FEDERAL WAY NATUROPATHY
Rooted in Your Well Being

PATIENT REGISTRATION FORM

Legal Name:_____ Birth Date: _____
Last First MI

Name I prefer to be called:_____ Former name, if any: _____

Gender:_____ Preferred pronouns:_____ Legal Gender: _____

Street address:_____ Home phone: _____

City:_____ State:_____ Zip Code:_____ Cell phone: _____

Email address:_____ Work phone: _____

I authorize Federal Way Naturopathy to leave voice mail messages concerning health information at the following numbers:
_____***Home***_____***Cell***_____***Work*** *(check all that apply)*

As a component of my care, I understand and agree that Federal Way Naturopathy may contact me using automated calls, emails and text messaging sent to my land-line and mobile device. These communications may notify me of scheduled appointments, preventive care, test results, treatment recommendations, outstanding balances or any other communications from Federal Way Naturopathy I may opt out at any time by calling Federal Way Naturopathy at (253) 942-3301 or by accessing my notification settings on my patient portal. By my signature, I authorize Federal Way Naturopathy to contact me by_____email_____phone____SMS text. *(check all that apply)*

_____
(patient or legal guardian signature)

GUARANTOR

Person responsible for bill: _____ Phone: _____

Relationship to patient:_____ Is this person a patient here? ____Yes_____ No Birth date: _____

Address (if different than above): _____

Other family members seen here:_____

IN CASE OF EMERGENCY

Name of local friend or relative: _____

Relationship to patient: _____ Home/Cell phone: _____ Work phone:_____

If patient is a minor:

Parent's relationship status: _____

Parent 1 name/relationship to minor: _____

Parent 2 name/relationship to minor:_____

Other parents/adults name/relationship to minor: _____

Is there a parenting plan or other legal documentation that dictates parental rights of the minor?_____

Please note that FWN will need a copy of any legal documents to properly enforce HIPAA laws. Please feel free to explain any circumstances FWN needs to be aware of for the minor's safety and protection of rights.

AUTHORIZATIONS

I_____give permission for Federal Way Naturopathy to give me medical treatment._____*(Initial)*

I understand I have the right to refuse any procedure or treatment. I understand I have the right to discuss all medical treatments with my clinician._____*(Initial)*

The above information is true to the best of my knowledge. 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)*

_____ ***Signature of patient (or personal representative)*** _____***Date***

If signed by personal representative:

Name:_____Relationship to patient_____

*Are you the parent of or legal guardian of the patient and legally authorized to make medical decisions?*_____Yes_____No

Federal Way Naturopathy
900 South 336th St, Federal Way, WA 98003
Phone (253) 942-3301 Fax(253) 237-0607 fwnmedical.com

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form will be retained in your medical record

By my signature below I,_____, acknowledge that I received a copy of the Notice of Privacy Practices for Federal Way Naturopathy.

The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy by visiting our website at fwnmedical.com or on request from our staff.

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 this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

*Are you the parent of or legal guardian of the patient and legally authorized to make medical decisions?*_____Yes____ No

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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. Your policy also lists the kinds of services that are not covered by your insurance company. These are your exclusions. You must pay for any uncovered medical care that you receive.

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. You may 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 bepaid and what will not.
- Your physician, not your insurance company, makes medical decisions and recommendations about what will benefit your health.

Some services, tests or therapies recommended by your provider may not be covered by your insurance 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. Claims may not be resubmitted with different codes if they have been denied for lack of coverage.

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.

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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.

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 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. Payment in full is due at the time of service. We are unable to extend a payment plan on our self-pay rates.
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 balance. 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 signing 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._____(Initial)
- 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._____(Initial)
- It is agreed that payment will not be delayed or withheld because of any insurance coverage or pendency of the claims thereon._____(Initial)
- I agree to pay for any missed appointments that were not canceled or rescheduled at least 24 hours in advance._____(Initial)

Federal Way Naturopathy 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 _____

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CONFIDENTIAL PATIENT HEALTH HISTORY

Name: _____ Date of Birth: _____ Age: _____

Preferred gender pronouns: _____ Gender: _____ Gender assigned at birth: _____

CURRENT HEALTH PRIORITIES

What goals do you have for your visit today? _____

PROBLEM/DURATION

1. _____
2. _____
3. _____
4. _____

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: _____

ALLERGIES:

Medications, Environment, Food: (include reactions / severity)

_____

_____

MEDICATION AND SUPPLEMENTS

Preferred Pharmacy: _____

Most recent Antibiotic Use: _____

Please include all 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

HOSPITALIZATIONS, SURGERIES OR SERIOUS INJURIES

Date and reason for each hospitalization:

Last Complete Physical Exam: _____ Last PAP: _____
Last mammogram: _____ Last Colonoscopy: _____
Last Bloodwork: _____ Any Abnormal results: _____
Dental procedures: _____ Last visit to doctor: _____

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CONFIDENTIAL PATIENT HEALTH HISTORY

Patient Name: _____

SOCIAL HISTORY

Occupation/Employment: _____

Relationship Status:

____Single___Married___Domestic Partnership/ Civil Union___Partnered____Involved with multiple partners

___Divorced/separated from spouse/partner____Other: _____

Sexual Orientation Identity:

___Heterosexual/straight___Bisexual___Gay___Lesbian___Queer___Not sure___Other: _____

Do you have any concerns related to your gender identity/expression or your sex of assignment?____Yes___No

Sexually active:____Yes___No If sexually active is it with___Men____Women____Both

In the past, have your sexual partners been____Men___Women___Both

Protected sex:____always___sometimes___never What safe sex methods do you use if any? _____

Do you need information about safer-sex techniques?____Yes___No If yes with:____Men____Women____Both

Are you currently experiencing any sexual problems? _____

Number of Children in Home:_____Ages:_____

___No children____My own children live with me/us____My spouse or partner's children live with me/us____Shared custody with ex-spouse or partner____Other:_____

Do you want to start a family?____Yes___No Are there any questions you have with respect to starting a family? _____

_____

PERSONAL HEALTH HABITS

Height: _____ Current weight:_____lb. 1 year ago:_____lb. Max Weight:_____lb.

Smoking status: Tobacco/ E Cig/ Vaping:___Yes___No Years smoked;_____Amount p/day:_____Year quit: _____

Recreational drug use? _____

Alcohol intake:___Yes___No Type:_____Frequency:_____History of Abuse?___Yes___No

Caffeine intake:___Yes___No Coffee/lattes:___Yes___No Cups/day_____Tea:_____Yes___No Soft Drinks___Yes___No

Water intake per day (in ounces): _____

Diet: Any food groups you AVOID? _____

List any foods/drink consumed in the last 24 hours:

Morning: _____

Afternoon: _____

Evening: _____

Regular exercise:____Yes___No

Type:_____Duration:_____Frequency:_____

Sleep: Average hours per night:_____Do you wake during the night?___Yes___No If yes, how often? _____

Digestion: What is the frequency of your bowel movements? _____

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CONFIDENTIAL PATIENT HEALTH HISTORY

Patient Name: _____

REVIEW OF SYSTEMS

Environmental:

Are you sensitive to smells?____Yes___No Is there mold in your home?___Yes___No

Ever lived near factories, incinerators, railroads, farms, golf courses or know hazardous dumps?___Yes____No

Known exposure to volatile chemicals, heavy metals, pesticides? ___Yes____No

Personal Medical History

Please ✓check only conditions that pertain to YOU personally

Current	Past		Current	Past		Current	Past		Current	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**
☐	☐	**Vision Changes**	☐	☐	**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**
☐	☐	**Frequent Colds or Illness**	☐	☐	**Raynaud's Syndrome**	☐	☐	**Anemia**	☐	☐	**Cancer***

**if yes: type*_____

Family Medical History

Please ✓check any disease a family member has had

RELATIVE AGE	Deceased	History Unknown	Arthritis	Asthma	Cancer	High Blood Pressure	Heart Disease /Stroke	Glaucoma	Gout	Epilepsy	Diabetes	Hypo-Thyroidism	Kidney disease	Stomach Ulcer	Neurological Disease	Obesity	Tuberculosis	Autoimmune Disease	Periodontal Disease	Other:
Father																				
Mother																				
Brothers																				
Sisters																				
Spouse																				
Children																				
Maternal Grandmother																				
Maternal Grandfather																				
Paternal Grandmother																				
Paternal Grandfather																				

Do you feel safe in your home?_____Yes_____No

Over the last two weeks how often have you experienced any of the following problems?

Little interest or pleasure in doing things:_____Not at all_____Several days____Half the time_____All of the time

Feeling down, depressed, or hopeless:_____Not at all_____Several days____Half the time_____All of the time