

# *Northwest Natural Health Specialty Care Clinic*

## REGISTRATION

Thank you for choosing the Northwest Natural Health Specialty Care Clinic.

Prior to your first appointment we are required to collect certain information and make you aware of your healthcare rights. We have made this process as simple and straightforward as possible. There are 5 forms attached.

### **1. Patient Initial Intake Profile**

This 2 page form (pages 1 and 2) should be filled out completely front and back, signed and dated. This provides important health and legal information needed before your appointment.

### **2. Insurance Information**

Fill out this form as completely as possible. A copy of the front and back of your insurance card will also be helpful. We are happy to check your insurance coverage on your behalf but cannot guarantee the accuracy of their response. Be certain to sign and date this form as well.

### **3. Authorization to Release Healthcare Information**

We will review your records from your other doctors and also provide regular reports to them for coordination. In order to do this, we need your permission. If you have more than one doctor, kindly fill in a form for each. We may need all or part of your most recent general medical information. If you check all of the boxes we will request only what we need. You may check fewer boxes and we will proceed with the information you have allowed. Remember to sign and date at the bottom.

### **4. Notice of Privacy Practices – Acknowledgement**

This sheet informs you of your important privacy rights. We need a signed and dated copy.

### **5. Provider List**

We normally provide regular reports to your other providers as part of our service. Kindly fill out this form as completely as possible including fax and phone number for each physician and other provider who is active in your care. Always include your primary care provider as well even if that person is not active during your medical specialist treatments.

It is best if all of these forms are received at least 3 business days before your appointment. For last minute appointments contact our staff to make special arrangements. Feel free to add pages if more space is needed.

Forms can be mailed or faxed to our Home Office address below. If you are using fax, we request that you bring the originals to your appointment.

We appreciate the opportunity to participate in your care.

The doctors and staff at  
Northwest Natural Health Specialty Care clinic  
6135 Seaview Avenue NW Suite 300  
Seattle, WA 98107  
Phone: 206-784-9111 Fax: 206-784-7444

# Northwest Natural Health Specialty Care Clinic

Dan Labriola, ND\* Patrick Buft, ND\* Kathleen Pratt, ND\*

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## PATIENT PROFILE

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ SEX: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ FOR HOW LONG: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMPLOYER NAME AND ADDRESS: \_\_\_\_\_

PATIENT ID OR SOCIAL SECURITY #: \_\_\_\_\_ EDUCATION: \_\_\_\_\_

EMERGENCY CONTACT: (NAME, ADDRESS, PHONE, RELATIONSHIP) \_\_\_\_\_

PLEASE LIST YOUR HEALTH CONCERNS IN ORDER OF IMPORTANCE:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

**YOUR HEALTH HISTORY:** Please check each relevant item

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer	<input type="checkbox"/> Sexually transmitted disease	<input type="checkbox"/> Psychological
<input type="checkbox"/> Allergies	<input type="checkbox"/> Colitis/bowel disorders	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Skin problem
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Injury (serious)	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart disorders	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Tuberculosis

Other: \_\_\_\_\_

**HOSPITALIZATIONS:** Please list dates, type of illness, procedure/operation

**KNOWN ALLERGIES/SENSITIVITIES** to foods, chemicals, pollens, etc.

**CURRENT MEDICATIONS:** Please list all prescriptions and over the counter drugs:

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<b>Seattle</b> Home Office-Suite #300 6135 Seaview Ave. NW Seattle, WA 98107 PH: (206)784-9111 FX: (206)784-7444	<b>Swedish Arnold</b> 1 <sup>st</sup> floor 1221 Madison St., Seattle, WA 98122 PH: (206)386-3015 FX: (206)784-7444	<b>Swedish Providence</b> CBC #305 1600 Jefferson Medical Office Tower Seattle, WA 98122 PH: (206)320-2000 FX: (206)784-7444	<b>Highline Medical</b> Center 16251 Sylvester Rd. Burien, WA 98166 PH: (206)784-9111 FX: (206)784-7444	<b>Bellevue Clinic</b> #112 1603 116 <sup>th</sup> Ave. NE Bellevue, WA 98004 PH: (425) 454-8541 FX: (206) 784-7444	<b>North Star</b> Yakima Clinic 808 North 39 <sup>th</sup> Ave Yakima, WA 98902 PH:(509)575-5525 FX: (206)784-7444
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Current Supplements: Please list all vitamins, minerals, herbs, etc.

Diet

Number of meals per day \_\_\_\_ % meals you eat out? \_\_\_\_ Food excluded from your diet: \_\_\_\_\_

Food intake last 24 hours:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Foods most frequently eaten \_\_\_\_\_

Foods you crave \_\_\_\_\_

Foods that bother you \_\_\_\_\_

Alcohol consumption now or in the past? Amount, type, when: \_\_\_\_\_

Coffee consumption (amount and time of day): \_\_\_\_\_

Soft drink (amount and type): \_\_\_\_\_

Have you now or ever used tobacco products (amount, type and when): \_\_\_\_\_

Exercise (type and frequency): \_\_\_\_\_

Family History:

Please mark B(brother), S(sister), M(mother), F(father), GM(grandmother), GF(grandfather)

- |                 |                    |                          |                     |
|-----------------|--------------------|--------------------------|---------------------|
| ____ Alcoholism | ____ Cancer        | ____ Hemophilia          | ____ Skin disorders |
| ____ Allergies  | ____ Diabetes      | ____ High Blood Pressure | ____ Stroke         |
| ____ Anemia     | ____ Glaucoma      | ____ Hypoglycemia        | ____ Thyroid        |
| ____ Arthritis  | ____ Gout          | ____ Mental Illness      | ____ Tuberculosis   |
| ____ Asthma     | ____ Heart Disease | ____ Seizures, epilepsy  |                     |

Other: \_\_\_\_\_

Female Only: Regular Menstrual Cycles? \_\_\_\_ Length of cycle \_\_\_\_\_ Hysterectomy \_\_\_\_\_

Number of pregnancies \_\_\_\_ births \_\_\_\_ miscarriages \_\_\_\_ terminations \_\_\_\_ Age at first period \_\_\_\_\_

Breast lumps now or in the past \_\_\_\_ dates \_\_\_\_ Birth control pills now or in the past \_\_\_\_\_

**\*\*I authorize Northwest Natural Health Clinic to review my records and discuss my health and treatment with other care providers. I am responsible for providing timely information to the Clinic if my condition or treatment changes and for payment of billings. I understand that a service fee will be charged for invoices on which no payment has been received for 30 days and for appointments not kept without 24 hour notice.**

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

# Northwest Natural Health Specialty Care Clinic

## Billing & Insurance Information

**Patient or responsible party, if a minor:** \_\_\_ Self \_\_\_ Spouse/Partner \_\_\_ Child \_\_\_ Parent  
Name (if different from patient): \_\_\_\_\_  
Address (if different from patient): \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

### Primary Insurance

Patient Name as it **appears** on card: \_\_\_\_\_  
Member #: \_\_\_\_\_ Group#: \_\_\_\_\_ Co-pay \_\_\_\_\_  
(Please include alpha prefix, if applicable)  
Insurance Company: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Address: \_\_\_\_\_  
Subscriber name: \_\_\_\_\_ Subscriber Birth date: \_\_\_\_\_  
Relationship to insured: [self] [spouse] [child]  
Employer: \_\_\_\_\_

### Secondary Insurance

Patient Name as it **appears** on card: \_\_\_\_\_  
Member #: \_\_\_\_\_ Group#: \_\_\_\_\_ Co-pay \_\_\_\_\_  
(Please include alpha prefix, if applicable)  
Insurance Company: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Address: \_\_\_\_\_  
Subscriber name: \_\_\_\_\_ Subscriber Birth date: \_\_\_\_\_  
Relationship to insured: [self] [spouse] [child]  
Employer: \_\_\_\_\_

**\*\*\*Medicare, Medicare supplemental and Medicaid insurance benefits do not cover Naturopathic consultations. Please call Medicare or your secondary insurance if you have any questions.**

I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Northwest Natural Health Clinic.

Medical coverage is determined by the insurance company when the claim is received and processed. Claims may be rejected or paid at a different rate based on claim review, current coverage information and eligibility. Benefits quoted by your insurance company are not a guarantee of payment. Please be advised that services rendered may still be the patient's responsibility. In those situations, Northwest Natural Health Clinic will be more than willing to work with you. Please notify us of any changes with your insurance coverage, so that we may update our records and make sure that your coverage for our services has not changed. Please feel free to contact us at any time regarding your treatment or status of your account. In either case, please be assured that we will provide the highest quality of care. Thank you for your confidence in our services and for allowing us to serve you.

**Signature of responsible party:** \_\_\_\_\_ **Date:** \_\_\_\_\_



# *Northwest Natural Health Specialty Care Clinic*

## **AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

I hereby request and authorize the following release of information:

**PATIENT NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**INFORMATION TO BE RELEASED BY:**

**INFORMATION TO BE RELEASED TO:**

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax#: \_\_\_\_\_

Northwest Natural Health Clinic

6135 Seaview Ave. NW, Suite# 300

Seattle, WA 98107

PH (206) 784-9111 FX (206) 784-7444

**MOST RECENT GENERAL MEDICAL INFORMATION:**

CLINIC RECORDS \_\_\_\_\_

MEDICATION LIST \_\_\_\_\_

LAB REPORTS \_\_\_\_\_

RADIOLOGY REPORTS \_\_\_\_\_

CONSULTATIONS \_\_\_\_\_

EKG'S \_\_\_\_\_

HOSPITAL RECORDS \_\_\_\_\_

OTHER (PLEASE SPECIFY) \_\_\_\_\_

**My rights:**

Please exclude information regarding the diagnosis or treatment of HIV/AIDS, other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment.

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility of benefits) except if I receive healthcare when the sole purpose of the healthcare is to create health information for a third party.

I understand that: a) I must revoke my authorization in writing and may do so by completing and signing the Revocation of Authorization form, DM-3523, available at my clinic's business or medical records office; b) If I revoke my authorization, it will not affect any actions already taken by NW Natural Health Clinic based upon this authorization; and c) I may not be able to revoke this authorization if the purpose of it was to obtain insurance.

Once NW Natural Health Clinic has disclosed health information, the recipient may re-disclose it in some situations. Privacy laws may no longer protect the information. This prohibition does not extend to insurance companies.

Date: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

\*Relationship to patient legally responsible: \_\_\_\_\_

# *Northwest Natural Health Specialty Care Clinic*

Please fill out the following in full so that the doctors can notify your healthcare team as well as forward on going progress notes.

**Primary Care Physician:** \_\_\_\_\_

Nurse: \_\_\_\_\_

Address: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**Specialty Care Physician:** \_\_\_\_\_

Nurse: \_\_\_\_\_

Address: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**Specialty Care Physician:** \_\_\_\_\_

Nurse: \_\_\_\_\_

Address: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**Specialty Care Physician:** \_\_\_\_\_

Nurse: \_\_\_\_\_

Address: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

*Northwest Natural Health Specialty Care Clinic*

**Nutritional Supplements**

**Notice to Patients**

The label accuracy and microbial screening of the nutritional supplements you use can affect your response to treatment and safety. For this reason, we recommend specific products, brands and batch numbers.

The supplements we recommend are manufactured by a number of different companies and are available in some hospital pharmacies, from our Seattle (Ballard) home office and, in some cases, on the internet or from retail sources. You are free to purchase these from whomever you wish. If you would like to shop around, our staff will gladly provide the full product information for each item in your individual plan to be certain that you get the correct product. Some of our specialized products are low-microbial Safe & Sound™ brand, manufactured by Advanced Health Concepts LLC, a company founded and owned by Dr. Labriola.

For safety reasons, we can no longer accept or resell returns.

Feel free to contact our staff if you have any questions about this or any other Northwest Natural Health Specialty Care Clinic policy.

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Patient Signature

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Date