Northwest Natural Health®
A Specialty Care Clinic

Patient Registration

Note: Starred (*) information is required per Standard of Care

*Name_____ *DOB _____/_____/_____ ☐ M ☐ F

*Street Address_____ *Home Phone: _____

*City_____*State_____*ZIP_____ *Cell Phone: _____

*Email _____*Social Security_____ *Work Phone _____

*Employer _____ *Occupation _____

*Emergency contact _____ *Relationship _____

*Phone _____ *Email _____

How did you hear about us? _____

*PLEASE LIST YOUR HEALTH CONCERNS IN ORDER OF IMPORTANCE:

1. _____ 2_____ 3. _____4. _____

***History and other concerns (check all that apply):**

_____ ADD/ADHD
_____ Anemia
_____ Blood Clots
_____ Depression
_____ Glaucoma
_____ Heart Disease
_____ High Cholesterol
_____ Hypoglycemia
_____ STD
_____ Stroke
_____ Alcohol or Substance Abuse
_____ Arthritis
_____ Cancer
_____ Diabetes
_____ Gynecological Problems
_____ Hepatitis or Liver disease
_____ High Blood Pressure
_____ Indigestion /GERD/Nausea
_____ Seizures/Epilepsy
_____ Skin Condition / Rash
_____ Asthma
_____ Colitis or Bowel disorder
_____ Eating Disorder
_____Immune disease, HIV/AIDS
_____ Multiple Sclerosis (MS)
_____ Psychological / Mental Health
_____ Thyroid Disease
_____ Vertigo / Dizziness
_____ Other

***List any other medical condition(s):** _____

***Females Only:** Age at onset of menstruation: _____ Last menstrual cycle: _____ Number. of Live Births: _____

***List all medications.** Include prescriptions, OTC medicines, and all supplements. Use a separate sheet if needed

Name of Drug/Supplement	Dosage	Frequency	Started Month/Year	Prescribed By	Reason

***Surgeries, Hospitalizations or other treatments** (Use a separate sheet if needed) Procedure/month/year/reason

_____

Are you on a special diet? _____ **Allergies/Sensitivities** _____

Northwest Natural Health®
A Specialty Care Clinic

Patient Registration

Please list your current providers.

***Primary Care Physician** _____

*Facility or Clinic Name _____ *Address _____

*City _____ *State_____ *Zip code _____ *Phone _____ *Fax _____

***Specialty Care Physician** _____

*Facility or Clinic Name _____ *Address _____

*City _____ *State_____ *Zip code _____ *Phone _____ *Fax _____

***Specialty Care Physician** _____

*Facility or Clinic Name _____ *Address _____

*City _____ *State_____ *Zip code _____ *Phone _____ *Fax _____

***Specialty Care Physician** _____

*Facility or Clinic Name _____ *Address _____

*City _____ *State_____ *Zip code _____ *Phone _____ *Fax _____

Please list your insurance details or enter NONE

*Name of responsible party, if a minor: _____

*Relationship to patient: ☐ Self ☐ Spouse/Partner ☐ Child ☐ Parent ☐ Other _____

*Address (if different from patient): _____

*Home Phone: _____ *Work: _____ *Cell: _____ Employer _____

***Primary Insurance Company:** _____

*Patient name as it appears on ID card: _____ Relationship to patient: _____

*Member #: _____ *Group#:_____ *Phone # on card: _____

*Subscriber name: _____ *Subscriber Birth date: _____

***Secondary Insurance Company:** _____

*Patient name as it appears on ID card: _____ Relationship to patient: _____

*Member #: _____ *Group#:_____ *Phone # on card: _____

*Subscriber name_____ *Subscriber Birth date: _____

Northwest Natural Health®
A Specialty Care Clinic

Patient Registration

Nutritional supplements: Notice to Patients

Nutritional supplements have been found, by the U.S. Food and Druga Administration, to, in some cases, have safety, purity and quality problems.
The clinic no longer screens or sells supplements for patients, but we do recommend the Safe & Sound® brand which is screened for label accuracy, heavy metals, pesticides, bacteria, yeast, molds and parasites. The Safe & Sound brand was created and is owned by Dr. Labriola.
If you would like to shop around for a similar product to the one prescribed, the clinic will provide the Supplement Facts for the one recommended.
For safety reasons, we cannot accept or resell returned supplements.

Telehealth

Telehealth visits by phone or internet are available. By signing this Registration you confirm that you are physically located in the State of Washington at the time of the visit.
Alternatively, a consultation can be arrange where our clinic accomplishes the consultation with a local, licensed physician who can then assess and administer our recommendations.
I understand any costs for an extended distance consultation not covered by insurance is my responsibility and authorize Northwest Natural Health Specialty Care clinic to charge my credit or debit card at time of service.

Authorization for release and submission of protected health records.

I authorize Northwest Natural Health Specialty Care Clinic to receive my health records and also to provide our records to my other healthcare providers for the purpose of providing healthcare subject to the following limitations:

*All medical records except (check all that you wish to exclude):
☐ Substance abuse ☐ STD ☐ HIV/AIDS ☐ Mental health disorders ☐ Other _____

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I understand that I may revoke this authorization in writing. I understand that the revocation will not apply to information that has already been used or released in response to this authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and that the information may no longer be protected by privacy laws. Copy fees may apply.
If dated separately, this authorization will expire one year from that date**.**
I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Northwest Natural Health® Specialty Care Clinic to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of the practice.

I have also been informed of and/or given the right to review and secure a copy of our Notice of Privacy Practices, which contains a more complete description of the use and disclosures of my protected health information, and my rights under HIPPA. I understand that Northwest Natural Health® Clinic reserves the right to change the terms of this notice from time to time and that I may contact the clinic at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that Northwest Natural Health® Clinic is not required to agree to these request restrictions. However, if they do agree, Northwest Natural Health® Clinic is then bound to comply with this restriction.

Northwest Natural Health®
A Specialty Care Clinic

Patient Registration

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected. If I do not sign this consent, or later revoke it, Northwest Natural Health® Clinic may decline to provide treatment to me.

Financial Agreement
I acknowledge that payment is due at time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for payment of all charges. If applicable, I authorize the 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.

Late Cancellation/No Show Policy and Associated Fees:
I understand that my appointment time is reserved exclusively for me, that 24-hour notice is required for cancellation and that my credit or debit card will be charged for no-show or late cancellation as follows:

- First Office Visit: $295
- Extended Return Office Calls: $197
- Missed appointment with less than 48 hours' notice $170

**Please Note: Insurance will not cover missed appointment fees.*

Payments:
I understand that co-pays are due at time of service and that I am financially responsible for all charges that are not paid by insurance. Co-pays not collected at time of service will be charged to my Credit or Debit Card on file.
Interest at the current rate in use by the clinic will be charged to my Credit or Debit Card on file for balances more than 30 days old.

Extended distance consultations - Telephone and Telehealth
Telephone and telehealth consultations are utilized for patients who cannot appear in person. They are normally coordinated with the patient's local healthcare providers. Most insurance companies do not cover telephone consultations.

I certify that by signing this form I have read and understand the information above and authorize Northwest Natural Health Specialty Care Clinic to proceed with my care as provided herein.

_____ _____

*Signature of Patient, Parent, Guardian or Personal Representative *Relationship to Patient

_____ _____

*Please Print Name of Patient, Parent, Guardian or Personal Representative *Date

P.O. Box 99124, Seattle WA 98139
Phone: 206-784-9111 Fax: 206-784-7444

Revision D