Federal Trade Commission's Identify Theft Prevention Red Flag Rule (15 CFR 681.2)**

**** Expect to be with us for an hour or longer on your first visit. Follow-up visits and acupuncture appointments after your "First Office Evaluation" will be 30-45 minutes.**

It would also be in your best interest to verify coverage/eligibility for naturopathic services. (See Insurance Form)

Please call <u>24 hours</u> prior if you need to reschedule or cancel your appointment. If we do not receive proper notification, you may be charged a fee of $35.00.

ADDRESS: 1403 Garfield Ave NW
Olympia, WA 98502
360-754-7775
www.nwcentermed.com

We are located corner of Plymouth St. and Garfield Ave.
Across from Garfield Elementary School. Parking on street and lot in back of building.