Monroe Naturopathic Medical Clinic, Inc.

17801 W. Main St, Monroe, WA 98272
(360) 794-4539

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.
Date & Time of Initial Visit: _____

Name *(Last, First, M.I.):* ☐ M ☐ F		**DOB:**
Social Security Number:		
Address: Street		
City, Zip code		
Email address:		
Home Phone:	**Cell Phone:**	
Preferred method of contact: **home phone / cell phone / other:**		
Emergency Contact:	**Phone Number:**	
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:	**Date of last physical exam:**	
How did you hear about us: Referred by: Dr. Alice Harper Website/ Health Profs Phone book / Newspaper Ad / Brochure in community / Saw Signs / Insurance Website / Other		

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	
Date of Last Tetanus Shot:	
List any medical problems that other doctors have diagnosed and approximate date of diagnosis (Past Medical History)	

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name of the Drug	Dosage	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

FAMILY HEALTH HISTORY

Do any of your direct family members have the following conditions? Please check if yes and indicate their relation to you.

☐Cancer:	**If yes, what kind?**
☐Diabetes:	If yes, what kind?
☐Heart Disease:	☐High Blood Pressure:
☐Alcohol or Drug Abuse:	☐Stroke:
☐Thyroid Disorders:	☐Autoimmune Disorders
☐Anemia:	☐Mental Illness (Please specify):

Other:_____

_____

_____

MENTAL HEALTH		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No
MENS HEALTH		
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

Monroe Naturopathic Medical Clinic, Inc.

INSURANCE INFORMATION

_____I do not have insurance or my insurance will not cover Naturopathic services and I am paying cash. (Please skip to next page)

_____Please bill my insurance and I will pay the remaining balance and copay.

My copay is: $_____

My insurance will cover _____% of Naturopathic Services and I am responsible for the remaining.

I, _____, certify that all the information and insurance cards provided are correct to the best of my knowledge.

Signature: _____ Date: _____

Monroe Naturopathic Medical Clinic, Inc.

SIGNATURE PAGE

FINANCIAL POLICY

PATIENT AUTHORIZATION AND UNDERSTANDING
I have read and understand the financial policies of Monroe Naturopathic Medical Clinic, Inc.. I agree to abide by the terms of the financial policy. I request that payment of benefits be made to Monroe Naturopathic Medical Clinic, Inc., and hereby authorize the release of any information necessary to determine the liability of payment and obtain reimbursement on any claim. I further authorize the use of my signature below on all insurance submissions for services rendered or to be rendered. I agree that a photocopy of this agreement shall be as valid as the original. This authorization shall remain valid until revoked by me in writing and there has been a termination of services with Monroe Naturopathic Medical Clinic, Inc..

PATIENT'S PRINTED NAME: _____ DATE OF BIRTH: _____

Signature: _____ Date: _____

Name of person completing form if other than patient: _____

Relationship to patient: _____

CONSENT FOR 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 Monroe Naturopathic Medical Clinic, Inc.. 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 a 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 (see *Notice of Privacy Practices*) 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

HIPAA

I hereby certify that I have received the *Notice of Privacy Practices* for **Monroe Naturopathic Medical Clinic, Inc.**. I understand that if I have objections or concerns with this policy, I must notify **Monroe Naturopathic Medical Clinic, Inc.** per the instructions in the *Notice of Privacy Practices*.

_____
Name (printed)

_____
Signature

_____
Date

Monroe Naturopathic Medical Clinic, Inc.

Financial Policy

Thank you for choosing Monroe Naturopathic Medical Clinic, Inc., for your Naturopathic care. We know you have many choices in providers and we appreciate your business. We look forward to a relationship with mutual trust and an opportunity to help you obtain optimal health. As you know, payment for services is part of your care and part of our professional relationship. We have developed a financial policy to make these obligations clear from the beginning.

CASH PAYMENTS

Payment is due at time of service (cash, check, or credit card), and reflects a pay-at-time-of-service 20% discount off our regular rates.*

FEE SCHEDULE (paid at time of service)

60 minutes	$250	15 minutes	$105
45 minutes	$200	10 minutes	$80
30 minutes	$140	5 minutes	$60

These fees do not include lab fees or supplements. *There is an additional discount for seniors who have only Medicare coverage.

INSURANCE COVERAGE AND PAYMENTS

We will gladly bill your insurance if you have a PPO or out-of-network coverage. Medicare does not cover naturopathic services. *It is your responsibility to obtain and verify your insurance coverage prior to your scheduled appointment.*

If you have a copay, this will be due at the time of service. If your insurance covers only a portion, *it is your responsibility to pay the remaining balance that will be billed to you by the clinic. If you have a deductible, this will be billed to you after receiving notification of payment from your insurance company.* This will be clearly noted on your bill, and you are obligated to pay your deductible. According to your insurance plan, *you are responsible for any and all co-payments, deductibles, and coinsurances.* Nonpayment of balance due within 90 days will result in collection procedures.

In the event that your insurance coverage has changed, you will be responsible for the **full cost** of the office visit that is not covered by your insurance company. At that time, you may personally submit the bill to your insurance company for reimbursement.

PAST DUE ACCOUNTS

If we need to turn your account over to collection, you will be responsible for all costs and expenses of collection including, but not limited to our reasonable attorneys' fees.

TELEPHONE CONSULTATIONS

Telephone consults are not covered by insurance. Telephone consults can be scheduled and will be billed the same pay-at-time-of service fees as established office visits (see above). The fee will be waived if it is determined that an in-person office visit is required or if you are referred for emergency services. The fee will also be waived if it is a question limited to a current and documented treatment plan.

EMAIL CORRESPONDENCE

Due to liability and privacy policies, email consultations are not permitted.

MISSED OR LATE CANCELLED APPOINTMENTS

It is a professional courtesy to provide 24 hours notice if you cannot keep an appointment. *There will be a charge of $80 for all "no shows" or appointments cancelled less than 24 hours in advance.*

If you are late to an appointment, please understand that you have a scheduled time and this may result in your appointment being cut short to remain within the parameters of your scheduled appointment time. If you are more than 15 minutes late, we may need to reschedule your appointment.

RETURNED CHECKS

There will be a $40 fee for returned checks. Please note that you will still be responsible for charges and asked to pay with a different form (cash or money order).

Monroe Naturopathic Medical Clinic, Inc.

NOTICE OF PRIVACY PRACTICES

This Notice dscribes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on January 8, 2013, and will remain in effect until amended or replaced by us.
It is our right to change our privacy practices provided law permits the change. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.
You may request a copy of our Privacy Notice at any time by contacting your practitioner.

Monroe Naturopathic Medical Clinic, Inc.
Dr. Alice Harper, ND
17801 W. Main Street
Monroe, WA 98272
Phone: (360) 794-4539
Fax: (425) 740-0277
Email: dr_alice_harper@yahoo.com

SECTION 1: We use and disclose your protected health information to carry out your treatment, obtain payment, and conduct health care operations.

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

SECTION 2: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

Per your Authorization: If you give us authorization to use or disclose your protected health information, you may revoke such authorizations at any time, in writing, except to the extent that our clinic has already taken action in reliance on the use or disclosure permitted in the authorization.

To Others Involved in Your Healthcare: Unless you object, we may disclose your protected health information to a member of your family, a relative, a close friend or any other person you identify, to the extent the information directly relates to that person's involvement in your health care. For example, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care or your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

With Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances and the use or disclosure is done in accordance with other applicable laws.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose healthcare information to report problems with products, reactions to medications, products recalls, disease/infection exposure and to prevent and control disease, injury and/or disability. Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or any other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

SECTION 3: Specially-Protected Information
Special laws may restrict the use and disclosure of medical information related to mental health conditions, substance abuse, sexually transmitted diseases and HIV/AIDS. For example, we generally do not disclose specially protected information in response to a subpoena or other compulsory process unless: 1) you provide written authorization; or 2) a court orders the disclosure and mandates the necessary safeguards to protect the information after it is release.

SECTION 4: Your Rights

Access: Upon written request, you have the right to copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine or copy your health information, you will need to submit your request in writing at the address listed at the beginning of this Notice.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this *Notice of Privacy Practices.* It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding disclosures going back 6 years. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

The right to request that you receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you fro information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.

The right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

SECTION 5: Complaints, Comments, and Inquiries
If you believe your privacy rights have been violated, you may report the suspected violation to us by contacting our clinic at (360) 794-4539 or by contacting the Secretary of Health and Human Services. We will take no punitive action against you for filing a complaint.

This notice becomes effective on January 8, 2013.

MONROE NATUROPATHIC MEDICAL CLINIC, INC.

CONSENT FOR TREATMENT

I hereby authorize Monroe Naturopathic Medical Clinic, Inc., 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 lab work, 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 creams, pastes, plasters, washes, suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.)

Pharmaceutical Prescriptions (prescribing of various pharmaceutical drugs within the scope of practice for Naturopathic Physicians which includes all Legend Drugs and specific Schedule III, IIIN, 4, & 5 per the WAC.)

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, neuromuscular 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 therapeutic ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, 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.