natural FAMILY MEDICINE ™

Lori D. Brown *ND, MA*
Park Tower III
222 NE Park Plaza Dr, Suite 111
Vancouver, WA 98684

360.882.1339
360.253.8006 fax
naturalfamilymedicine.com

Dear New Patient,

Welcome to our Clinic! We look forward to providing for your health care needs and encourage your questions and participation in all aspects of your health care.

You are important to us. As such, we feel that it is essential that we share a clear understanding of our economic relationship so as to enhance and not interfere with our therapeutic relationship. We recognize and appreciate that health care can involve a major financial commitment and wish to keep you informed of our policies regarding your payment responsibilities.

To clarify the business aspect of our relationship, the following are our payment policies:

- Charges are to be paid at the time of your visit unless specific arrangements have been made prior to your office visit.
- Please be aware that you have the primary relationship with your insurance company and are responsible for the entire amount that is owed per your insurance plan.
- Please note that health counseling is an important part of your health care. Your face-to-face time with Dr. Brown will likely be longer than with providers at more allopathic clinics (i.e., standard medical care). This includes education regarding diet, lifestyle, exercises, treatment options, etc. As a result, extended visits may occur which may or may not be covered by your insurance. If you wish to limit your appointment complexity, please notify Dr. Brown prior to your appointment.
- *Because your appointment time is reserved only for you, we require a minimum of 48 hours notice for cancellations. Without such notice you will be charged $50.00 for your appointment time*, and your insurance company cannot be billed for missed appointments. *There are two possible ways to avoid a fee for missed appointments*:
    - If there is another opening within that week, you may substitute for that appointment time.
    - If there is another patient who is able to take your scheduled time, you will not be charged.
- Dr. Brown may prescribe supplements which may be purchased either at Natural Family Medicine or elsewhere. Most insurance companies do not cover the medicinary items that we prescribe. Payment for all medicinary items is due at the time of purchase. For your safety, all supplement sales are final. Pharmaceutical treatments will be prescribed at your preferred pharmacy. In addition, *please allow at least 2 business days for refills.*
- Dr. Brown may also recommend compounded prescriptions which are also typically NOT covered by insurance.
- Dr. Brown strives to be prompt with appointment times, however, sometimes urgent medical needs cause delays. Please note that you will get your full allotted appointment if she is running late. Please note, however, that *if you are more than 10 minutes late for your appointment or arrive without your intake forms completed, you may be asked to reschedule*. If we can get you rescheduled to another time during that week, your missed appointment fee will be waived as noted above.
- We accept VISA, MasterCard, Discover, check and cash. There will be a charge of $35.00 for every returned check(s). If immediate full payment will present major difficulties for you, please arrange a payment plan prior to your visit.

We also request your participation in maintaining a healthy environment for you and all our patients. Due to the chemical sensitivities of many of our patients, we respectfully request you to **please refrain from wearing any perfumed products** during your visit. This includes perfumes, aftershaves, and other perfumed personal hygiene products.

We look forward to the opportunity to serve your health care needs!

In Health,
Dr. Lori Brown and Staff
Natural Family Medicine

. . . . . .

My signature below indicates that I fully understand and agree to comply with the above letter.

Patient Name (please print) _____
Signature of Patient (parent or guardian if patient is a minor) _____
Date _____

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PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date _____ Patient Name _____
SSN _____ Gender: Male Female Other Birthdate _____ Home phone _____
Address _____ Cell phone _____
City _____ State _____ Zip _____
Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's or parent's employer _____ Work phone _____
Business address _____ City _____ State _____ Zip _____
Spouse or parent's name _____ Employer _____ Work phone _____
If patient is a student, name of school/college _____ City _____ State _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____
In case of a medical emergency, if the patient is of school age 15+, it is all right to treat in my absence:
Signature _____ Date _____

Responsible Party:
Name of person responsible for this account _____ Relationship to patient _____
Address _____ Home phone _____
Driver's license # _____ Birthdate _____ Financial institution _____
Employer _____ Work phone _____
Is this person currently a patient at our office? ☐ Yes ☐ No

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I have read and understand your Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization at any time to obtain a current copy of the Notice of Privacy Practices. I also understand that if I have any questions or complaints, I may contact the organization. I have the right to revoke this authorization in writing except to the extent that Natural Family Medicine of Cascade Park, PC, has acted in reliance upon this authorization. My written revocation must be submitted to Natural Family Medicine of Cascade Park, PC, 222 NE Park Plaza Drive, #111, Park Tower III, Vancouver, WA 98684.

CONSENT FOR MEDICAL TREATMENT

I am requesting and hereby authorize services offered to me by Natural Family Medicine of Cascade Park, PC, including physical examination, any tests and/or treatment deemed appropriate by my provider. As a patient, I am to be fully informed of benefits and possible complications, as well as alternatives to the proposed treatment, including no treatment. I understand that I am responsible for all fees regardless of insurance coverage and/or treatment outcome.

I confirm that I have read and fully understand all of the above prior to my signing. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

Patient Name (please print): _____ Date: _____
Signature of Patient (parent or guardian if patient is a minor) _____

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HEALTH HISTORY

PATIENT NAME: _____ **BIRTHDATE:** _____ **DATE:** _____

To help us meet your healthcare needs, please fill out BOTH SIDES of this form completely. This is a confidential record of your medical history.

Chief Complaint(s): Please list your primary reason for today's appointment: _____

Place of birth: _____
Occupation: _____
Previous occupation(s): _____
Marital status: _____
Exercise: _____
Alcohol (type and amount/day): _____
Caffeine (type and amount/day): _____
Water (amount/day): _____
Smoking (type and amount/day): _____
If former smoker, date quit: _____
Street drugs (type and amount/day): _____
Please list all allergies (foods, drugs, and environmental):
_____
_____
_____
Height: _____ Weight: _____
Date of last dental exam: _____
Date of last eye exam: _____

Date of last physical exam: _____
Date of last blood work: _____
Doctor: _____ Phone: _____
Please list all medicines you are currently taking: ☐ None
_____
_____
_____
Please list all supplements you are currently taking: ☐ None
_____
_____
_____
Please list all serious illnesses, operations, injuries, head injuries, fractures or broken bones, and other hospitalizations you have experienced. Include the year these occurred: ☐ None
_____
_____
_____
_____

Past Medical History: Have you ever had the following? Circle "no" or "yes". Leave blank if uncertain.

Measles	no	yes	Epilepsy	no	yes	Hives	no	yes
Mumps	no	yes	Migraines	no	yes	Eczema	no	yes
Chickenpox	no	yes	Tuberculosis	no	yes	AIDS or HIV +	no	yes
Whooping cough	no	yes	Diabetes	no	yes	Infectious Mono	no	yes
Scarlet fever	no	yes	Cancer	no	yes	Bronchitis	no	yes
Diphtheria	no	yes	Polio	no	yes	Stroke	no	yes
Smallpox	no	yes	Glaucoma	no	yes	Hepatitis	no	yes
Pneumonia	no	yes	Hernia	no	yes	Ulcer	no	yes
Rheumatic fever	no	yes	Blood/Plasma transfusions	no	yes	Kidney disease	no	yes
Heart disease	no	yes	Back trouble	no	yes	Thyroid disease	no	yes
Arthritis	no	yes	High blood pressure	no	yes	Bleeding tendency	no	yes
Venereal disease	no	yes	Low blood pressure	no	yes	Any other disease	no	yes
Anemia	no	yes	Hemorrhoids	no	yes	Please list: _____		
Bladder infections	no	yes	Asthma	no	yes	_____		

Vaccine History: _____
_____

Family History: Has any blood relative had any of the following? Circle "no" or "yes". Leave blank if uncertain.

Cancer	no	yes	Epilepsy	no	yes	Obesity	no	yes
Type: _____			Allergies	no	yes	Low thyroid function	no	yes
Leukemia	no	yes	Anemia	no	yes	High thyroid function	no	yes
Tuberculosis	no	yes	Bleeding tendency	no	yes	Ulcer	no	yes
Diabetes	no	yes	Asthma	no	yes	High cholesterol	no	yes
Heart disease	no	yes	Depression	no	yes	Kidney disease	no	yes
High blood pressure	no	yes	Alzheimer's	no	yes	Glaucoma	no	yes
Stroke	no	yes	Migraines	no	yes	Gout	no	yes

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Family History (continued):

Present age or age of death: If living, health (good, fair, poor). If deceased, cause of death:

Father: _____

Mother: _____

Siblings: _____

_____

_____

Spouse: _____

Children: _____

_____

_____

In the past one year or do you now have: PLEASE circle "no" or "yes". (Any question left blank will be assumed to be a negative response)

Unexplained weight change	no	yes
Appetite change	no	yes
Fatigue	no	yes
Weakness	no	yes
Persistent fever	no	yes
Cold sensitivity	no	yes
Heat sensitivity	no	yes
Night sweats	no	yes
Hot flashes	no	yes
Recent trauma	no	yes
Recent infection	no	yes
Headaches	no	yes
Blurred vision	no	yes
Double vision	no	yes
Eye pain	no	yes
Do you wear glasses or contacts?	no	yes
Ear pain	no	yes
Hearing changes	no	yes
Ringing in ears	no	yes
Ear discharge	no	yes
Frequent nosebleeds	no	yes
Frequent colds	no	yes
Sore throat	no	yes
Sinus trouble	no	yes
Loss of smell	no	yes
Persistent hoarseness	no	yes
Difficulty swallowing	no	yes
Sore tongue	no	yes
Sore gums	no	yes
Face pain	no	yes
Lump or discharge from breast	no	yes
Shortness of breath	no	yes
Wheezing	no	yes
Difficulty breathing	no	yes
Bloody sputum	no	yes
Chronic cough	no	yes
Do you sleep propped up	no	yes

Chest pain	no	yes
Palpitations/Heart fluttering	no	yes
Heart murmur	no	yes
Enlarged veins	no	yes
Purple fingers or toes	no	yes
Swelling of hands, feet, or ankles	no	yes
Stomach pain	no	yes
Heartburn	no	yes
Frequent belching	no	yes
Nausea	no	yes
Vomiting	no	yes
Vomited or coughed up blood	no	yes
Chronic diarrhea	no	yes
Chronic constipation	no	yes
How often do you have a BM? _____		
Rectal bleeding	no	yes
Blood in stool	no	yes
Mucus in stool	no	yes
Undigested food in stool	no	yes
Dark urine	no	yes
Frequent urination	no	yes
Increased thirst	no	yes
Painful urination	no	yes
Blood in urine	no	yes
Difficulty starting urine flow	no	yes
Urination during night	no	yes
Leakage of urine	no	yes
Backaches	no	yes
Leg cramps	no	yes
Muscle cramps	no	yes
Joint pain or stiffness	no	yes
Swollen joints	no	yes
Skin rash	no	yes
Hair changes	no	yes
Nail changes	no	yes
Easy bleeding	no	yes
Easy bruising	no	yes

Itchiness	no	yes
Yellow jaundice	no	yes
Seizures	no	yes
Memory loss	no	yes
Paralysis	no	yes
Clumsiness	no	yes
Dizziness	no	yes
Fainting	no	yes
Numbness/tingling	no	yes
Depression	no	yes
Anxiety	no	yes
Difficult sleeping	no	yes

Men only:

Discharge from penis	no	yes
Pain in testicles	no	yes
Lump in testicles	no	yes
Impotence	no	yes

Women only:

Age period began: _____

Days periods bleed: _____

Days between periods: _____

Date of last period: _____

Date of last pelvic exam: _____

Date of last mammogram: _____

Abnormal PAP in past	no	yes
Heavy flow	no	yes
Bleed or spot between periods	no	yes
Pain or cramps	no	yes
Vaginal itching	no	yes
Pain with intercourse	no	yes

Type of birth control used: _____

Number of pregnancies: _____

Number of full-term births: _____

Number of pre-term births: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

Signature of patient (or parent if minor): _____ Date: _____

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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Cellphone (____) _____

- ❑ OK to leave message with detailed information
- ❑ Leave message with call-back number only
- ❑ OK to text appointment reminders

Work telephone (____) _____

- ❑ OK to leave message with detailed information
- ❑ Leave message with call-back number only

Written Communication:

- ❑ OK to mail to my home address
- ❑ OK to mail to my work/office
- ❑ OK to fax to this number (____) _____

Other:

- ❑ OK to email appointment reminders _____
- ❑ OK to discuss my health care with _____
- ❑ OK to _____

_____ Patient Signature

_____ Printed Name

_____ Date

The Privacy Rule generally requires healthcare providers steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.
NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To	(1)	Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T = Treatment Records; P = Payment Information: O = Healthcare Operations
(3) Enter how disclosure was made: F = Fax; P = Phone; E = Email; M = Mail; O = Other

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CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

Patient Name: _____

1. **Purpose and Benefits**: The purpose of this telemedicine visit is to enable access to medical care remotely.
2. **Nature of Telemedicine Consultation**: During the telemedicine consultation:
   a. Details of your and/or your child's medical history, examinations, imaging, and/or tests may be discussed.
   b. Physical examination of you or your child may take place.
   c. Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit.
3. **Medical Information and Records**: All existing laws regarding access to my medical information and copies of my medical records apply to this telemedicine consultation.
4. **Confidentiality**: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation. All existing confidentiality protections under federal and Washington State law apply to information disclosed during this telemedicine consultation.
5. **Risks and Consequences**: The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a physician at a distance. At first you may find it difficult or uncomfortable to communicate using video images. There are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties despite use of a HIPAA-compliant platform. My health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. The use of video technology to deliver healthcare and educational services may not be equivalent to direct patient-to-physician contact. Following the telemedicine consultation, your physician may recommend an office visit or urgent care visit or transport to ER for further evaluation.

By signing this form, I certify:

- That I have read and/or had this form explained to me,
- That I fully understand its contents including the risks and benefits of the telemedicine encounter,
- That I have been given ample opportunity to ask questions and that they have been answered to my satisfaction.

Patient's or Parent/Guardian's Signature: _____ Date:_____

Witness Signature: _____ Date: _____