New Patient Health Record

NP

At Water's Edge, our naturopathic doctors take the time to learn all about your health history and help you achieve your wellness goals. Please complete and return this **Patient Health History form** to tell us important information about you.

Please call our office and schedule a new patient appointment *before* you fill out and submit this questionnaire.

Return your completed form to us at least 48 HOURS before your first appointment.

How to complete and return this form to us:

1. Complete the form using Microsoft Word. Save the file with a new filename that includes **your name** (e.g., "*New-Patient-Health-Record-MarySmith.doc*"). (NOTE: Please do not convert it to another format such as HTML.)
2. Return the form to us by mail or fax:

   Send to: 3131 Elliott Ave Suite, 740 Seattle, WA 98121

   FAX: 206.283.1924

NOTE: If you are unable to send this form in email, please print your completed form and mail it to our office at the address below. ****Be sure to mail it at least 5 days before your appointment so we receive it 24-48 hours in advance**.

If you have any questions, please call us at **206. 283. 1383**.

Thank you and we look forward to working with you!

New Patient Health Record

New Patient Appointment Date: ___________________ Time: ________________ Today's Date: ___________________

Patient's Information

Name ____

Prefer to be called ______________________________

Spouse/Partner_________________________________

Address ______________________________________

City _________________ State______ Zip ________

Home Phone __________________________________

Work Phone __________________________________

E-mail Address _________________________________

Birth Date ____________________ Age ____ ______

Gender: ☐ Female ☐ Male

Marital Status: ☐ Married ☐ Partnered ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

General Information

Do you have a Primary Care Doctor? ☐ No ☐ Yes

Physician's name: _____________________________

Physician's Contact Number: _____________________

Have you consulted a doctor about your current condition(s)? ☐ No ☐ Yes

Please state diagnosis, therapy and the results:

____

____

Account Information

Person responsible for the account _______________ ___

Occupation ______________________________________

Employer ____

Business Address _________________________________

City ____________________ State ___ Zip ___________

Business Phone ___________________________________

Your Spouse/Partner

Occupation ______________________________________

Employer ____

Business Address _________________________________

City ____________________ State ___ Zip ___________

Business Phone ___________________________________

Person to Contact in Case of Emergency

Name ____

Relationship ______________________________________

Address ____

City ____________________ State ___ Zip ___________

Telephone ____

Authorization for Treatment

I, the undersigned, hereby authorize the doctor to perform diagnostic tests deemed necessary for my care and to perform any and all forms of treatment, medication, and therapy that are indicated and are in accordance with the Standards of Naturopathic Care.

Patient's Signature ____ Date ________________________________

Parent of Responsible Party ____ Relationship to Patient _________________________

Personal History

Patient's Name ____ Date __________________________________

Number of Children ______ Names & Ages ____

Current Health Condition

(Please list your present health problems and concerns.)

Problem or Concern	Date of Onset
1.	
2.	
3.	
4.	
5.	

Please list the most significant, stressful events in your life, from the most recent to the most distant.
Are any of these situations continuing to impact your life? If so, please indicate these clearly.

Event	Continuing?
	☐ Continuing
	☐ Continuing
	☐ Continuing
	☐ Continuing

Family Medical History

From the following list, please write next to each family member all conditions that apply.

Conditions	
AIDS	HIV+
Alcoholism	Kidney disorder
Allergies	Mental illness
Anemia	Migraines
Arthritis	Obesity
Asthma	Osteoporosis
Breast Cancer	Psoriasis
Cervical Cancer	Senility
Ovarian Cancer	Seizures
Prostate Cancer	Sexually Transmitted Disease
Uterine Cancer	Skin problems
Other Cancers (list types)	Stroke
Diabetes	Suicide
Eczema	TB
Gout	Thyroid problems
Heart Disease	Ulcer
Hemophilia	Other
High blood pressure	

Family members affected
Mother:
Father:
(Maternal) Grandparents:
(Paternal) Grandparents:
Siblings:
Other Family:

Name ______________________________ Date ______________________

Medications and Hospitalizations

Please include all your current **prescription medications** (sleeping pills, birth controls pills), **non-prescription medications** (aspirin, antacids, laxatives, antihistamines), vitamins, minerals, herbs, etc. (**Include dose for each**.)
Attach a separate sheet, if necessary.

Medication	Dose per day	Reason for use	Prescriber	Date started Med.
Hospitalization, surgeries or serious injuries (dates and types of illness or operation):				

Allergies

Drugs, food or other substances	Reaction

Name ______________________________ Date ______________________

Health Data

(Please fill in completely)

Exam	Date	Result	Due	Screening Recommendations
Last Pap Smear/Gynecologic Exam				Yearly starting after first intercourse or age 21
Mammogram				Yearly starting at age 40
Bone Density Test (DEXA)				Every 2 years starting at age 50
Colonoscopy				Every 10 years starting at age 50
Prostate or Testicular Exam				Yearly for men starting at age 40
Other	**Date**	**Location**	**Result**	
Physical Exam				
Foreign Travel History & Immunizations				
Tuberculosis (TB) skin test				
Diagnostic Imaging (X-Ray, Ultrasound, MRI, CT, Angiogram, etc.)				
Other				

Health History

Please CHECK any conditions you **currently have** or **have had in the past year ONLY**.

General	Gastrointestinal	Eye/Ear/Nose/Throat	Cardiovascular
☐ Chills	☐ Poor Appetite	☐ Bleeding gums	☐ Chest pain/pressure
☐ Depression	☐ Bloating	☐ Blurred vision	☐ High blood pressure
☐ Dizziness	☐ Bowel changes	☐ Crosses eyes	☐ Irregular heart beats
☐ Fainting	☐ Constipation <1 stool/day	☐ Difficulty of swallowing	☐ Low blood pressure
☐ Fever	☐ Diarrhea	☐ Double vision	☐ Poor circulation
☐ Forgetfulness	☐ Excessive hunger	☐ Ear ache	☐ Rapid heart beat
☐ Headache	☐ Excessive thirst	☐ Ear discharge	☐ Varicose veins
☐ Loss of sleep	☐ Gas	☐ Hay fever	☐ Edema
☐ Nervousness	☐ Hemorrhoids	☐ Hoarseness	
☐ Numbness	☐ Indigestion	☐ Loss of hearing	
☐ Sweats	☐ Nausea	☐ Nosebleeds	
	☐ Rectal bleeding	☐ Ringing in the ears	
	☐ Stomach pain	☐ Sinus infections	
	☐ Vomiting	☐ Vision “flashes”	
	☐ Vomiting blood	☐ Vision “halos”	
	☐ Parasites		

Name ______________________________ Date ______________________

Health History (continued)

Please CHECK any conditions you **currently have** or **have had in the past year ONLY**.

Respiratory	Skin	Muscle/Joint/Bone	Genito-Urinary
☐ Shortness of breath	☐ Acne	Pain, weakness, or numbness in:	☐ Blood in the urine
☐ Persistent cough	☐ Bruise easily	☐ Arms	☐ Frequent urination
☐ Wheezing	☐ Itching	☐ Back	☐ Lack of bladder control
☐ Cough with blood	☐ Change in mole(s)	☐ Feet	☐ Painful urination
	☐ Rash	☐ Hands	
	☐ Scars	☐ Hips	
	☐ Sore that won't heal	☐ Legs	
		☐ Neck	
		☐ Shoulders	
		☐ Loss of height	

Please CHECK any conditions you **currently have** or **have ever had**.

☐ AIDS	☐ Frequent antibiotic use	☐ Panic attacks
☐ Alcoholism	☐ Hay fever	☐ Parasites
☐ Allergies	☐ Headaches	☐ Pneumonia
☐ Anemia	☐ Hemorrhoids	☐ Prostate problems
☐ Anorexia	☐ Hemophilia	☐ Psoriasis
☐ Appendicitis	☐ Problems with gums and teeth	☐ Psychiatric care
☐ Arthritis	☐ Gall bladder problems	☐ Rheumatic fever
☐ Asthma	☐ Glaucoma	☐ Spontaneous abortion (miscarriage)
☐ Bladder/urinary problems	☐ Goiter	☐ Seizures
☐ Bleeding disorders	☐ Gout	☐ Sexual abuse
☐ Breast lump	☐ Hair falling out	☐ Sinusitis
☐ Bronchitis	☐ Heart Disease	☐ Skin problems
☐ Bulimia	☐ Hernia	☐ Stroke
☐ Cataracts	☐ High Cholesterol	☐ Suicidal attempt
☐ Cancer (list type)	☐ Hypoglycemia	☐ Thyroid problems
☐ Chemical dependency	☐ Irritable bowel/colitis	☐ Tonsillitis
☐ Diabetes	☐ Jaundice	☐ Ulcers
☐ Digestive disorders	☐ Joint problems	☐ Varicose veins
☐ Ear problems	☐ Kidney disease	☐ Vaginal infections
☐ Edema, dropsy or water weight	☐ Liver disease	☐ Weight gain/weight loss
☐ Eczema	☐ Lung problems	☐ Other:
☐ Emphysema	☐ Migraine headaches	
☐ Epilepsy	☐ Multiple sclerosis	
☐ Eye problems	☐ Obesity	
☐ Fatigue (chronic)	☐ Osteoporosis	
☐ Female gynecological problems	☐ Pacemaker	

Name ______________________________ Date ______________________

Health History (continued)

Please CHECK any conditions you **currently have** or **have ever had**.

Infectious diseases:		
☐ Chicken pox	☐ Measles	☐ Scarlet fever
☐ Chlamydia	☐ Mumps	☐ Syphilis
☐ Gonorrhea	☐ Mononucleosis/Epstein-Barr	☐ Tuberculosis
☐ Hepatitis	☐ Polio	☐ Typhoid fever
☐ Herpes	☐ Papilloma virus	☐ Other:
☐ HIV positive	☐ Rubella	

Please CHECK Yes or No for any conditions you **currently have** or **have ever had**.

Yes	**No**	Breast/Prostate cancer
Yes	**No**	Uterine/Cervical cancer
Yes	**No**	Currently pregnant
Yes	**No**	Currently breastfeeding
Yes	**No**	Heart or Liver or Kidney disease
Yes	**No**	Thrombophlebitis (deep vein pain/clotting issue)
Yes	**No**	Thromboembolic disorder (blood clotting problem)
Yes	**No**	Estrogen-related cancer
Yes	**No**	Undiagnosed abnormal genital bleeding
Yes	**No**	Family history of Breast cancer
Yes	**No**	Family history of Uterine cancer or Cervical cancer or Prostate cancer
Yes	**No**	Breast cysts, breast nodules, fibrocystic breasts, abnormal mammogram
Yes	**No**	Severe liver disease
Yes	**No**	History of severe hypersensitivity to drugs
Yes	**No**	Genital cancer (Vaginal or Testicular cancer)
Yes	**No**	Use of blood thinning medications
Yes	**No**	Severe reaction to estrogen or progesterone or testosterone or DHEA or Cortisol
Yes	**No**	Currently active cancer
Yes	**No**	Myocardial infarction or other acute heart disease
Yes	**No**	High blood pressure or intracranial hypertension
Yes	**No**	BPH (Benign Prostatic Hypertrophy) causing obstructed urine flow

If you answered **Yes** to any of the above, please describe in detail.

Name ____ Date ____________________________

Hormone Medication History

Please complete the following table, using the examples below.

Hormone	DHEA	Progesterone	Estrogen	Testosterone
Hormone Name				
Dosage				
Date Started				
Date Ended				
Using Currently				
Days of month used				
Natural				
Synthetic				
Cream				
Suppository				
Caps/Tablets				
Drops				

Reason for use:
List reactions to hormones:

EXAMPLE:

Hormone	DHEA	Progesterone	Estrogen	Testosterone
Hormone Name		Prometrium	Estradiol	
Dosage		100 mg	1.0 mg	
Date Started		6/05	6/05	
Date Ended				
Using Currently	No	Yes	Yes	No
Days of month used		Days 15-30	Days 1-20	
Natural				
Pharmaceutical		Yes	Yes	
Cream				
Suppository				
Caps/Tablets		Yes	Yes	
Drops				

Name ______________________ Date ______________________

Personal Health Habits

Height:	Current Weight (lbs):		1 Year Ago (lbs):	Max. Weight (lbs):	Date:
Item	**No**	**Yes**	**Details**		
Tobacco Use			Smoke or Chew: Years:	Amt Per Day:	Year Quit:
Alcohol Use			Type:	Drinks per week:	
Rec. Drug Use			Type:	Frequency:	
Coffee:			Cups Per Day:	Caffeinated or Decaf:	
Tea			Cups Per Day:	Caffeinated or Decaf:	
Sodas			Type:	Cans Per Day:	
Chocolate			How Often:		
Exercise			Type:	Frequency:	Duration:

Occupational and Household Exposure

What is your occupation?				Average hours you work per week:
Please describe your work:				
Situation	**No**	**At Times**	**Yes**	**Details**
Do you work in the presence of toxic fumes or chemicals?				
Have you ever worked near toxins?				If yes, please provide details:
Are you exposed to second-hand smoke?				
Do any of your hobbies involve toxic materials?				If yes, what kind (paints, plastics, gases, lead, etc.):
Do you wear sunglasses, contact lenses, or glasses when outside?				
Do you have house pets?				Type:

Detoxification

Situation	No	At Times	Yes	Details
Have you ever participated in a detox program supervised by a qualified health professional?				If yes, please explain:
Do you fast?				
Do you feel well rested on waking in the morning (ready to get up and going)?				
How many hours do you sleep on the average night:				
On a scale from 1 to 10, how do you rate the quality of your sleep? (0 = no sleep and 10 is great):				

Name ______________________ Date ______________________

Digestion and Eating Habits

Description of diet	**No**	**At Times**	**Yes**	**Details (Describe each meal below)**
Do you eat **breakfast**?				
Do you eat **lunch**?				
Do you eat **dinner**?				
Do you eat **snacks**?				Number of times a day: What do you eat?:
Do you diet often?				
Are you on a special diet?				If yes, describe:
What kind of foods do you **crave**?	List:			
What kinds of foods cause you **problems**?	Describe the food and the problem you experience when you eat it:			
What foods do you eat every day?				
Do you often eat at fast-food restaurants?				
Do you often eat in restaurants?				
Do you use NutriSweet (aspartame) or other artificial sweeteners?				
How do your bowel movements tend to be?	☐ Constipated ☐ Loose ☐ IBS ☐ IBD ☐ _________			

Skin

Do you perspire when you exercise? ☐ Lightly ☐ Moderately ☐ Heavily
Do you perspire other than when exercising? ☐ No ☐ At Times ☐ Yes When?
Do you have difficulty perspiring? ☐ No ☐ At Times ☐ Yes
Does your perspiration smell strong? ☐ No ☐ At Times ☐ Yes Does it smell like urine? ☐ No ☐ At Times ☐ Yes

Life Style Index

Please rate your level of functioning for each area of you life on a scale of 1-10 (10 = best)

Function	**Rating**	**Function**	**Rating**	**Function**	**Rating**
Mental		Family		Social	
Emotional		Creativity		Spiritual	
Physical		Fun		Career	

Name ______________________________ Date ______________________

Vitality Survey

Scoring: Never —0 Seldom — I Occasionally —2 Often —3 Very Often —4

How often do you…	Score
Lose your sense of humor/take life too seriously?	
Experience doubt or indecision?	
Experience worry and anxiety?	
Feel over-cautious or pessimistic?	
Lack self confidence or feel low self-esteem? -	
Experience stress or feel nervous or tense?	
Feel irritable or oversensitive?	
Experience difficulty concentrating and loss of clear thought?	
Experience inadequate energy (fatigue)?	
Have coffee, tea, tobacco, sugar or other stimulants as a pick up?	
Experience nervous indigestion?	
Experience loss of sex drive?	
Experience difficulty sleeping?	
Experience difficulty getting up in the morning?	
Feel run down?	
Feel depressed?	
Feel like crying for no reason?	
Find it difficult to sit quietly (without fidgeting, talking, reading, watching TV, etc.)?	
Find it difficult to express your feelings?	
Experience rapid heart beat or panic? -.	
Feel moody?	
Feel suicidal or wonder whether life is worth living?	
Have anxiety about not having enough money?	
Fear ill health?	
Fear criticism?	
Fear loss of love?	
Fear old age or death?	
Feel “something is the matter with me” but don’t know what?	
Think that you might be going crazy (losing it)?	
TOTAL SCORE:	

0 — 30 POINTS = Powerful Nerve Force HIGH VITALITY 31— 45 POINTS = Strong Nerve Force GOOD VITALITY 46 — 60 POINTS = Moderate Nerve Force AVERAGE VITALITY 61 — 75 POINTS = Low Nerve Force LOW VITALITY	76 — 90 POINTS = Nervous Fatigue NERVOUS FATIGUE 91 — 105 POINTS = Nervous Depletion NERVOUS EXHAUSTION 106 — 120 POINTS = Serious Nervous Exhaustion SEVERE BURNOUT

Name ____ Date __________________________________

Women Only

Gynecologic History	Yes	No	Details
Age your period began:			**Abnormal Pap smear? Date:**
Menopause			If yes, date of last period:
Perimenopause			If yes, describe symptoms:
Ovaries removed (one/both)			If yes, when:
Uterus removed			If yes, when:
DES – did your mother take it during pregnancy?			
Are you still menstruating?			**If yes, complete the section below; if no, skip that section**

Menstruation	Yes	No		Yes	No
Regular periods			Bleeding between periods		
Irregular menses Symptoms:			Spotting		
Cramps / # of days: Mild___ moderate___ severe____			Midcycle spotting		
PMS / # of days: Symptoms:			Spotting instead of period		
Oral contraceptives (past/present)			Weight gain (how many lbs)		
Periods every _____days (length of cycle) Duration: _____ days (flow days) Flow: heavy__ medium___ light___					
Date your last 6 periods began: _____ ______ ______ ______ ______ _____					

Pelvic Exam	
Date of last pelvic exam:	Performed by:
Date of last PAP smear:	Result:
Recurrent vaginal yeast infections Yes____ No ____	Are you sexually active: Yes____ No ______

Breast Health	Yes	No		Yes	No
Breast pain			Fibrocystic breast disease		
Breast lumps			Do you perform monthly breast exam on yourself?		
History of abnormal mammogram			Currently breastfeeding		
Nipple discharge			Breast implants / Type:		
Date of last mammogram:		**Results:**	**Location of diagnostic center:**		

Pregnancy	Yes	No		Yes	No
Currently pregnant			Planning pregnancy (If yes, when:)		
Desire pregnancy			Pregnancy complications (If yes, describe)		
Prior pregnancies: #___ Births #___ C-Sections #__ Miscarriages #___ Abortions #____					

Name ____ Date ______________________________

Female Hormone Imbalance Rating

Please rate the severity of the symptom(s) or condition **if it's present** by rating it on a **Wellness Gauge Scale 0 to 10 when 0 = symptom is not present ☺ and 10 = symptom is severe ☹**

	Abdominal pain		Fibroids		Mood swings
	Allergies		Fluid retention		Night sweats
	Anger easily		Food cravings/binge eating		Ovarian cyst(s)
	Back pain		Heavy menstrual bleeding		PMS
	Bloating		Vaginal dryness		Rheumatoid arthritis
	Chronic stress		Hot flashes		Skin problems
	Depression		Insomnia		Spotting
	Disinterest in sex/low sex drive		Irregular menstrual cycle		Subfertility
	Endometriosis		Irritable or anxious		Other:
	Fatigue		Meat eater (rate frequency)		
	Fibrocystic breast disease		Menstrual migraines		
				TOTAL SCORE:	

Past or Present Condition (0 = none, 10 = yes)

	Ovarian Cancer		Infertility (never able to conceive)
	Uterine Cancer		Loss of height/ bone loss
	Cervical Cancer		Miscarriage
	Breast Cancer		Premature menopause (<45 yrs old)
	Estrogen/Progesterone sensitive Cancer		Pain with intercourse
			TOTAL SCORE:
			GRAND TOTAL SCORE:

Are you completely satisfied with your sexual experience: Yes____ No ____
Please explain:

Name ______________________________ Date ______________________

Men Only

	Yes	No		Yes	No
Breast lump			DES – did your mother take it during pregnancy?		
Lump in testicle			Date of last genital exam:		
Penis discharge			Date of last prostate exam:		
Sore on the penis			Date of last PSA test: Result:		
Erection difficulties					

Male Hormone Imbalance Rating

Please rate the severity of the symptom(s) or condition **when it's present** by rating it on a **Wellness Gauge Scale 0 to 10, when 0= symptom is not present ☺, 10= symptom is severe ☹**

	Abdominal pain		Thinning armpit, head, pubic hair		Urine flow dribbling at the end
	Joint pain/Stiffness		Skin problems/dryness		Blood in urine
	Anger easily		Excessive sweating (day or night)		Urinary incontinence
	Back pain		Mood swings		Pain with urination
	Rheumatoid arthritis		Lack interest in leisure/social activities		Pain with ejaculation
	Chronic stress		Low stamina		Bloody ejaculation
	Depression		Difficulty obtaining erection		Pain with intercourse
	Disinterest in sex/low sex drive		Difficulty maintaining erection		Unable to conceive (subfertility)
	Erectile dysfunction		Pain with erection		Mass in genital organs
	Fatigue		Lack of nocturnal erections		Heavy drinking (past/ present)
	Insomnia		Lack of morning erections		Frequent urination
	Irritable or anxious		Urine flow slow to start		Other:
	Food cravings/binge eating		Weak urine stream		
	Breast enlargement		Unable to void bladder completely		
				TOTAL SCORE:	

Past or Present Condition (0 = none, 10 = yes)

	History of mumps infection		Infertility (never able to conceive)
	History of mass in genitalia		Loss of height/bone loss
	History of testicular/scrotal surgery		Cancer: (list type)
	Developmental issues w/sex organs		Other:
	Family history of prostate cancer		**TOTAL SCORE:**
			GRAND TOTAL SCORE:

Water's Edge
NATURAL MEDICINE

Office Guidelines

To make sure we share a common understanding, please read and sign our office guidelines. We welcome any questions you may have, and if there's anything we haven't covered, please feel free to ask. We want to have all your questions answered so we can move ahead with your healing process. Thank you-- we look forward to helping you!

Payment for Services, Lab Test and Health Products

- **Full payment is required at the time of service**. It's been our experience that people get well faster if they don't have to worry about doctor bills piling up. **Initial:______**
- **All in-person/phone visits will be paid in full at the end of your visits**. **Payment method on file will automatically be processed, unless another method is provided. Initial:______**

Insurance billing/Medical Forms

- We do not bill insurance companies or communicate with them. We'll provide you with an insurance-coded receipt and you can submit it to your insurance company for reimbursement, if they do so. For more information, please see ***Chapter 1: Payment Options & Insurance***. **Initial:______**
- Forms/Letters: 1) If you have an insurance denial coverage and you want your provider to write an appeal letter. 2) FMLA letters. 3) Medical Necessity letter. The processing fee is **$70**, payment is due when the forms/letter are requested. We require 5-7 business day turnaround time. 3) Prior authorizations for prescriptions are **$50** fee. **Initial:______**

Returned Checks

- There will be a $40.00 charge for returned checks. **Initial:______**

Office Hours, Appointment Cancellations, Reschedules, No Shows

- Hours may vary due to holidays and clinic closures. Whenever possible we post notification of changes to our regularly scheduled ours.
- If you need to cancel or change a scheduled appointment, please call Monday - Friday during or before office hours, (2) or more business days before your appointment.
- **If a change is made with less than 48 hour business notice, you will be charged the full visit fee. Initial:______**

Medical messages and questions

- If you have a brief question about your care that can be answered by our staff, there is no charge. If you call about a new health concern or need to talk directly with one of the doctors, ***the cost is $55.00 for up to 10 minutes***; calls longer than 10 minutes are charged the full office visit fee. **Initial:______**
- Lab results must be obtained directly from your doctor during a visit, before we can change your treatment plan. **Initial:______**

Refilling and Mailing your Medications

- You may come to our clinic any time during normal business hours to purchase medications prescribed for you. For best service, please call several days in advance to allow the doctor to authorize the refills and quantities you've requested**.** Your Personalized Care Plan indicates how many refills the doctor has ordered. ***Prescriptions requiring a re-test will not be renewed until the test results have been reviewed by the doctor.*** Please be prepared to wait briefly, as we may be serving other patients, and will process your order as soon as possible after you arrive. **Initial:______**
- We are happy to mail medications your doctor has prescribed for you. A handling charge is added to the postage fee for all mailings, to cover the cost of shipping supplies. Orders are generally processed 24 to 48 business hours from when they are placed. Requests made on Fridays will not go out until the next business day. Mailed items must be paid for at the time of the order**.** **Please note we cannot be responsible for lost packages; *if you request a mailing or drop box you assume the risk and cost.*** **Initial:______**
- In addition, for any orders placed over the phone or email, our staff will charge credit card on file. **Please specify which credit card you would like to use and if it is a pick up or mail out.**

Return Policy

- You may return any unopened, unexpired medicines purchased within **45-days**, thereafter all sales are final. (Items presented for returns without the original receipt may be exchanged for the same item or a refund in the form of an office credit. A refund for a return without a receipt may be limited to the lowest advertised price in the **45-day** period prior to the return.) **Initial:______**
- Test kits are non-refundable after **30-days** of purchase, thereafter all sales are final. **Initial:______**

I accept the above Office Guidelines. Signature: ____
Date: _________________

Consent for Leaving Messages/Share Information with Family/Friends

I understand that my healthcare information at Water's Edge Natural Medicine is protected and I have received a copy of the Notice of Privacy Practices.

In order for the clinic to leave detailed messages on my voice mail or answering machine, I need to give permission to Water's Edge Natural Health Services.

Consent for Leaving Messages (please check box)

▫ Yes ▫ No best number to leave messages________________________

I consent to information regarding myself (or my child's) appointment reminders/instructions be left on my voicemail or answering machine.

Consent for Shared Information with Family and Friends (please check box)

▫ Yes ▫ No

I wish family members or friends to have access to my healthcare information. The name(s) listed below are family members or friends to whom I grant access to my healthcare information. I will rely on the professional judgment of my provider and her designee to share such information, as they deem necessary.

I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information form.

NAME	RELATIONSHIP
1.________________________________	________________________________
2.________________________________	________________________________
3.________________________________	________________________________

(print)______________________________ ______________________________

patient name **patient/parent signature**

date of birth______________ **date**__________

This consent will be considered valid until such time that I cancel it. I reserve the right to cancel it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships change may change over time. I understand that any cancellation can only apply to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.

Authorization for Treatment

I, the undersigned, hereby authorize the doctor to perform diagnostic tests deemed necessary for my care and to perform any and all forms of treatment, medication, and therapy that are indicated and are in accordance with the standards of Naturopathic Care.

Patient's Signature______________________________ Date ________________________

Parent of Responsible Party (optional) _________________ Relationship to Patient___________

Doctor and Patient Information and Responsibilities for patients of Water's Edge Clinic

As a Doctor:

- ✓ I will treat you with compassion and respect. I will listen and communicate well.
- ✓ I will respect your health choices and preferences.
- ✓ I can work as part of a health team, communicating and referring to other providers.
- ✓ I will be prompt in answering your phone messages via my staff.
- ✓ I will go to seminars, lectures and keep current in my fields of training and interest.
- ✓ I will let you know what I think is causing your symptoms, as well as what the options are for diagnosis and treatment.
- ✓ I will think about the complex inter-relationships in your body and will work on improving function, decreasing symptoms as well as optimizing wellness.
- ✓ I will think about prevention of heart disease and cancer if you tell me this is a priority for you.
- ✓ I will consider lifestyle interventions as well as other interventions that could benefit you.
- ✓ I can provide you, at the initial office call, with an estimate of costs and upon request.
- ✓ The front desk, with my assistance, will prepare an invoice with the appropriate diagnosis and procedure codes for your visit and services, which you can submit to your insurance provider.

Information and responsibilities for you as patient:

I as patient agree to:

- ✓ Know that my body is unique and may react in unique ways to treatment.
- ✓ Avoid blaming you for my health problems and symptoms during my treatment and know that we are a team working together to advise, coach, and improve me.
- ✓ Take charge of my attitude and work on improving it in regard to my physical, emotional, or financial health.
- ✓ Let you know if there are ways to communicate with me better.
- ✓ Tell you my goals and priorities for each visit as well as my long-term health goals (if appropriate).
- ✓ Give you feedback as to how things are going for me and how things could go better.
- ✓ Let you know if I have a side effect from anything.
- ✓ Do my "health homework" (exercises, diet, supplements, lab tests etc.) to the best of my abilities or not do something if I have side effects from it.
- ✓ Tell you at the time of my visit (or by phone or fax) if I do not agree with something or do not want a test, physical exam, medication or supplement.
- ✓ **Have another doctor on my team in case of an emergency if you are not reachable.**
- ✓ **Call the office if I am running late.**
- ✓ **Office policies hold for less than 48-hour notice on cancellations.**
- ✓ Take the responsibility for scheduling my appointments and for scheduling my health homework so as to make the changes successfully that I want.
- ✓ Know that I have the right to obtain the kind of healthcare that I need. If I choose to pay for healthcare outside of my insurance, that is my decision and option for my well being. As a patient I am aware that I have the right to invest in my healthcare needs even if my insurance does not or only partly reimburses me. Investing in my body now can have a big payoff in the future, actually saving me money in the long run.
- ✓

I have read the above and agree with it. I know I can make additions or changes in the section above.

Patient signature: _________________________________ Date: ________________ rev 4-27

HIPAA NOTICE OF PRIVACY PRACTICES

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this Notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the term of the Notice that is currently in effect

How we may use and disclose health information about you:

- For treatment
- For payment
- For health care operations
- For appointment reminders
- As required by law
- To avert a serious threat to health and safety
- As required by the Military of Veterans and Workers
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners, and funeral directors
- National Security and Intelligence activities
- Protective Services for the President and others
- Security Officials for Inmate
-

Your rights regarding health information about you:

- Right to inspect and copy
- Right to amend
- Right to an accounting of disclosures
- Right to request restrictions
- Right to request confidential communications
- Right to a paper copy of this notice

Complaints:

If you believe your privacy rights have been violates, you may file a complaint with us. All complaints must be in writing.

Acknowledgements of receipt of this Notice:

We will request that you sign on a separate form acknowledging you have received a copy of this notice. The acknowledgement will become a part of your records

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA),
I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *HIPAA Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *HIPAA Notice of Privacy* Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *HIPAA Notice of Privacy Practices*.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____

Relationship to Patient: ____

Signature: ____

Date: ___________________________

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:__________Initials:_______Reason:____

RECORDS RELEASE AUTHORIZATION

I hereby authorize:

WATER'S EDGE NATURAL MEDICINE
3131 ELLIOTT AVE, SUITE 740
SEATTLE, WA 98121
TEL: 206-283-1383 FAX: 206-283-1924

To release the following confidential medical information from the health record of:

Name: ____

Date of Birth: _________________

_____Copy of complete health record From: ______________ To:_______________

_____Lab results (specify)

_____X-Ray reports/film (specify)

_____Other (specify)

Information is to be released to (self or other):

Paper copies of medical records may be released upon receipt of written authorization of patients over the age of 18 or a legal guardian. Once authorization is received, it may take *up to 10 business days* to process your request.

There is a charge to obtain copies of medical records. If requested for private use by patients or guardians:

- No charge to the patient when records are sent via fax.
- No charges for page count if 10 pages or less.
- $0.20 per page for 10 pages and over plus shipping/handling.

If the records are needed for continuing care, there is no charge to the patient when records are sent (via fax) directly to your *physician* or the *facility providing treatment*. If records are needed for treatment or for an appointment within the next 48-72 hours, physicians can request records by fax when you arrive in his/her office for treatment.

This authorization is valid for 365 days from the date signed. I understand this consent can be revoked at any time to the extent that disclosure made in good faith has already occurred in reliance on this consent.

I also understand that my records are protected under the federal and state confidentially regulations and cannot be disclosed without my written consent otherwise provided for in the regulations.

Patient/Guardians Signature ___________________________________ **Date** ___________________

NOTE: Records containing information in relation to drug, alcohol, mental health and sexually transmitted diseases testing, diagnosis and treatment require a SPECIAL AUTHORIZATION.