

Sound Naturopathic Clinic

20270 Front Street, Suite 103

Poulsbo, WA 98370

(360) 598-6999 (Phone)

(360) 598-2104 (Fax)

Welcome to Sound Naturopathic Clinic!

Please complete the patient information forms prior to your NAET (allergy elimination) appointment. Bring them to your visit, which is scheduled for 30 minutes.

Special Instructions:

- We are a fragrance and chemical free environment. Please do not wear any perfume or use heavily scented soap prior to your visit with us.

Office Location:

Our office is located on the ground floor of the two story brown building on the corner of Bond Road and Front Street (suite103). When you are facing the building, the entrance is located on the LEFT side of the building.

Office Hours:

Monday - Thursday from 9:00 am - 6:00 pm and Friday from 9:00 am - 1:00 pm. We are closed for lunch from 1:00 pm – 2:00 pm.

If you have any questions please give us a call at (360) 598-6999. We look forward to meeting you.

In Health,

The Physicians and Staff at SNC

New Patient Intake

Patient Information

Date _____ Birth Date _____ Age _____ E-Mail _____

Name _____
Last Name First Name Middle Initial

Address _____ Hm Ph# _____ Cell _____

City _____ State _____ Zip _____

Sex M F Single Married Long Term Partner Divorced Widowed Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

How did you hear about us? _____

In case of emergency, who should we contact? _____ Phone _____

Spouse's name _____

Reason for Visit

Please state your present concerns in order of their significance _____

Health History

When was your last physical exam? _____ Physician's Name _____

Hospitalizations (year and reason) _____

Surgeries (year and type) _____

Serious illness or injury (year and cause) _____

Last immunization(year, type, adverse reaction)? _____

Medications

List medications you are currently taking _____

Health Habits

Alcohol Y N Tobacco Y N Caffeine Y N Soda Y N Filtered water Y N Sugar Y N

Meat Y N High fiber diet Y N Fast food Y N Dairy Y N Wheat Y N

Symptoms you experience now:

Nausea after eating Food regurgitates Fullness after meals No interest in food Pain/burning after meals

Exercise regularly? Y N What type? _____ Duration? _____ Days per week? _____

Do you sleep well? Y N Wake rested? Y N Average hrs of sleep _____

Allergies

Please list any allergies you may have to: Foods _____ Medications _____ Other _____

What happens when you have an allergic reaction? _____

Have you ever been tested for food allergies? __Y __N Method? _____

Elimination Assessment

Bowel Movements: _____ to _____ times per day. Do you use a stool softener, laxative or herbal laxative? __Y __N

Stools are: __ Soft, well formed __ Large, hard __ Large (2"x 6"L) __ Difficult to pass __ Medium (1"x4")

__ Diarrhea __ Loose, not watery __ Often float __ Thin, long, narrow __ Sink __ Alt between constipation and diarrhea

Stool Odor: __ Offensive usually __ Occasionally __ Little Odor Daily gas __Y __N Daily bloating __Y __N

Stool Color: __ Brown __ Yellow brown __ Dark or black __ Greasy __ Shiny __ Mucous __ Blood __ Greenish __ Varies

Have you ever had internal bleeding? __Y __N When? _____

Have you ever had rectal bleeding? __Y __N When? _____

Have you ever had a barium enema? __Y __N When? _____

Have you ever been diagnosed with cancer? __Y __N

If yes, have you had Chemotherapy? __ Present __ Past When? _____ Radiation? __ Present __ Past When? _____

Family Health History	Age	Present health good/poor	Cause of death	Age at death	Type of Cancer	Diabetes	Heart disease	Other
Father								
Mother								
Brothers								
Sisters								
Children								
Pat Gr. Mother								
Pat Gr. Father								
Mat Gr. Mother								
Mat Gr. Father								
Spouse								

Review of Systems **Y** = a condition you have now

P = a condition you have had in the past

GENERAL

- Chills
- Depression/Nervousness
- Dizziness/Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Poor sleep habits
- Loss of weight
- Sweats
- Numbness

GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive thirst
- Vomiting
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Itchy anus
- Vomiting blood
- Stomach pain

EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache/Ear discharge
- Ringing in ears
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Vision – Flashes/Halos
- Sinus problems
- Dry eyes

MEN Only

- Erection Difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other

WOMEN Only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Vaginal discharge
- Nipple discharge
- Hot flashes
- Painful intercourse
- Other

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- Arms
- Hips
- Back
- Legs
- Feet
- Neck
- Hands
- Shoulders

CARDIOVASCULAR

- Chest pain
- High/Low blood pressure
- Irregular/Rapid heart beat
- Poor circulation
- Swelling of ankles
- Varicose veins

SKIN

- Bruise easily
- Hives
- Itching/Rash
- Change in moles
- Scars
- Sores that won't heal

Date of last menstrual period _____

Date of last Pap _____

Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

- AIDS
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Cancer
- Cataracts
- Chemical Dependency

- Chicken pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Heart Disease
- Hepatitis
- Herpes
- High Cholesterol
- Gallstones

- HIV positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Mumps
- Multiple Sclerosis
- Pacemaker
- Pneumonia

- Polio
- Prostate Problem
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers
- Venereal Disease

Others: _____

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HIPPA NOTICE OF PRIVACY PRACTICES

Effective date: April 14, 2003

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 care and service you received from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice apply to all 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 in ways in which we may use and disclose health information about you. We also describe your rights to 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 indemnifies you is kept in private.
- Give you this notice of our legal duties and privacy practice with respect to health information about you.
- Follow the terms of Notices that is currently in effect.

How we may use and disclose health information about you:

- For treatment
- For payment
- For health care operation
- For appointment reminders
- As required by Law
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiner and funeral directors
- National Security and Intelligence activities
- Protective Service for the President and others
- Security officials for Inmates

Your rights regarding Health Information about you:

- Right to inspect and copy
- Right to Amend
- Right to an Accounting of Disclosure
- Right to request restriction
- Right to request Confidential Communications
- Right to a paper copy of this Notice (full Notice is available upon request)

Change to this Notice:

We reserve the right to change this Notice. We will post a copy of the current notice in our facility with the effective date on the first page.

Complaints:

If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint.

Acknowledge:

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

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NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGMENT

We keep a record of the health care service 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 contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

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.

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

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship
(Parent, legal guardian, personal representative)

This area for staff notes (if any):

This form will be retained in your medical record.

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**Informed Consent
for NAET Treatments (Allergy Elimination Technique)**

I, _____, acknowledge that I am accepting treatment from a Naturopathic doctor at Sound Naturopathic Clinic and understand and agree to the following conditions:

- There are intrinsic differences between the care of Naturopathic doctors and medical doctors. At this time it is my decision to pursue NAET treatment for allergies and that, as with any medical treatment, there is no guarantee that this treatment will offer complete resolution to my condition.
- The Doctor is only available for questions regarding NAET treatments and will not provide consultation or advice for any other medical conditions unless/until I complete a regular First Office appointment.
- NAET charges are not billable to my health insurance.
- Sound Naturopathic Clinic is not to be held responsible for any adverse reaction that I may experience.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship
(Parent, legal guardian, personal representative)

Physician/Witness

Date

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Patient's Waiver

I _____, understand that particular charges are not billable to my health insurance, including charges for:

1. Cancellation charge (\$45.00 - \$65.00 for less than 24 **business** hours notice)
2. Colon Hydrotherapy (colonic)
3. Eustachian Tube Adjustment
4. Hydrotherapy
5. Micro-current
6. N.A.E.T (allergy elimination treatment)
7. B.E.S.T (Balance/Manual Therapy)
8. Nasosympatico
9. Reiki
10. Telephone consultation
11. IV push – Myers' Cocktail
12. Therapeutic Injection (B-12, Mesotherapy, Neural therapy, Prolo therapy, etc)
13. Wet sheet wrap
14. Supplements

I understand that I am financially responsible for all charges (listed above) **at the time of service**. This does not include the payable amount by insurance, we strongly suggest that you call your insurance company prior to your office visit, not all policies cover naturopathic care i.e. Regence Federal and Regence Boeing.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship
(Parent, legal guardian, personal representative)

Witness/Physician

Date

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Client Fees

1. **First Office Visit** (90 minutes): \$210.00
Extended First Visit: \$245.00

2. **Return Office Visit** (30 minutes): \$85.00
Extended Return Visit: \$125.00

These fees are minimal charges for office visits. Visits that extend past their specified time will be charged for an extended office visit. There is an additional fee for various procedures that may be performed in this office such as therapeutic injections, PAP tests, and blood draws. Supplements are also an additional charge.

3. **Phone consultation:** Brief (1-15 minutes): \$55.00
Extended (16-30 minutes): \$85.00

This fee is NOT charged if the patient is calling for clarification of on-going therapy or if the doctor has asked the patient to call. Telephone consultations are available for established patients when an office visit may not be deemed necessary or possible. Phone consultations are not covered by insurance.

4. **Cancellation Charge and No Show Fee:** There is no charge if your appointment is canceled with a minimum of 24 business hours notice. If the office is notified with less than a 24-business hour notice, you will be charged \$45.00 - \$65.00. If we do not receive notice, the full service fees will be charged.

5. **Payment: Payment is required at the time of service.** We accept VISA, Master Card, American Express, cash and checks. There is a \$45 insufficient funds fee.

6. **Insurance:** We are an insurance provider for the following companies: Kitsap Physician Service (KPS), Regence Blue Shield, Premera, Lifewise, Aetna, Cigna, and First Choice Health Plan Network. For all other insurance companies we will provide documentation to make it possible for you to submit claims. Laboratory work originating from this office may be covered by your insurance. The laboratory handles all billing and will bill either you or your insurance company.

7. **These procedures are not covered by insurance and are separate cost:**

Colon Hydrotherapy (colonic with Hydrotherapist) \$85.00, Colon Hydrotherapy (colonic with Naturopath) \$95.00, Eustachian Tube Adjustment \$20.00, Hydrotherapy \$45.00, B.E.S.T (Balance/Manual Therapy) \$50.00, N.A.E.T (allergy elimination treatment) \$50.00, Reiki \$30.00, Therapeutic Injection (B-12) \$20.00, Mesotherapy \$40.00, Neural therapy \$40.00, R.I.T. \$150.00, Hado Scan \$140, Wet Sheet Wrap \$40.00, Phone Consultations \$55.00-\$85.00.

We are committed to providing economical, quality health care.
Thank you for your patronage.