NATURAL HEALTH CLINIC
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1707 F Street, Bellingham, WA 98225
(360) 734-1560

Welcome!

Whom may we thank for referring you? _____

Naturopathic physicians are primary health care providers emphasizing optimal health, as well as the natural treatment and prevention of disease.

The goal of your naturopathic physician is to help you enhance the quality of your health and life by working with various treatment modalities such as lifestyle counseling, clinical nutrition, botanical medicine, and homeopathy. Your physician will develop a therapeutic plan that is best suited to you and is most appropriate to your situation. Physicians may perform physical exams and order lab or other studies to gather the information needed to make diagnostic and treatment decisions. Your physician will make referrals to specialists if she believes it is in the best interest of your health.

* *

Initial Free Consultations: (15 minutes) Offered as an introduction to your doctor, and Naturopathy with focus on your particular health problem. This time is not intended for treatment. **If a free consultation is longer than 15 minutes, or culminates in treatment, you will be charged for an office visit.**

Office visits: Charge is based on the complexity of your appointment, and according to allowable standard insurance rates.

Acute care: One of the best benefits of a group practice is that if you have an urgent need, or sudden onsets of symptoms: ear infection, mastitis, or urinary tract infection, for example, you may call for a 5 minute visit with one of our doctors, and we will get you in as soon as possible; usually the same day you call, however it may be with a different doctor than who you've established care with.

Lab and pharmacy: Charges will vary depending on item(s) provided.

Telephone/Email Care: No charge for first 5 minutes. Phone calls that extend beyond 5 minutes will be charged based on office call rates, and cannot be billed to insurance.

- Continued on the next page -

Payment is expected immediately following your visit unless other arrangements have been made with the office manager. If you need to cancel or reschedule your appointment, please give us 24 hours notice. This allows other patients the opportunity to fill your time slot. There will be a $50.00 fee charged for cancellations made with less than 24 hour notice.

Insurance: Please provide office personnel with any insurance information prior to your visit. While many companies do cover naturopathy in whole or part, it is better for all parties for patients to understand coverage in advance. Depending on your coverage, we may ask that you pay for services at the time of the visit and be reimbursed directly by your insurance.

Please feel free to ask questions and offer comments about our services! It is our mission to provide quality health care in a comfortable, supportive environment. Thank you.

I have read this handout explaining fees and services.

Patient Printed Name

Patient signature Date

The Natural Health Clinic
1707 F Street
Bellingham WA 98225
360.734.1560

Patient Name: _____ Date: _____
First Last M.I.
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Social Security Number: _____ Patient's Sex: _____ Marital Status: _____
Telephone Numbers: _____ _____ _____
Home Mobile Work
E-mail Address:_____
Employer: _____ Employer's Address: _____
Primary Care Physician: _____ Referring Physician: _____
Emergency Notify (Name & Relationship): _____ Phone: _____

INFORMATION REGARDING THE INDIVIDUAL RESPONSIBLE FOR PAYMENT:
Name: _____ Social Security #: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone Numbers: _____ _____ _____
Home Mobile Work
Employer: _____ Employer's Address: _____

INSURANCE INFORMATION: (Note: If card is provided, only complete Insured's Name & Insurance Carrier's Name)

PRIMARY Insurance Carrier: _____ ID Number: _____
Insured's Name: _____ Relationship to Patient: Self _____ Spouse _____ Parent _____
Insured's Social Security Number: _____ Date of Birth: _____
Group Name &/or Number: _____ Insurance through Employer? Yes No
Claims Mailing Address: _____
Office Visit Copay: _____

SECONDARY Insurance Carrier (if any): _____ ID Number: _____
Insured's Name: _____ Relationship to Patient: Self _____ Spouse _____ Parent _____
Insured's Social Security Number: _____ Date of Birth: _____
Group Name &/or Number: _____ Insurance through Employer? Yes No
Claims Mailing Address: _____
Office Visit Copay: _____

AUTHORIZATION FOR INSURANCE, RELEASE OF INFORMATION, AND CONSENT
I hereby authorize payment directly to The Natural Health Clinic, or it's designate, for medical benefits payable for services rendered in the course of my treatment. I authorize The Natural Health Clinic, or it's designate, to release my medical information to my insurance carrier or a third party administrator in order to secure settlement of my health insurance claim(s.) I understand that I am fully responsible for prompt payment of all fees remaining after the insurance carrier settlement, if any, of the claim. I understand that if I neglect my personal financial responsibility, my account will be sent for formal collection proceedings, and I will also be responsible for payment of all associated fees for such services.

Responsible party's Signature: _____ Date: _____

Visit us online at www.fstreetnaturalhealthclinic.com and Like us on Facebook

NATURAL HEALTH CLINIC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Laura Shelton, N.D., Emily Sharpe, N.D., or Kelsi Ervin, N.D..

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. This notice is posted for your review at all times in the Clinic waiting room. You may request a copy for your records if you wish.

By my signature below I acknowledge the availability of the Notice of Privacy Practices.

Patient or legally authorized individual signature Date

Printed name if signed on behalf of the patient Relationship to patient

This form will be retained in your medical record.

NATURAL HEALTH CLINIC

CHILD HEALTH HISTORY

To help us meet all your healthcare needs, please fill out this form completely in ink. This is a confidential record of your child's health history.

Today's date: _____

Child's name (Last, First, MI):_____
Date of birth: _____ Age:_____
Parents' names (Last, First, MI):_____ Phone: _____
_____ Phone: _____

In what way is your child unhealthy? (If here for a well child exam, please state that):
_____
_____
_____

What have you, the parent, already done to help your child be healthier?_____
_____
_____

FAMILY BACKGROUND:
Who does your child live with?_____
Are parents divorced?_____ If so, what type of arrangements (visitation, etc.) are made for the other parent?_____

FAMILY MEDICAL HISTORY:
Please mark relationship of anyone in your family that has had the following conditions: (M = mother, F = father, S = sister, B = brother, A = aunt, U = uncle, MM or FM = mother or father's mother, MF or FF = mother or father's father, MGM or FGM = mother or father's grandmother, MGF or FGF = mother or father's grandfather).

High blood pressure	_____	Tuberculosis	_____	Diabetes	_____
Bleeding tendency	_____	Heart disease	_____	Stroke	_____
Drug/alcohol problem	_____	Epilepsy	_____	Allergies	_____
Chronic lung disease	_____	Cancer	_____	Asthma	_____
Mental Illness	_____	Leukemia	_____	Obesity	_____
Migraine headaches	_____	Ulcer	_____	Depression	_____
Thyroid disease	_____	Gout	_____	Glaucoma	_____
High cholesterol	_____	Kidney disease	_____		

Over please……

Child's name: _____

BIRTH HISTORY:

1. Did mother receive prenatal care? _____ Take prenatal vitamins?_____
2. State of mother's health during pregnancy _____
3. Did mother smoke cigarettes? _____ Drink alcohol? _____ Take drugs?_____
4. What type of birth? _____ How long was labor? _____
5. Carried to term? _____ If no, how premature? _____
6. Birth weight?_____ Apgar scores (if you remember)_____
7. Any complications of labor or delivery? _____

HEALTH HISTORY: How often does your child get:

Colds	_____	Sore throats	_____	Diarrhea	_____
Earaches	_____	Coughs	_____	Constipation	_____
Headaches	_____	Tummy aches	_____	Diaper rash	_____

Others_____

Has your child been immunized? Update: DPT_____ Polio_____ HIB_____
Hep B_____ MMR_____

What medications has your child been on? (Include details: How often, how long, for what?)

_____

_____

ENVIRONMENTAL HISTORY:

Do you have indoor pets? _____ If so, what types? _____
What type of dwelling do you live in? _____ How old? _____
Any home remodeling recently? _____
Has your child been exposed to any chemicals or toxins? _____
Do you heat with a wood stove? _____
Does anyone in the family smoke cigarettes? _____

DIET:

1. What did your child eat and drink yesterday?
   Breakfast: _____
   Snack: _____
   Lunch: _____
   Snack: _____
   Dinner: _____
   Snack: _____

Is this typical? _____ If not, what is?_____

Over please……

Child's name: _____

2. What foods does your child enjoy? _____
   Dislike? _____

3. What supplements does your child take and how often? _____
   _____

STRESSES:
Has your child experienced many stresses in his/her life-time? ____ What?_____
_____

SLEEP:
How much sleep does your child get? _____ From: _____ p.m., to _____ a.m.

Is there anything not covered by this questionnaire that you feel is important for a caring doctor of yours to know about?

_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the doctor's office of any changes in my child's medical status. I also authorize the healthcare staff to perform the necessary health care services my child may need.

X_____ _____
Signature of patient's parent Date