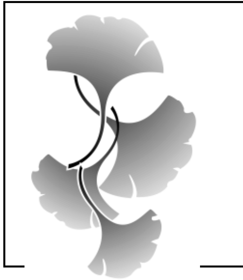

Sound Naturopathic Clinic
Ruth Urand, ND
20270 Front Street, Suite 103
Poulsbo, WA 98370
(360) 598-6999 (Phone)
(360) 598-2104 (Fax)

Welcome to Sound Naturopathic Clinic!

Please print and complete all (10 pages) of the following paperwork. Please allow 90 minutes
for your office call and checking in and out.

Special Instructions:

- Please bring any supplements or medications you are currently taking (the actual bottles).
- If you have had any lab work done in the last year please bring the results with you.
- We strongly suggest that you contact your insurance company prior to your visit, not all policies cover naturopathic care. Some policies list us as a provider, but the specific plan does not cover naturopathy.
- Please do not wear any perfume or use heavily scented soap prior to your visit with us. we are a fragrance and chemical free environment.

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. 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

Dr. Ruth Urand
And Sound Naturopathic Staff

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_

Insurance Information

(Please complete even if your insurance may not cover you)

Person Responsible for Account ____
Last Name First Name Initial

Relationship to patient___________________________Birth Date____________________Hm Ph#______________________

Address____

City____State_______________________Zip _______________________

Responsible Party Employed By____Business Phone _________________________

Business Address____Occupation _______________________________

Insurance Company ____

Subscriber ID#______________________________Group #____________________

INSURANCE ASSIGNMENT AND RELEASE
I certify that I have insurance coverage with____________________________________and assign directly to Dr. Urand all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my treatment plan is completed.

Signature____Date____

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 hours 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

MUSCLE/JOINT/BONE
Pain, weakness, or numbness in:
___Arms ___Hips
___Back ___Legs/Knees
___Feet ___Neck
___Hands Shoulders

GENITO-URINARY
___Blood in urine
___Frequent urination
___Lack of bladder control
___Painful urination

GASTROINTESTINAL
___Appetite poor
___Bloating
___Bowel changes
___Constipation
___Diarrhea
___Excessive thirst
___Vomiting
___Gas
___Hemorrhoids
___Indigestion
___Nausea
___Rectal bleeding
___Itchy anus
___Vomiting blood
___Stomach pain

CARDIOVASCULAR
___Chest pain
___High/Low blood pressure
___Irregular/Rapid heart beat
___Poor circulation
___Swelling of ankles
___Varicose veins

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

SKIN
___Bruise easily
___Hives
___Itching/Rash
___Change in moles
___Scars
_ Sores that won't heal

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

Date of last menstrual period____________
Date of last Pap Smear____________
Have you had a mammogram?_______
Are you pregnant?______

___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 applies 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 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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Informed Consent

I,______________________________________, acknowledge that I am accepting treatment from a naturopathic doctor at Sound Naturopathic Clinic. I understand that there are intrinsic differences between the care of naturopathic doctors and medical doctors. At this time it is my decision to pursue naturopathic treatment for any condition that I have. Also, I understand that, as with any medical treatment, there is no guarantee that this treatment will offer complete resolution to any or all conditions that I may have. Furthermore, I understand that 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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Authorization to Release of Confidential Medical Records

I hereby authorize :(From previous clinic or doctor)

Facility Name: ____

Address: ____

City/State/Zip: ____

Phone # ______________________ Fax #______________________

To release information from the health records of:

Name: ____

Date of Birth: ____

Dates of treatment: From: **2019** To: **Present**

Information to be released:

______ **Lab results: 2019 to Present Lab Work ONLY**

_______Other (specify) ____

Information is to be released to: **Ruth Urand, ND and/or**

Sound Naturopathic Clinic
20270 Front Street, Suite 103
Poulsbo, WA 98370

*Purpose of disclosure**: Continuation of care***

This authorization is valid for ninety (90) days from the date signed. I understand this consent can be revoked by me at any time, unless disclosure has already occurred in compliance with this consent. I also understand that my records are protected under state and federal regulations regarding confidentiality and cannot be released or discussed without my written consent unless otherwise provided for in the regulations.

Unless specifically excluded, this authorization includes release of *specially protected records* requiring specific written consent. This includes referral to, diagnosis of, and treatment for substance abuse, mental health conditions, and sexually transmitted diseases including HIV (CFR 42, part 2).
Certain records also require a ***minor's consent*** *. This applies to persons aged 13 to 18 for records pertaining to substance abuse and mental health records, or persons aged 14 to 18 for records pertaining to sexually transmitted diseases and HIV/AIDS. I specifically consent to the release and disclosure of this information.

* Minor/witness signature ____ Date: ______________

Patient/guardian signature ____ Date: ______________
(Fax or copy regarded as original.)

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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.

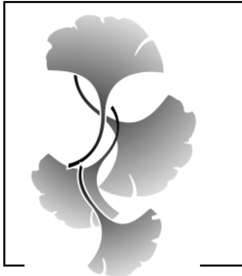
By my signature below I acknowledge receipt of the Notice of Privacy Practices.

______________________________ ______________________________
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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Patient's Waiver

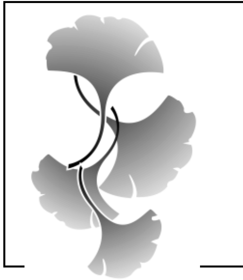
I _____________________________ , understand that particular charges are not billable to my health insurance, including charges for:

1. Cancellation charge (for less than 24 business hours notice)
2. Colon Hydrotherapy (colonic)
3. Eustachian Tube Adjustment
4. N.A.E.T (allergy elimination treatment)
5. Nasosympatico
6. IV push – Myers' Cocktail
7. Therapeutic Injection (B-12, Neural therapy, Prolo therapy, etc)
8. Supplements
9. Hip adjustment

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.

____________________________________ ________________
Patient or legally authorized individual signature Date

________________________________ _____________________
Printed name if signed on behalf of the patient Relationship to Individual



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Client Fees

1. **First Office Visit** (60 minutes): $255.00
2. **Return Office Visit** (15-30 minutes): $110.00 Extended Return Visit: $195.00

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): $85.00 Extended (16-30 minutes): $110.00 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 always covered by insurance.

4. **Cancellation Charge and No Show Fe**e: 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 $60.00. If we do not receive notice, the full service fee may 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 $60 insufficient funds fee.

6. **Insurance:** We are an insurance provider for the following companies: Regence, Blue Cross Blue Shield, Aetna, Premera, Kaiser (PPO Only) 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 $150.00, Eustachian Tube Adjustment $40.00,
N.A.E.T (allergy elimination treatment) $80.00, Therapeutic Injection (B-12) $40.00,
Neural therapy $85.00, R.I.T. (Prolotherapy) $210.00, PRP $325.00.

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