REGISTRATION FORM

PATIENT INFORMATION			
Patient's last name:	**First:**	**Middle initial:**	Preferred name:
❑ Married ❑ Single ❑ Domestic Partner ❑ Widowed ❑ Separated ❑ Divorced ❑ Other			
Former name, if any:	Social Security number	Birth date: / /	Gender
Street address:			Home phone : ( )
City:	State:	Zip Code:	Cell phone: ( )
Email address:	Employer:		Work phone: ( )
I authorize Federal Way Naturopathy to leave voice mail messages concerning health information at the following numbers: ***❑ Home ❑ Cell ❑ Work***			
Other family members seen here:			

INSURANCE INFORMATION			
It is recommended that you contact your insurance company to verify coverage for naturopathic physicians and services. Your policy may not cover claims made by this office.			
Person responsible for bill:	Address (if different):		Phone: ( )
Is this person a patient here? ❑ Yes ❑ No	Relationship to patient:		Birth date:
Employer:	Employer address:		Work phone: ( )
Is this patient covered by insurance? ❑ Yes ❑ No		Referral needed from PCP?	
Name of primary insurance	ID number	Group number	Co-payment: $
Subscriber's name:		Subscriber's S.S#	Birth date:
Patient's relationship to subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other		
Name of Secondary Insurance (if any):	Subscriber's name:	Group #:	Policy #:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other		Subscriber's Birth Date	

The above information is true to the best of my knowledge. By my signature below, I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Federal Way Naturopathy or my insurance company to release any information required to process my claims. ________
Initial

By my signature below, I ____, acknowledge that I received a copy of the privacy practices for Federal Way Naturopathy. __________
initial

I hereby designate the following individual(s) to receive communications from Federal Way Naturopathy that may include health information about me:

____

____________________________________ ____________________
Signature of patient (or personal representative) ***Date***

If signed by personal representative:

*Name*____ *Relationship to patient*_________________________________

CONFIDENTIAL PATIENT HEALTH HISTORY

PERSONAL HISTORY

Name: Age: Date of Birth: Sex: ☐ Female ☐ Male

Number of Children: Ages: Profession:

Referred to this office by:

IN CASE OF EMERGENCY: Name of local friend or relative:

Relationship to patient: Home/Cell Phone: ( ) Work phone: ( )

CURRENT HEALTH PRIORITIES

PROBLEM/DURATION

1.

2.

3.

4.

5.

What, if any, treatments have you tried?

Has anything recently changed or become worse?

Are you currently being treated by a physician Yes No

Physician(s) Condition

MEDICATION AND SUPPLEMENTS

Please include all of your prescription medications, non-prescription medication (aspirin, antacids, laxatives, vitamins, minerals, herbs, etc.) If additional room is needed attach a list.

Medication/Supplement	Prescribing Doctor	Dose	Time using

ALLERGIES

Such as medication, supplements, pollens, foods, etc.

HOSPITALIZATIONS, SURGERIES OR SERIOUS INJURIES

Date and reason for each hospitalization.

Last Complete Physical Exam: Last Pap: Mammogram:

Last Bloodwork: Last visit to Doctor:

Most recent Antibiotic Use: Dental procedures:

SYSTEMS REVIEW

PERSONAL HEALTH HABITS

Height:_________________ Current Weight:_________________lbs 1 year Ago:_______________ Maximum Weight:________________

Smoker: □ Yes □ No Years Smoked:___________ Amount per day:_____________ Year Stopped:___________ Recreational Drug use?_____________

Alcohol Use: □ Yes □ No Type:__________________________ Frequency:________________________History of Abuse?_____________________

Water intake per day (in ounces) _____________ Coffee/lattes: ☐ Yes ☐ No Cups/day___________ Tea: ☐ Yes ☐ No Soft Drinks ☐ Yes ☐ No

Diet: *Any food groups you avoid?* □ Yes □ No Describe:____

List foods/drinks consumed in the last 24 hours:

Morning: ____

Afternoon: ____

Evening: ____

Regular exercise: □ Yes □ No Type:________________________ Duration:________________________ Frequency:_________________________

Average Hours of sleep per night:__________________ Do you wake during the night? □ Yes □ No If yes how often?____________________

MEDICAL HISTORY

Please √ check only conditions that pertain to YOU personally

Present	*Past*		*Present*	*Past*		*Present*	*Past*		*Present*	*Past*	
☐	☐	Weight Problems	☐	☐	Eye Discomfort	☐	☐	Cough	☐	☐	Painful Periods
☐	☐	Insomnia	☐	☐	Sinus Congestion	☐	☐	Chest Pain	☐	☐	Menopause
☐	☐	Fatigue	☐	☐	Colored Nasal Mucous	☐	☐	Asthma	☐	☐	Erectile Dysfunction
☐	☐	Diabetes	☐	☐	Nose Bleeds	☐	☐	Nausea and/or Vomiting	☐	☐	Fertility Problems
☐	☐	Fever	☐	☐	Sore Throat	☐	☐	Diarrhea	☐	☐	Miscarriage(s)
☐	☐	Sweats	☐	☐	Difficulty Swallowing	☐	☐	Constipation	☐	☐	Backache
☐	☐	Frequent Colds or Illness	☐	☐	Hoarse	☐	☐	Abdominal Pain	☐	☐	Arthritis
☐	☐	Eating Disorder	☐	☐	Snoring	☐	☐	Hepatitis	☐	☐	Muscle pain
☐	☐	Headache	☐	☐	Mercury Amalgams	☐	☐	Gallstones	☐	☐	Numbness/Tingling
☐	☐	Hair Loss	☐	☐	Dental Issues	☐	☐	Kidney Issues	☐	☐	Acne
☐	☐	Fainting	☐	☐	Thyroid Issues	☐	☐	Frequent Urination	☐	☐	Other Skin Problems
☐	☐	Head Injury	☐	☐	Shortness of Breath	☐	☐	Nighttime Urination	☐	☐	Depression
☐	☐	Hearing Loss	☐	☐	High Blood Pressure	☐	☐	Painful Urination	☐	☐	Anxiety
☐	☐	Ringing in Ears	☐	☐	Stroke	☐	☐	Incontinence	☐	☐	Suicidal Thoughts
☐	☐	Vision Changes	☐	☐	Raynaud's Syndrome	☐	☐	Anemia	☐	☐	Cancer
										if yes:	Type: ________________

FAMILY MEDICAL HISTORY

Please √ check any disease that a family member has had

RELATIVE	AGE	Living	Deceased	Arthritis	Asthma	Cancer	High Blood Pressure	Heart Disease or Stroke	Glaucoma	Gout	Epilepsy	Diabetes	Hypo-thyroidism	Kidney Disease	Stomach Ulcer	Neurological Disease	Obesity	Tuberculosis	Autoimmune Disease	Peridontal Disease	Other:
Father																					
Mother																					
Brothers																					
Sisters																					
Spouse																					
Children																					
Maternal Grandmother																					
Maternal Grandfather																					
Paternal Grandmother																					
Paternal Grandfather																					

Patient Name:

Federal Way Naturopathy's Financial Policy

Health insurance is a contract between the patient and their insurance carrier. The insurance policy lists a package of medical benefits such as treatment services, tests, office visits and therapies. The insurance company agrees to cover the cost of certain benefits listed in your policy. These are your covered services.

Keep in mind that a medical necessity is not the same as a medical benefit. A medical necessity is something that your doctor has decided is necessary. A medical benefit is something that your insurance plan has agreed to cover. In some cases, your doctor might decide that you need medical care that is not covered by your insurance policy. Insurance companies determine what tests, therapies and services they will cover. Your insurance company's choices may mean that the test, therapy or service you need isn't covered by your policy. When you have a test or treatment that isn't covered, your insurance company won't pay the bill. You can still obtain the treatment your doctor recommended, but you will have to pay for it yourself.

By understanding your insurance coverage, you can help your doctor recommend care that is covered in your plan. Federal Way Naturopathy will try to be familiar with your insurance coverage so we can provide you with covered care. However, there are so many different insurance plans that it's not possible for your doctor to know the specific details of each plan.

- Take the time to read your insurance policy. It's better to know what your insurance company will pay for before you receive a service, get tested or fill a prescription. Some kinds of care may have to be approved by your insurance company before your doctor can provide them.
- If you still have questions about your coverage, call your insurance company and ask a representative to explain it.
- Your insurance company, not your doctor, makes decisions about what will be paid and what will not.
- Your physician, not your insurance company, makes medical decisions and recommendations about what will benefit your health.
- Claims may not be resubmitted with different codes if they are denied coverage by your insurance company

Preventive office visits

Well-child exams, annual gynecological exams, and routine physicals are coded differently from standard office visits, and are based on the age of the patient and whether you are a new or established patient. Your preventive benefits only cover services provided in the absence of illness or complaints. Legally we are not permitted to resubmit claims with a new diagnosis or procedure code if the claim was accurately submitted as a non-preventive visit. If there are additional concerns brought up at a preventive office visits, there will be an additional brief medical office visit fee.

Billing:

If you receive a bill from us, it is because we believe the balance is your responsibility. Please contact your insurance company first, if you think there is a problem. If you have any questions about your bill, please call our billing department immediately. If you cannot pay your entire balance, please call to make payment arrangements.

Please note: Labs and other ancillary services – i.e. lab testing, medical imaging, etc. are not part of our practice. Please call the number(s) listed on those statements for assistance.

It is the policy of Federal Way Naturopathy to collect all payments or insurance information at the time services are rendered. For your convenience, we accept cash, check, Visa or MasterCard.
We will submit your insurance claims directly to any insurance your doctor is contracted with, provided the information we have obtained from you is accurate and complete, however the patient assumes responsibility for all unpaid balances, co-payments, and deductibles due, as well as any non-covered service by the insurance company, including cost of collection. It is the patient's responsibility to provide the most current insurance information to our office at the time services are rendered. A rebilling charge of **$5.00** will be added if claims need to be resubmitted to the correct insurance company.

It is your responsibility to know the limits and exclusions to your insurance coverage.

AUTOMOBILE ACCIDENT PATIENTS: We do treat automobile accident patients. However, we are unable to monitor long term accounts and we will not accept a letter of protection from an attorney as a guarantee of payment or third party insurance payments.
DISPENSARY: All dispensary products will be paid for at the time of pickup. If products are mailed, a Visa or MasterCard number will be required for billing. Shipping and handling charges of **$8.00** will be added to the bill.
SELF-PAY PATIENTS: If you have no insurance coverage for our services, we offer a **20%** discount on office visits and procedures. This discount is only valid if payment in full is made at the time of service.
NSF: All checks returned for non-sufficient funds will result in a **$25.00** service charge to be collected at the next visit, or within 30 days (whichever comes first).
UNPAID STATEMENTS: A **$5.00** rebilling fee will be charged each month on any outstanding balances. If no payment is received on an account after 90 days, the account will be sent to the collection agency.
PHONE VISITS: Phone visits are charged at a rate of **$15.00** for each 5 minutes and are not billable to insurance. The phone visit option is only for established patients.
REPORTS, FORMS & LETTERS: A fee of **$15.00** for the first page and **$5.00** p/ea. additional page will be charged for forms, reports and/or letter requests for military, work, personal or other reasons.
An itemized receipt is provided to the patient at each office visit or dispensary purchase. A patient contract is also provided at each visit and will serve as a letter of medical necessity for HSA & FSA accounts if needed. A fee of **$5.00 per receipt** will be charged when reprints are requested.
PAGER: A fee of **$50.00** will be charged for a non-emergent page to the physician.

A fee of $30 will be charged for cancellations made less than 24 hours from your scheduled appointment. A no show fee of $75 will be assessed for patients that fail to show up for a scheduled appointment.

By accepting this form:

- I understand and agree that my health insurance is an arrangement between my insurance carrier and myself; that all services furnished to me are charged directly to me and that I am personally responsible for payment of all services.
- I authorize treatment and agree to pay all charges. Charges shown on statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing.
- It is agreed that payment will not be delayed or withheld because of any insurance coverage or pendency of the claims thereon.
- I agree to pay for any missed appointments that were not canceled or rescheduled at least 24 hours in advance.

FWN firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or need clarification regarding these policies please call us at (253) 942-3301.

Signature____Date__________

Print Name____