Sound Holistic Health
Your Integrated Natural Medicine Clinic

Patient Information

Last Name: _____ First Name:_____ Middle Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth:_____ Sex:_____ Other names that records may be kept under:_____

Email Address: _____

Home Ph: (_____) _____ -_____ Work Ph: (____) _____-_____ Cell Ph: (_____) _____-_____

May we leave confidential voice-mail messages for you at any of the above numbers? ____ No ____ Yes

Would you like to receive _____voicemail ____text or _____email appointment reminders?

Employer/School (if student): _____

Mother's Name (minors only): _____ Father's Name (minors only):_____

Emergency Contact: _____ Relationship to Emergency Contact: _____

Emergency Contact's Phone #: (____) _____-_____ ___Home ___Work ___Cell

Insurance: (<u>please provide front desk staff with your current insurance card so we have a copy on file</u>)

Primary insurance company**:** _____ Subscriber ID: _____

Subscriber's name (<u>if different than patient</u>): _____ **Subscriber's Date of Birth:** _____

Address: _____ City: _____ State: _____ Zip Code: _____

Current Marital Status (circle):

Single/never married, Married, Divorced, Separated/Divorced, Widowed, Domestic Partnership

How did you hear about us (circle):

Website, Workshop/ Event, Medical Referral, Friend/Family:_____, Insurance. Co.

Other: _____

Terms of Admission

Privacy Terms: We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so. Sound Holistic Health is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgment that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning that management of your healthcare information at our clinic, wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please call our office at (425)258-4633.

I hereby acknowledge that I have received a copy of Sound Holistic Health/Healthy Balance Natural Medicine's Notice of Privacy Practices. Should I refuse or fail to sign this form, I acknowledge that Healthy Balance Natural Medicine has made a good faith effort to obtain my acknowledgment.

_____ _____
Patient's Signature **Date**

_____ _____ _____
Guardian/Representative's Signature **Relationship to Patient** **Date**

2804 Grand Ave, Ste 300, Everett, WA 98201
Phone: 425.258.4633 Fax: 425.258.4644 www.shhclinic.com

Sound Holistic Health
Your Integrated Natural Medicine Clinic

Office Policies

At Sound Holistic Health we strive to maintain a positive provider-patient relationship. Outlining our policies allows for effective communication to ensure we meet that goal. Please read this carefully and do not hesitate to ask our staff any questions.

Cancellation and No Show Policy

If you are unable to keep your appointment, please call the clinic with at least 24 business hours notice before returning visits and 48 hours for first visits. This allows us time to offer the spot to another patient. A $30 fee may be charged for late cancellations and missed appointments. Exceptions can be made for extenuating circumstances and emergencies.

Fragrance Free/Low Scent Policy

Sound Holistic Health Clinic is a fragrance free environment as many people are sensitive to synthetic fragrances. Please refrain from wearing perfumes, colognes, or highly scented body products.

Insurance

It is your responsibility to understand your insurance, flexible spending, and health benefit plan(s). If benefits are denied, you are responsible for payment in full. Coverage and benefits disputes should be addressed to your insurance company as they determine your coverage, copayments, coinsurance, and deductibles. If our providers do not participate in your insurance plan, we may submit an out-of-network claim on your behalf. You may be responsible for the balance due depending on your out-of network coverage.

Financial Terms and Payment

All payments are due at the time of service, including copayments. You, or your guarantor, are responsible for all charges and services rendered whether covered by your insurance or not. Excessively overdue accounts may incur finance charges and will be forwarded to an outside collection agency. You will be responsible for any fees generated as a result of collection efforts. A guarantor, other than yourself, is not authorized to receive any of your medical information unless authorized by you in writing.

Labs

We strive to use the most accurate functional measures of health to best guide your health care decisions while working to keep the cost to the patient as low as possible. As such, we charge a $10 phlebotomy handling and convenience fee to cover the cost of offering optimal lab services to you at our clinic.

I have read and understand the aforementioned policies:

_____ _____
Patient's Signature Date

This section must be completed if someone other than the patient is financially responsible for the patient's account

Last Name: _____ First Name:_____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip Code: _____ Phone: (___)_____-_____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed above.

_____ _____
Guarantor's Signature Date

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Phone: 425.258.4633 Fax: 425.258.4644 www.shhclinic.com

Sound Holistic Health
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Insurance Coverage Checklist

Sound Holistic Health Clinic will bill several insurance companies as a service to you. However, all plans are different and subject to change. We are unable to verify your specific benefits. **Please check with your insurance company to determine if your specific plan and network provides coverage for our services and our providers**. We want you to understand your insurance benefits so that you know your financial responsibility and that your time here is spent on health and wellness.

Below is a list of questions to ask your insurance company so you may determine your out-of- pocket costs*:

Date: _____ Time: _____ Representative: _____

❒ Do I have covered benefits for:
❒ naturopathic medicine ❒ acupuncture

❒ Do I need a referral for this provider or these services? ❒ YES ❒ NO

❒ Do I need a pre-authorization or pre-notification for any of these services? ❒ YES ❒NO

❒ Is the provider I'm seeing in-network or out-of-network on my specific plan? (Providers may be listed as practicing at Sound Holistic Health or Healthy Balance Natural Medicine.) ❒ YES ❒ NO

Naturopathic Physician and Acupuncturist: Dr. Kevin Shaw ND, LAc - NPI Number: 1659570893

Naturopathic Physician: Dr. Leila Kuehner, ND - NPI Number: 1417401928

❒ Are my benefits grouped in with other benefits (acupuncture, chiropractic, physical therapy, massage, etc.)?

❒ What are my In-Network co-pay, annual deductible and/or coinsurance costs per member or family?

❒ Does my plan have Out of Network (OON) coverage? ❒ YES ❒ NO

If so, does my plan have a specific OON co-pay, annual deductible, or coinsurance per member or family? ❒ YES ❒ NO

❒ Is there a limit on the number of visits or maximum dollar amount per year for in or out of network benefits ? If yes, how many? _____

❒ Does my insurance, flex benefit program, and/or health savings account cover prescribed dietary supplements or medical foods? ❒ YES ❒ NO

*****This form is for your records only and does not guarantee payment by your insurance. Please let staff know if you have any changes to your insurance or billing on your account. *****

DATE _____

PATIENT PROFILE

Last Name:_____ First Name:_____ MI:____

Nickname:_____ Birth date:_____ Sex:_____

A note to our patients: *Please complete this questionnaire as thoroughly as possible in order to aid your clinicians in their diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except when you have provided us with written authorization to do so. Thank you.*

PRESENT HEALTH CONCERNS

Please list most important health concerns in their order of significance.	Details, painful or distressed areas:
1.	
2.	
3.	
4.	
5.	

What goals do you have for your visit at the clinic today?_____

_____

Have you ever consulted a: ❑Naturopathic physician, ❑Acupuncturist, ❑Nutritionist, ❑Counselor

Do you have any questions about our clinic or the care that you've chosen today?_____

_____

Please list prescription medications that you are currently taking, with dosages: ❑None

1._____ 2._____ 3._____

4._____ 5._____ 6._____

7._____ 8._____ 9._____

List vitamins, minerals, herbs, homeopathics that you are currently taking, with dosages: ❑None

1._____ 2._____ 3._____

4._____ 5._____ 6._____

7._____ 8._____ 9._____

Allergies: ❑None
Severe or life-threatening allergies:_____

Food, Environmental, Drug allergies:_____

Personal Habits:

Do you follow any particular diet regimens or restrictions? ❑Yes ❑No

Diet Details:_____

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Alcohol (# / week) _____ Coffee / tea (# / week) _____ Soda (# / week) _____

Tobacco (# / day) _____ Drugs (for non medical purposes, # / week) _____

Water (# / day) _____

Do you exercise regularly? ❑Yes ❑No

What type?_____

How long?_____How often?_____

Sleep (hours / night) _____ Bedtime:_____ Wake-up time:_____

# of Times Waking Up:_____

Past History:

Primary Care Physician:_____

Specialists:_____

_____

Hospitalizations & Dates:_____

_____

Serious Illnesses and Injuries & Dates:_____

_____

Date of last physical/annual exam_____ Date of last blood tests:_____

Social History:

Please circle those that apply: ❑Single ❑Married ❑Significant other

Do you have any children? ❑Yes ❑No Please list their age(s)_____

Occupation:_____

Hobbies:_____

Personal and Family History:

Family: M, F, B, S, MGM, MGF, PGM, PGF

Alcoholism/Drug Addiction	❑Self, current ❑Self, past ❑Family:_____	Headaches	❑Self, current ❑Self, past ❑Family:_____
Allergies	❑Self, current ❑Self, past ❑Family:_____	Heart Disease	❑Self, current ❑Self, past ❑Family:_____
Alzheimer's / Dementia	❑Self, current ❑Self, past ❑Family:_____	Hepatitis	❑Self, current ❑Self, past ❑Family:_____
Anemia	❑Self, current ❑Self, past ❑Family:_____	Herpes	❑Self, current ❑Self, past ❑Family:_____
Anxiety	❑Self, current ❑Self, past ❑Family:_____	High Blood Pressure	❑Self, current ❑Self, past ❑Family:_____
Arthritis	❑Self, current ❑Self, past ❑Family:_____	High Cholesterol	❑Self, current ❑Self, past ❑Family:_____
Asthma	❑Self, current ❑Self, past ❑Family:_____	Kidney Disease	❑Self, current ❑Self, past ❑Family:_____
Autoimmune	❑Self, current ❑Self, past ❑Family:_____	Lung Disease	❑Self, current ❑Self, past ❑Family:_____
Cancer	❑Self, current ❑Self, past ❑Family:_____	Mental Illness	❑Self, current ❑Self, past ❑Family:_____
Depression	❑Self, current ❑Self, past ❑Family:_____	Osteoporosis	❑Self, current ❑Self, past ❑Family:_____
Diabetes	❑Self, current ❑Self, past ❑Family:_____	Sexually transmitted infections	❑Self, current ❑Self, past ❑Family:_____
Eczema	❑Self, current ❑Self, past ❑Family:_____	Stroke	❑Self, current ❑Self, past ❑Family:_____
Epilepsy	❑Self, current ❑Self, past ❑Family:_____	Thyroid disease	❑Self, current ❑Self, past ❑Family:_____
Gout	❑Self, current ❑Self, past ❑Family:_____	Other	❑Self, current ❑Self, past ❑Family:_____

Issues with:	Details	Issues with:	Details
Weight		Lungs / breathing	
Sleep		Digestion / bowel movements	
Headaches		Urination	
Mood		Muscles / joints / bones / spine	
Eyes / vision		Skin / hair / nails	
Ears / hearing		Nerves	
Nose / smelling		Reproductive	
Mouth / Gums / Jaw		Sexual	
Heart		Other	
Circulation			

*Please indicate the top 3 issues that you have above.

NATUROPATHIC MEDICINE
INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize the private practitioners of Healthy Balance Natural Medicine, PLLC to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

General Diagnostic Procedures (including but not limited to venipuncture, pap smears, radiography, and blood and urine labwork, general physical exams, neurological and musculoskeletal assessments)
Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions
Herbs/Natural Medicines (prescribing of various therapeutic substance including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical cremes, pastes, plasters washes; suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.)
Dietary Advice and Therapeutic Nutrition (use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.)
Soft Tissue and Osseous Manipulation (use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy)
Electromagnetic and Thermal Therapies (includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and infrared and ultraviolet therapies or moxa—warming or indirect burning of an acupuncture point and hydrotherapies.)

Potential Risks: Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Kevin Shaw, N.D., L.Ac., L.M.T. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

_____ _____
Guardian/Personal Representative's Name (PRINT) Patient's Name (PRINT)

_____ _____
Guardian/Personal Representative's Signature Patient's Signature

_____ _____
Relationship/Representative's Authority Date

_____
Date

ACUPUNCTURE AND ORIENTAL MEDICINE
INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize the private practitioners of Healthy Balance Natural Medicine, PLLC to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Acupuncture: insertion of special sterilized needles through the skin into underlying tissues at specific points on the surface of the body.
Cupping: a technique to relieve symptoms in which cups made of glass or other materials are placed on the skin with a vacuum created by heat or other device.
Gua Sha: a rubbing on an area of the body with a blunt, round instrument.
Herbs: may be given in the form of pills, powders, tinctures, pastes, plasters, or other forms such as raw herbs to be cooked. Cooked herbs may be given to take internally or externally as a wash. Herbal formulas may include shell, mineral, and animal materials.
Moxa: indirect burning on an acupoint using stick, string, or ball moxa to relieve symptoms.
Tuina: an ancient massage used to treat a wide variety of common disharmonies.
Dietary Advice: based on traditional Chinese Medical Theory.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: discomfort, pain, infection, or blistering at the site of the procedure; temporary discoloration of the skin; nausea, loose bowel movements, abdominal cramping; and aggravation of symptoms existing prior to the acupuncture treatment.

Potential benefits: drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem and the strengthening of the constitution.

Notice to Pregnant Women: We do not use labor-stimulating acupuncture points unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment. All female patients must alert the intern or doctor if they know or suspect they are pregnant.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the Healthy Balance Natural Medicine or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or if it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last treatment. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

_____ _____
Date Signature of Patient

_____
Signature of Patient Representative or Guardian

Original to: Chart
Copy to: Patient (if requested)