



WHIDBEY ISLAND NATUROPATHIC

"Your partners in optimal health"

CLINIC POLICIES

Welcome to Whidbey Island Naturopathic (WIN Clinic). We will do our best to serve your healthcare needs, provide natural and safe treatments, and serve as a resource for natural health education. It is important to us that you read and understand our clinic policies. If you have questions about the policies, please be sure to ask. We encourage you to communicate any issues, complaints or special needs with us.

Payment. Payment is due at the time of service for office visits (non-insurance), copays and dispensary items. We accept cash, checks, Visa, and Mastercard. Payment plans are available upon request.

Prices. The following fees are for payment at time of service. Insurance billing prices differ, and you may notice the amounts billed to insurance are higher than those listed here, although the amounts we actually get paid are often lower.

15 minute consult	\$60	
30 minute consult	\$90	Generally, follow-up visits are 30 minutes
60 minute consult	\$140	Generally, first visits are 60 minutes
Blood draw fee	\$10 and up	

Insurance. It is your responsibility to make sure that your insurance policy covers the treatment you are receiving. It is helpful if you call your insurance company before your visit and get specific information regarding your policy coverage. You can find this information on your insurance's website.

If you are unable to do this, please ask us and we can help you make sense of your insurance. It is best to do this before your appointment to avoid unnecessary costs.

There are treatments we may do that aren't covered by insurance, in which case you will be responsible for payment. We will try to let you know before we perform any "uncovered services," but they vary from plan to plan and sometimes we are unaware that a specific plan won't pay, in which case it will be your responsibility.

I understand that I am financially responsible for all charges and agree to pay for services. If applicable, I authorize the provider to release to my insurance company any information necessary to process a claim. I authorize the insurance payment be made directly to the provider. Initials _____ Date _____

Supplements. We stock a moderately large dispensary in our office and will prescribe items that you can buy here. When you need refills, it's best if you call a few days ahead to make sure we've got your items in stock. Sometimes, due to vendor backorders or other circumstances, we will not be able to get the same item and will give you a similar product as a substitute.

If you need to pick items up when we are not in the office, we have a pick-up box outside of the clinic where we will leave items for you when appropriate.

Contacting us. We prefer to be contacted via our main phone at (360) 679-8946. We are in the office Monday through Thursday from 10-5 with a lunch break between 1-2 pm.

If you have an urgent need to reach us during office hours, after hours, or during days off (Friday through Sunday), call our emergency cell phone (360) 929-2550. As reception goes in and out, you may need to leave a message and we return your call asap.

Email is available at contact@whidbeynaturopathic.com. However, we are not able to access our email outside of the office, so it is often a matter of days until we are able to return emails. If you have any urgent matters, it is much better to call us.

Cancellation policy. We are a small clinic and do our own scheduling. We appreciate if you give us at least 3 days notice before canceling an appointment so we have sufficient time to fill that spot. Because we dedicate 30 minutes to 1 hour of our time for your appointment, if a time spot is empty as a result of your late cancellation, it hurts our business. For this reason, if you cancel your appointment with less than 24 hours notice, there is a \$50.00 charge for your empty time slot. The charge will only be waived in emergency situations.

I have read and understand that if I cancel within 24 hours of an appointment, I will be liable for a \$50.00 cancellation charge. Initials _____ Date _____

No Show Policy. If you make an appointment and don't call or show up for that appointment (barring emergency situations in which a call cannot be made) there is a charge of \$50.00. This is charged to you and not your insurance. We provide courtesy reminder calls about appointments the night before (Thursday evening for Monday appointments), but it is still your responsibility to keep track of your appointment times even if you do not receive a reminder call. We reserve the right to discontinue care to patients who do not keep their appointments.

I have read and understand the "No Show" policy and understand that if I fail to show up at my appointed schedule time, I will be charged \$50.00. Initials _____ Date _____

Confidentiality. You have the right to know how your privacy is being protected in accordance with the HIPAA Act of 1996. Your healthcare information is private and cannot be shared with anyone else without your signed consent. Your records are kept in your chart and secured in our clinic at all times. If charts are in the open, names are covered. Access to the clinic is limited to practitioners, employees, and supervised guests.

I have read and understand my right to privacy, as stated above, and agree to allow WIN Clinic to maintain my records confidentially in accordance with the law. Initials _____ Date _____

PATIENT SIGNATURE _____ DATE _____

NEW PATIENT INTAKE FORM

PATIENT INFORMATION

Name _____ Phone/s _____
Address _____ City _____ State _____ Zip _____
Date of Birth _____ Social Security Number _____ Age _____
Relationship Status: _____ Married/Partnered _____ Divorced/Separated _____ Single/Widowed
Live with: _____ Spouse _____ Partner _____ Relative/s _____ Friend/s _____ Parent/s _____ Kid/s _____ Pet/s
Emergency Contact _____ Phone _____
How did you hear about us? _____

EMPLOYMENT INFORMATION

Employer _____ Position _____
Address _____ Phone _____

INSURANCE INFORMATION

Insurance Company/Plan Name _____
ID Number/Claim Number _____ Group Number _____
Insurance Phone _____ Whose Policy is this: Self Spouse Third Party
(If not self, please list name & date of birth of policy holder) _____

It is your responsibility to familiarize yourself with your insurance policy. If you are unsure whether you have naturopathic coverage, please call your insurance company or check online to verify. It is important to know if you have a deductible, if you have preventative care, and which labs are covered by your insurance. Copays are due at the time of service. Whether or not you have insurance, if you pay for your visit at the time of service, you'll receive our time of service discount (rates are on the Clinic Policies form). Supplements are not covered by insurance.

_____ (initial) I understand that I am financially responsible for all charges and agree to pay for services not covered by insurance.

_____ (initial) I authorize the provider to release to my insurance company or companies, any and all information necessary to process any claim. I further authorize that payment/s be made directly to the provider.

PATIENT SIGNATURE _____ DATE _____

CONFIDENTIALITY

You have the right to confidentiality when receiving care from providers. We will not disclose medical information to anyone unless directed to do so in writing by you. If you would like us to leave messages regarding your health care on an answering machine or with another person, please list them below and indicate which voice mail or email we may leave messages on:

YOUR CURRENT HEALTH

What is your main reason for coming in today?

MEDICAL HISTORY

What kind of medical or health treatment have you received lately and from whom?

When was your last blood test or diagnostic test & what were the results?

Have you had any X-rays, CAT scans, Ultrasound, or MRI's done & what were the results?

What childhood illnesses have you had? _____

What adult illnesses have you had? _____

Previous surgeries and hospitalizations (include approximate dates): _____

Do you have any allergies to any drugs, herbs, foods, animals or other?

PATIENT SIGNATURE _____ DATE _____

CURRENT MEDICATIONS

Please list any other medications, vitamins, herbs or supplements you are taking:

FAMILY HISTORY OF HEALTH PROBLEMS (and age of death, if applicable)

Your Mother _____
Your Father _____
Your Siblings _____
Grandparents _____

PERSONAL HABITS

What do you enjoy most in your life? _____
What are your main interests or hobbies? _____
Do you regularly use alcoholic beverages, how much? _____
Do you smoke (how much & for how long)? _____
Do you use recreational drugs (which & how much)? _____
How often do you watch television? _____
Do you have a religious or spiritual practice? _____
Do you enjoy your work? _____ Do you take vacations? _____
Do your work or hobbies expose you to toxic chemicals, heavy metals, mold or second hand smoke?

STRESS

On a scale of 1-10 (10 being high), how do you rate your stress level? 0 1 2 3 4 5 6 7 8 9 10
What are the most significant stressors in your life or areas of disharmony?

PATIENT SIGNATURE _____ DATE _____

SLEEP

On a scale of 1-10 (10 being great), how do you rate your sleep? 0 1 2 3 4 5 6 7 8 9 10

Do you have problems falling or staying asleep (which)? _____

How many hours do you sleep at night? _____ Do you awaken refreshed? _____

ENERGY

On a scale of 1-10 (10 being great), how do you rate your energy? 0 1 2 3 4 5 6 7 8 9 10

Are your daily tasks affected by your being tired? _____

EXERCISE

What type, how much, & how often do you exercise? _____

DIET

Do you follow a special diet? _____ Do you eat at least 3 meals a day? _____

Are you satisfied with your diet? _____ How much water do you drink daily? _____

Please list the foods/amounts you've eaten in the past 24 hours:

Is this a typical daily food intake for you? _____

PATIENT SIGNATURE _____

DATE _____

HEALTH CONCERNS (Please circle items that are current or recent)

GENERAL: fever, night sweats, fatigue/tiredness, unusual weight gain or weight loss, appetite changes

SKIN: rash, infection, growths/bumps, hair or nail problems, itching, thinning/sensitive skin, acne, oily skin

HEAD: frequent headaches, migraines, head injury, light-headedness, hair loss/thinning

EYES: vision problems, eye pain, double vision, floaters/spots, eye redness/watery eyes, tearing problems

EARS: hearing loss, ringing, earache, dizziness, itchy ears, hearing aids

MUSCULOSKELETAL: joint pain/stiffness, injury, muscle cramps/spasms, weakness, osteoporosis

NOSE/SINUS: frequent colds, nose bleeds, sinus problems/discharge, hay fever/allergies, loss of smell, snoring

MOUTH/THROAT: frequent sore throat/hoarseness, sore tongue, mouth sores, dental problems, phlegm

NECK: swollen glands, pain, enlarged thyroid, trouble swallowing, neck pain

BLOOD: easy bruising/bleeding, anemia, excessive clotting, thin/brittle nails, paleness

RESPIRATORY: cough, sputum, wheezing, chest pain, shortness of breath

HEART: chest pain or discomfort, high blood pressure, heart murmur, palpitations, swelling, dizziness, history of heart attack or TIA/stroke, history of angina, rheumatic fever.

DIGESTION: heartburn, ulcer, abdominal pain, nausea, vomiting, blood/food/mucus in stools, black tarry stools, abdominal bloating, belching, excessive gas, bad breath, hemorrhoids, hepatitis, colon cancer, polyps, constipation, diarrhea, food allergies or sensitivities:

URINARY/MALE REPRODUCTION: pain with urination, urgency, frequency, dribbling, incontinence, bladder infections, cloudy/foul smelling urine, prostate inflammation, kidney stones, blood in urine, urinating at night, erectile difficulties, hernia, genital sores/discharge

CIRCULATORY: varicose veins, pain in legs, leg swelling, cold /discolored extremities, lymph node swelling/pain

MENTAL-EMOTIONAL: depression, sleep problems, mood swings, anxiety, irritability, tearfulness, insomnia, nervousness, tension, phobias, psychiatric disorder, suicidal thoughts/plan, alcohol/drug dependency

ENDOCRINE: thyroid problem, dry skin or hair, low temperature, hot flashes, diabetes, low blood sugar, high blood sugar, sugar cravings, swelling/edema, abnormal hair growth, difficulty perspiring, rapid aging, loss of muscle mass

FEMALE REPRODUCTION: heavy bleeding, pain, clots, PMS, PCOS, infertility, lack of bleeding, irregular cycles, discharge, odor, itching, sores, painful intercourse, breast pain/lumps, lack of sex drive, fibroids, ovarian cysts, vaginal dryness, hysterectomy (total or partial?), age of first period ____, age of last period ____, number of pregnancies ____, number of children (ages) _____

PATIENT SIGNATURE _____

DATE _____