ORIGINS
NATURAL HEALTH
& MIDWIFERY

PATIENT REGISTRATION FORM

Today's Date

PATIENT INFORMATION

Name: | Date of Birth: | Age:

Gender: ☐ M ☐ F | Marital Status:

Address: | Phone (hm):

City/State/Zip: | Phone (cell):

Email: | May we leave messages at these numbers? ☐ H ☐ C

Preferred method of communication: ☐ Email ☐ Home phone ☐ Cell phone

Emergency Contact: Phone:

Their relationship to you:

For Minors Only: Name of Mother: Name of Father:

HOW DID YOU HEAR ABOUT US?

☐ Family/Friend ☐ Insurance ☐ Physician Referral

☐ Internet: Specify ☐ Other:

BILLING FORMATION

Is patient covered by insurance? ☐ Yes ☐ No | If No, Name of Person Responsible for Bill:

Primary Insurance: | *Address and Phone Number of Responsible Party (if different from above)

(PLEASE GIVE YOUR CARD TO THE RECEPTIONIST)

Subscriber's Name Employer: Occupation: Date of Birth:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Subscriber #: Group #:

Secondary Insurance: Subscriber's Name Employer: Date of Birth:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Subscriber #: Group #:

☐ By checking this box, I am verifying that the above is true to the best of my knowledge.

Date: _____

119 Cedar Avenue | Snohomish, WA 98290
P: (360) 863-3223 | F: (888) 875-1198 | www.originsnaturalhealthandmidwifery.com

ORIGINS
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119 Cedar Ave, Snohomish, WA 98290 *Phone: 360-863-3223* *Fax: 888-875-1198*

Consent for Treatment

I, the undersigned, hereby authorize the physicians listed above to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

General Diagnostic Procedures, which may include but is not limited to venipuncture, PAP smears, radiography, and blood and urine lab work, general physical exams, neurological and musculoskeletal assessments.

Lifestyle Counseling and Hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, immunization, psychological counseling, and balancing of work and social activities.

Dietary Advice and Therapeutic Nutrition: use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.

Herbs/Medicines: prescribing various therapeutic substances including plants, minerals, animal materials, and some pharmaceuticals, and non-drug contraceptive devices. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical creams, pastes, plasters, washes, suppositories or other forms.

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.

Homeopathic Remedies: use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.

Minor office procedures: Dressing wounds, ear cleansing, care of superficial lacerations.

Electromagnetic and Thermal Therapies: The use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, infrared and ultraviolet therapies, and hydrotherapy.

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

Potential risks: Discomfort, pain, minor bruising, infection, blistering, loss of consciousness or deep tissue injury from, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements, soft tissue or bone injury from physical manipulations, temporary discoloration of the skin, temporary dizziness and lightheadedness, and aggravation of pre-existing symptoms.

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, 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.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me 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 or permitted by applicable 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 her ability.

_____	_____
Patient's Name (Print)	Guardian's Name (Print)
_____	_____
Patient's Signature	Guardian's Signature
_____	_____ _____
Date	Relationship to Patient Date

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Acknowledgement of Receipt:

Financial Policy

The following outlines our financial policy. Please review carefully and sign/date it.

- Payment is due at time of service, including copays. The provider may arrange this differently under certain circumstances. Acceptable forms of payment include cash, check, Visa, & MasterCard. Insurance is also accepted.
- Patients who pay out of pocket for their visit will ONLY be given a 20% discount if they pay at time of service.
- Incurred balances are due before your visit with the provider.
- Nutritional supplements must be paid for at the time of purchase, regardless of insurance.
- Please give us 24 hours' notice if you can't make your appointment. Failure to give 24 hours advance notice for appointment cancellations may result in a fee. Patients will now be billed

  $50.00 for appointments that are cancelled with less than 24 hours' notice. Special circumstances may waive this fee. The front desk will now remind patients of this policy when they call for appointment reminder.
- Repeat no-show appointments may result in dismissal from clinic care at the discretion of the providers.
- May be responsible for a $40 charge incurred by using the practitioner's pager, cell phone, or text service. We encourage all patients to call the front desk with immediate concerns during regular business hours.
- Patients are responsible for all bank charges and fees resulting from a returned check.
- Accounts more than 60 days overdue will incur financing charges of 0.75% per month on any outstanding balance.
- There may be an associated form fee at physician's discretion of $25. Forms include but aren't limited to letters of medical necessity.

Insurance: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance as a courtesy for which we are contracted providers, as long as you provide us with your current and correct information.

I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize my provider or my insurance company to release any information required to process my claims. I understand that payment is dependent on my eligibility at the time of service and ALL terms and conditions of my insurance plan. I also acknowledge that certain services may not be covered by my benefit plan, or deemed medically unnecessary, and agree to pay for any Non-Covered Service, such as phone or email consultations and outside labs. This authorization shall remain valid until revoked by me in writing.

Payment Issues: If financial problems arise, please contact our office ASAP. Installment or payment arrangements can be implemented. Balance will become due immediately if you break rules of the plan.

I have carefully read the Financial Policy. I understand and agree to the terms therein.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Print Patient Name Date of Birth

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Acknowledgement of Receipt:

Notice of Privacy Practices:

- I have been offered a copy of the Notice of Privacy Practices for the Practitioner that I am seeing. For future reference, I may access a copy at the front desk or on the website.

_____ _____
Signature of Patient or Responsible Party Date

Acknowledgement of Confidentiality:

- **Voicemail (please check one circle)**:

I hereby give permission for Origins Natural Health to leave the following on my voicemail:

- Detailed medical information
- Limited medical information (please specify with your provider)
- Billing and appointment information

_____ _____
Signature of Patient or Guardian Date

- **Email (please check one circle)**:

I hereby give permission for Origins Natural Health to leave the following on my email:

- Detailed medical information
- Limited medical information (please specify with your provider)
- Billing and appointment information

_____ _____
Signature of Patient or Guardian Date

_____ _____
Print Patient Name Date of Birth

ORIGINS
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PATIENT INFORMATION RE: CREDIT CARD ON FILE POLICY

At the time of registration, we will request your credit card information. Your credit card numbers will be encrypted and stored securely off-site. No credit card numbers will be stored at our practice. Once we receive your Explanation of Benefits (EOB) (what the insurance company will pay towards your visit), we will wait 30 days to allow you time to pay the balance on your account. If your balance is not paid, your credit card will be charged for the outstanding balance that is your responsibility. Co-pays must be paid at the time of visit. If you have any questions about this payment method, please do not hesitate to call us at 360-863-3223.

How does credit card on file benefit me?

Using credit card on file, you will be able to:

- Pay balances and co-pays conveniently
- Make payments automatically using your credit card of choice
- Avoid writing checks to pay bills by mail
- Receive notifications and receipts sent via email

Please note that all of your rights with respect to the use of your credit card will remain in effect. This new policy will in no way prevent you from being able to dispute a charge or question your insurance company's determination of payment.

Your credit card on file can be used for the following reasons:

-Visit payments not collected from you at the beginning of the visit
-No show or late cancellation charges
-Insurance discrepancies
-Outstanding balance greater than 31 days past due

Billing Address _____ City _____ State _____ Zip _____

Phone Number _____ Email _____

Patient Name _____ DOB _____ Patient Name _____ DOB _____

Patient Name _____ DOB _____ Patient Name _____ DOB _____

I authorize Origins Natural Health and Midwifery to charge the credit card above per the terms of this policy. This authorization shall remain in effect until ONHM has received written notification from me of its termination.

Signature _____ Date _____

The credit card number will be redacted prior to scanning this form into the Electronic Medical Record.

What is a deductible and how does it affect me?
An annual deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance coverage begins to pay. For example, if your policy has a $2,000 deductible, you must pay the first $2,000 of medical expenses before the health insurance company begins to pay for any services. This works just like the deductible for your car or homeowner's insurance policy.

When do I have to pay for services?
You, the patient, are ultimately responsible for all charges any time you receive medical care. You are expected to pay in full for your services until your deductible and any applicable co-insurance is met.

How will I know when my deductible has been met? How will I know how much you are going to charge me?
You can call your insurance company at any time to check on how much of your deductible has been met. Some insurance companies provide this information on-line. Every time you receive medical services, you will receive notification from your insurance company with how much they paid or did not pay when they send you an Explanation of Benefits (EOB). We look at your EOB carefully to determine the amount that is to be paid by you, the patient. That is called the Balance Due.

But I always pay my bills, why me?
We have to be fair and apply the policy to all of our patients. Keeping a credit card on file makes the check-out process easier, faster and more efficient and helps you to take care of the amount that you may owe.

What about identity theft and privacy?
Under HIPAA, we are under strict rules and guidelines in terms of protecting patient privacy, and the credit card is considered protected health information. Credit card numbers are encrypted and stored securely off-site. No credit card numbers are stored at our practice.

What if I don't have a credit card?
You are welcome to leave a HSA (Health Savings Account), Flex Plan, or Debit card on file or pay with cash or check for our standard visit cost. We understand there are legitimate reasons you may not have a credit card. In that case, we will work out a payment plan for you. Payment for service is due upon receipt of your billing statement after your insurance plan processes your claim. If your account remains unpaid, subsequent statements will be sent to the address we have on file. When your balance is 90 days past due, your account will be turned over to a collection agency and will be assessed a $50.00 release fee. You will be dismissed as a patient from our practice.

When will my card be charged?
We will submit your claim to your health insurance company if applicable. Once your insurance company processes your claim, you will have 30 days upon receipt of your billing statement to pay the amount due in any manner you wish. If you do not pay the amount due within 31 days, your credit card will be charged the Balance Due.

What if I have two insurance plans?
Even with two insurance plans, you may still owe a small balance that is your responsibility to pay.

How will I know that you have charged my credit card? How do I get a receipt?
You will receive an email receipt when your credit card is charged.

Is this the same as "signing a blank check"?
No. Credit card on file is similar to what a hotel or rental car company does at check-in. All credit card contracts give cardholders the right to challenge any charge against their accounts.

Is this "Balance Billing"?
No. "Balance Billing" is asking the patient to pay the difference between our fee and what is contracted with your insurance company. This is a breach of our contracts. The charge to your credit card is **only** the patient responsibility. For example, you see one of our providers at NW Asthma & Allergy Clinic and incur a charge fee of $200. We have a contract with your insurance company that states we will accept a payment of $100 for the visit. The insurance company agrees to only pay 80% of that amount. Your responsibility (as the patient) is the remaining $20 which will be charged to your credit card. We can not charge you the difference between the charged fee and the contracted fee.

What charges will my card be used for?
Your credit card will be used only when a balance becomes due.

What if my card is declined or expired?
We will contact you to update the information. If your account becomes delinquent, you will be sent to collections.

What if I want to change the credit card on file?
You can give us your new credit card number at any time.

What if I need to dispute my bill?
We will work with you to understand if there has been a mistake. We will refund your credit card if we or your health insurance company has made a billing error.

When do I give you my credit card?
We ask that you complete the Credit Card Authorization Form. This agreement will apply to all family members under your account. Once we have entered your credit card information into our financial institution's encrypted system, the credit card information will be destroyed. Our staff will only be able to see the last 4 digits. You can also deliver your credit card information over the phone or by mail.

What if I have more questions?
Our staff is happy to speak with you about your account at any time. Please call our **Office: 360-863-3223**.

HEALTH HISTORY QUESTIONNAIRE *For Men*

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: *(Last, First, M.I.)*	**Date**	**DOB**
PRIMARY CARE PHYSICIAN:	**Physician Phone #**:	
OTHER HEALTHCARE PRACTITIONERS: Include acupuncturist, chiropractor, massage therapist, medical doctor, nutritionist, osteopath, other specialists etc.:		
Name:	**Type of practice:**	**Phone number:**

Date of last physical exam:	**Date of last prostate exam:**	**Date of last fasting blood labs:**

Please list your current health concerns in order of their importance to you

Concern:	Date of onset:
1.	
2.	
3.	
4.	
5.	

Previous medical diagnoses

Diagnosis:	Diagnosed by:	Date of diagnosis:
1.		
2.		
3.		
4.		
5.		

Traumas, Car Accidents, Injuries:

Surgeries and Hospitalizations:

Year	Reason	Hospital

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

MEDICATIONS

PRESCRIPTION & OTC MEDICATIONS	SUPPLEMENTS
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

ALLERGIES

Drug Allergies	Reaction
1.	
2.	
3.	
Food Allergies	**Reaction**
1.	
2.	
3.	
Environmental Allergies	**Reaction**
1.	
2.	
3.	

CHILDHOOD MEDICAL HISTORY

Prenatal history: Any complications during your mother's pregnancy with you? ☐ Yes ☐ No
If so, describe:

Birth History: ☐ Vaginal ☐ Cesarean Section ☐ Forceps/Vacuum ☐ Other, describe:
Newborn problems: ☐ Jaundice ☐ Hospitalization ☐ Other, describe:

Childhood Illnesses: List Any Medical Problems **Y**ou Had As A Child:

How often did you get sick as a child? ☐ Often ☐ Not often
What kind of illnesses did you usually experience? (i.e. ear infections, sore throat, cough, allergies, asthma…)
How often did you take antibiotics? ☐ Often ☐ Not often
Other medications taken regularly as a child?

Home Environment as a child:

# of Siblings: Birth order: What adults lived with you?

Was your home safe? Did you have any traumas or losses as a child?

Did you grow up in the: ☐ City ☐ Suburbs ☐ Rural area Exposure to smoke or use drugs regularly? ☐ Yes ☐ No

SOCIAL AND LIFESTYLE FACTORS

HABITS	**Yes**	**No**	**Details**
Current tobacco use	☐	☐	Packs per day:
Past tobacco use	☐	☐	Packs per day: When did you quit?
Alcohol consumption	☐	☐	Per day? Per week? Types:

Are you concerned about the amount you drink? ☐ No ☐ Yes
Have you ever had a problem with drinking in the past? ☐ No ☐ Yes

Recreational drug use	☐	☐	Types:
Ever been treated for drug/alcohol abuse?	☐	☐	When?
Seat belt use	☐	☐	
Caffeine use	☐	☐	Cups per day? Types:
Regular exercise?	☐	☐	How much? What type?

SOCIAL	**Yes**	**No**	
Happy with your relationship?	☐	☐	Length?

What is your predominant emotion?

Do you feel well-supported socially?

Are you religious or spiritual? Explain:

Have you ever been emotionally or physically abused? ☐ Yes ☐ No
Do you have concerns about abuse/violence in your life right now? ☐ Yes ☐ No

HOME	**Yes**	**No**	
Is your home a sanctuary?	☐	☐	

Who lives with you?

Do you have any pets?	☐	☐	What type and how many?
Does your home have lead paint?	☐	☐	
Is your home moldy/damp?	☐	☐	
Is your home safe?	☐	☐	
Is their a gun in your home?	☐	☐	If yes, is it locked away or kept safe?

OCCUPATION	**Yes**	**No**	

Type of work?

How many hours per week? How many days per week?

Do you take vacations?	☐	☐	
Do you enjoy your work?	☐	☐	

STRESS

Stress level: ☐ Low ☐ Medium ☐ High
Stress source: ☐ Money ☐ Job ☐ Family/Relationship ☐ Other:
What do you do to relieve stress?

SLEEP	**Yes**	**No**	
Problems falling asleep?	☐	☐	
Problems staying asleep?	☐	☐	
Do you wake up refreshed?	☐	☐	

How many hours of sleep do you normally get per night?

SEXUAL AND REPRODUCTIVE HEALTH

All questions contained in this questionnaire are optional and will be kept strictly confidential.

SEXUAL HEALTH INFORMATION

Are you currently sexually active? ☐Yes ☐No With: ☐Men ☐Women ☐Both

Have you been sexually active with: ☐Men ☐Women ☐Both ☐Neither ☐Bisexual Men ☐Bisexual women ☐Prostitutes ☐IV drug users

Are you satisfied with your sex life? ☐Yes ☐No | Do you practice safer sex? ☐Yes ☐No

Do you have need for birth control? ☐Yes ☐ No | Number of sexual partners this year:

STDs: ☐ HIV ☐Herpes ☐ HPV/Warts ☐Gonorrhea ☐Chlamydia ☐Syphilis ☐Hepatitis

Have any of your partners become pregnant?

Number of children:

MALE HEALTH INFORMATION

Condition	Never	Past	Current	Notes
Difficult urination	☐	☐	☐	
Testicular pain/Swelling	☐	☐	☐	
Impotence/Sexual difficulties	☐	☐	☐	
Prostate problems	☐	☐	☐	
Other:	☐	☐	☐	

FAMILY HEALTH HISTORY

Are you adopted? ..... ☐ Yes ☐ No

Mother:	☐ Living ☐ Deceased	Cause:	Age:
Father:	☐ Living ☐ Deceased	Cause:	Age:
Siblings:	Number living:	Number deceased:	Causes/Ages:
Children	Number living:	Number deceased:	Causes/Ages:

Has any family member (or you) been diagnosed with:	**YES**	**NO**	**Who? At what age?**	**Details**
Asthma	☐	☐		
Emphysema	☐	☐		
Severe allergies	☐	☐		
Thyroid problems	☐	☐		
Stroke	☐	☐		
Heart disease	☐	☐		
Heart attack	☐	☐		
Blood clots in lungs or legs	☐	☐		
High blood pressure	☐	☐		
High cholesterol	☐	☐		
Ulcers	☐	☐		
Kidney disease	☐	☐		
Gallbladder disease	☐	☐		
Osteoporosis	☐	☐		
Liver disease	☐	☐		
Colitis/Crohn's/Celiac	☐	☐		
HIV/AIDs	☐	☐		
Anemia	☐	☐		
Blood disorder	☐	☐		
Diabetes	☐	☐		
Alcohol or drug problems	☐	☐		
Eating disorders	☐	☐		
Cancer	☐	☐		
Mental illness/depression	☐	☐		
Alzheimer's disease	☐	☐		
Other:	☐	☐		

REVIEW OF SYSTEMS			
(Please check if you have had problems with the following)			
Now	**Past**	**Condition**	**Notes**
		1. General	
		Weight loss/gain (circle)	
		Poor memory/Brain fog	
		Fatigue	Energy level (1 – 10)?
		Decreased libido	
		Too hot/cold (circle)	
		Excessive sweating/Night sweats	
		Frequent colds/flus	
		2. Skin	
		Dryness	
		Rashes/Itching/Eczema	
		Hair or nail changes	
		Easy bruising	
		Acne	
		3. Head/Neck	
		Headache/Migraines	
		Ringing in ears	
		Poor hearing	
		Earaches	
		Tooth/Gum problems	Number of mercury fillings?
		Hoarseness	
		Sore throat	
		Poor vision	When was your last eye exam?
		Light sensitivity	
		Blurred/Double vision	
		Dry eyes	
		Poor night vision	
		4. Lungs	
		Difficulty breathing	
		Persistent cough	
		Wheezing	
		5. Cardiovascular	
		Heart palpitations	
		Chest pain	
		Irregular heartbeat	
		Swelling in hands or feet	

Now	Past	Condition	Notes
		6. Gastrointestinal	
		Change in appetite	
		Nausea/Vomiting	
		Abdominal pain	
		Difficulty swallowing	
		Indigestion/Reflux	
		Gas/Bloating	
		Constipation	
		Diarrhea	
		Blood/Mucus in stool	
		7. Genitourinary	
		Pain with urination	
		Urgency/Frequency	
		Bladder incontinence	
		Excessive thirst	
		8. Musculoskeletal	
		Muscle pain	Where?
		Joint pain	Where?
		9. Neurological	
		Dizziness/Vertigo/Fainting	
		Problems with speech/coordination	
		Paralysis/Numbness	
		Tremors	
		10. Psychological	
		Depression	
		Anxiety	
		Mood changes	

AND LAST OF ALL

Is there anything else I should know?

Thank you for taking the time to fill out this questionnaire. I look forward to working with you.

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