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.

PATIENT/GUARDIAN SIGNATURE ________________________________ DATE ________________

If you need to pick items up when we are not in the office, w 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/GUARDIAN SIGNATURE _________________________________ DATE ________________

NEW PATIENT INTAKE FORM
For Children

PATIENT INFORMATION

Name ________________________________ Phone/s _____________________________________

Address _________________________________City _______________State ______Zip _________

Date of Birth _________________ Social Security Number _______________________ Age_______

Mother's Name ______________________Occupation _________________Phone _______________

Father's Name ______________________Occupation _________________Phone _______________

INSURANCE INFORMATION

Insurance Company/Plan Name ____

ID Number/Claim Number _______________________________ Group Number _________________

Insurance Phone ___________________ Whose Policy is this: Self Parent Guardian

(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.

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 child's health care with another person, please list them below:

____

PATIENT/GUARDIAN SIGNATURE _______________________________ DATE _______________

YOUR CHILD'S CURRENT HEALTH

What is your main reason for bringing in your child today?

____

____

____

____

MEDICAL HISTORY

What kind of medical or health treatment has your child received lately and from whom?

Previous surgeries and hospitalizations (include approximate dates):

____

____

Does your child have any allergies to any drugs, herbs, foods, animals or other?

____

CURRENT MEDICATIONS

Please list any other medications, vitamins, herbs or supplements your child is taking:

____

____

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

Mother ____

Father ____

Siblings ____

Grandparents ____

PERSONAL INFORMATION

Do anyone in the house smoke?________ Do you have pets? ______________________________

Does your child have siblings? If so, list name, age & sex

____

____

How often does your child watch television/computers? ____________________________

Does your family have a religious or spiritual practice? ____________________________

Do your work or hobbies expose your child to toxic chemicals, heavy metals, or mold?

____

Does eat a special diet? If yes, please describe

____

____

PATIENT/GUARDIAN SIGNATURE ______________________________ DATE _______________