Natural Healthcare Northwest
509 Olive Way, Suite 1315, Seattle, WA 98101
(206) 382-9977

PATIENT INFORMATION FORM

First Name: Middle Initial:

Last Name:

Address:

City/State/Zip:

E-mail Address:

Home Phone: Work Phone:

Cell Phone: Date of Birth: / /

Social Security Number: / /

Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Widowed ☐

Occupation:

Name of Company:

In Case of Emergency Contact:

Phone:

Relationship:

How Did You Hear About Us?

Referred by: Advertisement in:

Coupon in: Internet site:

(Over Please)

Please fill out the following information as accurately as possible. This information will help the doctor with diagnosis and treatment plans.

Please List Specific Health Concerns in Order of Importance to You:

1. _____

Date Began: ____ / ____ / ____

What makes it better? _____ Worse? _____

Have you seen other health care providers for this? Yes ☐ No ☐

If yes, what medications or treatments were given: _____

2. _____

Date Began: ____ / ____ / ____

What makes it better? _____ Worse? _____

Have you seen other health care providers for this? Yes ☐ No ☐

If yes, what medications or treatments were given: _____

3. _____

Date Began: ____ / ____ / ____

What makes it better? _____ Worse? _____

Have you seen other health care providers for this? Yes ☐ No ☐

If yes, what medications or treatments were given: _____

Do you have any opinions regarding what may have caused your health conditions?

Do you have any specific goals for your health?

Medical History

Allergies (Medications, Food, Environmental):

Please List Past Surgeries or Hospitalizations:

Surgery:	Date:
Name of Hospital:	Outcome:
Surgery:	Date:
Name of Hospital:	Outcome:
Other Hospitalization:	Date:
Treatment:	Outcome:
Other Hospitalization:	Date:
Treatment:	Outcome:
Injury:	Date:
Treatment:	Outcome:
Injury:	Date:
Treatment:	Outcome:

Please Indicate if You or a Relative Have Experienced Any of the Following:

☐ Alcoholism	☐ Hemophilia
☐ Allergies	☐ High Blood Pressure
☐ Anemia	☐ High Cholesterol
☐ Arthritis	☐ Mental Health Condition
☐ Asthma	☐ Migraines
☐ Auto immune Disorder	☐ Obesity
☐ Cancer	☐ Osteoporosis
☐ Depression	☐ Other Addiction
☐ Diabetes	☐ Psoriasis
☐ Eczema	☐ Seizures
☐ Glaucoma	☐ Sickle Cell Anemia
☐ Gonorrhea	☐ Skin Disorder
☐ Gout	☐ Stroke
☐ Hay fever	☐ Syphilis
☐ Heart Attack	☐ Suicide Attempt
☐ Heart Disease	☐ Thyroid Disorder

(Over Please)

Current Health Information

Please List Medications You Are Taking:

Med:	Dosage:	Times/Day:	Doctor:
Med:	Dosage:	Times/Day:	Doctor:
Med:	Dosage:	Times/Day:	Doctor:
Med:	Dosage:	Times/Day:	Doctor:
Med:	Dosage:	Times/Day:	Doctor:

Please List Supplements / Herbs You Are Taking:

Type:	Dosage:	Times/Day:	Doctor:
Reason for Taking:			
Type:	Dosage:	Times/Day:	Doctor:
Reason for Taking:			
Type:	Dosage:	Times/Day:	Doctor:
Reason for Taking:			
Type:	Dosage:	Times/Day:	Doctor:
Reason for Taking:			
Type:	Dosage:	Times/Day:	Doctor:
Reason for Taking:			

Please Indicate Any of the Following:

☐ Smoke How Long:	Number/Day:
☐ Alcohol Type:	How Often:
☐ Caffeine What Drink:	How Often:
☐ Sugar How Much:	How Often:
☐ Artificial Sweetener Type:	How Often:
☐ Exercise Type:	How Often:
☐ Food Cravings What:	How Often:
☐ Sleep Problems Type:	How Often:
☐ Weight Change Gain/Loss:	When:
☐ Diet Restrictions	What:

I hereby allow my health insurance company to reimburse Natural Healthcare Northwest directly for services rendered by this office. I understand and agree to pay, in a timely manner, any fees not covered or denied by my insurance company, including annual deductibles. Co-payments are due at time of service.

Signature:_____ Date:_____

Natural Healthcare Northwest

Notice of Privacy Practice Summary
(164.520)

This summary discloses how health information about you may be used. A full notice of your privacy rights is available upon request.

Natural Healthcare Northwest uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.

Natural Healthcare Northwest will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Natural Healthcare Northwest may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Natural Healthcare Northwest may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations. a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of you health records.

You may complain to the Privacy Officer Richard Sullens and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Natural Healthcare Northwest must maintain the privacy of protected health information, provide your with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions of complaints please contact Richard Sullens at 206-382-9977.

Signature of Patient or Personal Representative	Date Signed
Name of Patient or Personal Representative	Description of Personal Representative's Authority

509 Olive Way, Suite 1315 · Seattle, WA 98101 · 206.382.9977

Natural Healthcare Northwest

Consent for Purposes of Treatment, Payment and Health Care Operations (164.506)(a)(b)

I consent to the use or disclosure of my protected health information by Natural Healthcare Northwest for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Natural Healthcare Northwest.

I understand that diagnosis or treatment of me by Natural Healthcare Northwest may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Natural Healthcare Northwest is not required to agree to the restrictions that I may request. However, if Natural Healthcare Northwest agrees to a restriction that I request, the restriction is binding on Natural Healthcare Northwest.

I have the right to revoke this consent, in writing, at any time, except to the extent that Natural Healthcare Northwest has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Natural Healthcare Northwest Notice of Privacy Practices prior to signing this document.

The Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the [Health Care Provider].

The Notice of Privacy Practices for Natural Healthcare Northwest is also provided 509 Olive Way, Suite 1315 - WA - Seattle - 98101 and on the Natural Healthcare Northwest web-site.

This Notice of Privacy Practices also describes my rights and the duties of Natural Healthcare Northwest with respect to my protected health information.

Signature of Patient or Personal Representative

Date Signed

Name of Patient or Personal Representative

Description of Personal Representative's Authority

Natural Healthcare Northwest

Consent for Lab Results
Addendum to the Notice of Privacy Practice

Please read this consent form in its entirety before selecting which option best suits your needs for privacy. Without written consent we are obliged to follow the guidelines set by the HIPPA Notice of Privacy Practice.

I understand that by signing the HIPPA Notice of Privacy Practice (form 164.520) I have revoked consent to have voice mail or email messages left for me by the Doctor or other representative of Natural Healthcare Northwest. By reading and signing this consent form, I have amended that notice. I further understand that I have the right to change the specifications of this addendum or revoke consent as needed.

I hereby request Dr. Buxton and all other representatives of Natural Healthcare Northwest to handle my lab results and diagnostic imaging results in the following manner:

I.

☐ Please leave a message informing me of my laboratory or diagnostic imaging results, including doctor's interpretation and treatment suggestions on my voice mail at the following number:
_____

II.

☐ Please do not leave information about the following:
- ☐ Sexually transmitted diseases
- ☐ Mental health condition issues.
- ☐ Other (please specify:) _____

Please be aware, with certain lab results, such as an HIV test, the doctor must have you return to the office to receive your results in person.

Signature: _____ Date: _____

Print Name: _____

Relation to patient if other than patient: _____

Natural Healthcare Northwest Inc PS
509 Olive Way, Suite 1315
Seattle, WA 98101

SERVICE RATE SHEET as of March 1, 2009

First office visit		195.00
Return office visit 60 min		130.00
Return office visit 45 min		95.00
Return office visit 30 min		75.00
First office visit for Acupuncture		95.00
Return Acupuncture treatment		75.00
Phone consult each 15 min		37.50
Other Services each 15 min		37.50
Administrative services, forms, letters, etc.		10.00
Injection, therapeutic		20.00
Blood Draw		15.00

Forms of Payment:
Natural Healthcare Northwest accepts cash, check, Visa, MasterCard and AMEX as forms of payment. **Payments are expected at time of service**.

Insured Patients:
Patients with health insurance are required to **pay co-pays at time of service**. Any remainder or co-insurance payments will be billed to patients after insurance reimbursements have been received. Please note that **patients are responsible for any fees not covered or denied by their insurance company, including annual deductibles.**

Phone Consultations:
Consultations are available under special circumstances. **The fee for phone consultations is $37.50 for each 15 minutes**. This fee does not apply to consults to clarify current treatment plans or if the doctor initiates the call. We will make every effort to return phone calls within 24 hours. Due to unexpected emergencies, a return call may be delayed. If a return call has not been received within 24 hours, please call again.

Email:
The fee for email correspondence taking **less than 10 minutes is $15.00**. **Emails over ten minutes response time will be billed $37.50 for each 15 minutes.**

Cancellation Policy:
There is no charge for appointments cancelled 24 hours prior to the appointment time. **Patients who miss their appointments without 24 hours notice will be charged $50.00** missed appointment fee. Please note that **insurance companies do not reimburse for missed appointments**.

I have read and agree to the policies and fees set forth by Natural Healthcare Northwest. Any changes to policies and fees will be posted in the office.

Signature_____ Date_____

Print Name_____