BAINBRIDGE Natural Health

PATIENT INFORMATION

Name _____
First Name Last Name Middle Initial

Address _____

City _____ **State** _____ **Zip** _____

Date of Birth_____/_____/_____ **Age**_____ **Email**_____

Preferred Phone Number_____ Cell Home Work Other

Alternate Phone Number_____ Cell Home Work Other

Sex: __M__ F **Relationship:**__Single __Married __Long Term Partner __Divorced __Widowed __Separated

Occupation _____ **Employer**_____

Emergency Contact_____**Phone**_____**Relationship**_____

How did you hear about us? _____

INSURANCE INFORMATION

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

Primary Insurance Company & Plan Name_____

Subscriber ID #_____ **Group/ Policy #**_____

Name of policy holder _____
Last Name First Name Middle Initial

Relationship to patient _____ **Date of Birth** _____/_____/_____ **Phone**_____

Policy holder employed by _____ **Business Phone** _____

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned, pledge that the above information is accurate and complete to the best of my knowledge. I understand that payment is due at the time of service for all visits unless prior arrangements have been made. I understand that if I am providing insurance billing information, I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize Bainbridge Natural Health, PLLC to release all information necessary to secure the payment of insurance benefits, and I authorize the use of this signature on all my insurance submissions.

_____
Signature of Patient Date

_____
Signature of Patient Representative or Guardian Relationship Date

9431 Coppertop Loop, #206 – Bainbridge Island, WA 98110 – Tel (206) 486-0381 – Fax (888) 965-5157
www.bainbridgentauralhealth.com

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INFORMED CONSENT

I, _____, acknowledge that I am accepting treatment from a naturopathic physician at Bainbridge Natural Health, PLLC. I understand that there are intrinsic differences between the care that naturopathic doctors and medical doctors provide. At this time, it is my decision to pursue naturopathic treatment for any condition that I have. I authorize the naturopathic physicians of Bainbridge Natural Health, PLLC to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

- Common diagnostic procedures: e.g. venipuncture, PAP smears.
- Minor office procedures: e.g. cleaning, suturing, and dressing a wound, ear lavage, skin scraping, nasosympatico.
- Medicinal use of nutrition: e.g. nutritional supplementation, intramuscular, intravenous vitamin injections.
- Botanical medicine: e.g. botanical substances may be prescribed as teas, tinctures, capsules, tablets, creams, plasters, or suppositories.
- Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.
- Lifestyle and hygiene counseling: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.
- Physical medicine: e.g. craniosacral therapy, bio-energetic synchronization technique, hot and cold therapy, stretching, manipulation, yoga.
- Psychological Counseling, Contraception, and Vaccination.

I recognize the potential risks and benefits of these procedures as described below:

• **Potential risks:** allergic reactions to prescribed herbs and supplements, side effects of natural medications or vaccinations, aggravation of pre-existing symptoms, discomfort, pain, infection, burns, nausea, light headedness, inconvenience of lifestyle changes, injury from injections, venipuncture, or procedures. Notify Bainbridge Natural Health, PLLC, if you experience any symptoms, which may be secondary to the above procedures.

• **Potential benefits:** restoration of health and the body's maximal functional capacity without the use of drugs or surgery, relief of pain, and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to pregnant women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

Bainbridge Natural Health is not an urgent care center and cannot be utilized as such. Our clinic will do our best to schedule acute patient visits when needed, but cannot guarantee an available appointment time. Bainbridge Natural Health, PLLC, is not open on weekends. Please utilize an urgent care center, when appropriate, for acute care needs.

With this knowledge, I voluntarily consent to the above procedures. I realize that no guarantees have been given to me by Bainbridge Natural Health, PLLC, or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself, or my representative, or unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of seven, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential.

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FINANCIAL AND CLINIC POLICIES

Visit Fees First Office Visit: $250.00 - $300.00
Return Visit: $100.00 - $200.00

The fees stated above are examples of typical rates and are based on time spent and the complexity of care given.

Payment
Payment for office visits, copays, supplements, and all procedures is due at time of service. We accept cash, checks, and all major credit cards. We can accept payment from your HSA. The fee for returned checks or notice of insufficient funds is $45.

Procedure Fees
There are additional fees for various procedures that may be performed in this office such as Therapeutic Injections, PAPs, Blood Draws, BioEnergetic Synchronization Technique, and CranioSacral Therapy.

Insurance
Bainbridge Natural Health is a preferred provider (in-network) with: Regence, Premera, and LifeWise. It is your responsibility to know what your insurance company will cover. For out-of-network coverage we will provide you with a receipt of payment (superbill) for you to submit to your insurance company for reimbursement.

Services not covered by or billable to insurance include: BioEnergetic Synchronization Technique ($60.00), CranioSacral Therapy ($120.00/ hour), B12 Injections ($20.00)

Cancellation Charge
We require 24 hours notice for canceled or rescheduled visits. There is no charge for visits canceled with 24 hours notice. Half the cost of the scheduled visit will be charged for cancellations with less than 24 hours notice. Full fee is charged if no notice is received.

Phone Consultations
Phone consultations are available for established patients. The minimum fee for a phone consult is $50.00. All phone consults lasting longer than 15 minutes will be charged at the regular visit rate. You will not be charged for a phone consult if your physician asked you to call, or if you have a question about on-going therapy.

Lab Work
Lab work originating from our office *may* be covered by your insurance company. The laboratory handles all billing and will bill you or your insurance company directly.

Return Policy
All pharmacy items must be paid for at the time of purchase. Credit on your account will be given for unopened items in perfect condition if returned within 30 days. No credit will be given for items returned after 30 days. Refunds cannot be made. Refrigerated products, compounded products, and homeopathic remedies cannot be returned.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL AND CLINIC POLICIES OF BAINBRIDGE NATURAL HEALTH, PLLC.

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name:_____

We keep a record of your health care services that we have provided. You may ask to see and/ or to 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 our office.

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

_____

Patient or legal authorized individual signature Date

_____

Signature of Patient Representative or Guardian Relationship Date

AUTHORIZATION FOR VERBAL RELEASE OF INFORMATION

In the course of your care at our clinic, another individual (example: spouse, children, etc) may request information regarding your treatment, test results, diagnosis, or other medically pertinent information. Unless we have your authorization we cannot release or discuss your healthcare with any other individual. You may authorize our office to leave a message or speak with another individual. Please review the options below and check any or all that apply. This release will be in effect until revoked by you, in writing.

___Release the information only to me
___I give permission to discuss my healthcare with _____
(name of spouse, child, partner, friend)

___I give permission to leave my healthcare information on my home answering machine
___I give permission to call me at work. Work # _____

_____

Signature of Patient Date

_____

Signature of Patient Representative or Guardian Relationship Date