Sound Naturopathic Clinic

20270 Front Street, Suite 103

Poulsbo, WA 98370

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 Light and Appreciation,

Ruth Urand ND
Dr. Sayre Limburg ND &
Staff at Sound Naturopathic Clinic

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								

Family Health History	Age	Present health good/poor	Cause of death	Age at death	Type of Cancer	Diabetes	Heart disease	Other
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.