

**Patient Information**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SSN: \_\_\_\_\_ Gender:  Female  Male Date of Birth: \_\_\_\_\_

Check appropriate box:  Partner  Single  Married  Divorced  Widowed  Separated

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Best number to contact you/leave messages: \_\_\_\_\_

Email address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse/Partner or Parent's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Person to contact in case of an emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to emergency contact: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**Responsible Party**

Name of person responsible for this account: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Insurance Information**

Insured's name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 hours in advance, I may be assessed a fee. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

X \_\_\_\_\_ Date: \_\_\_\_\_

Patient (Guardian) Signature

Dr. Kimberly Otis  
Naturopathic Physician

**Adult Intake Form**

**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Naturopathic and preventative healthcare are only possible when the physician has a complete picture of the client physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Thank you.**

**PRESENT HEALTH CONCERNS:** (Please list most important health concerns in their order of significance.)

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

**HAVE YOU BEEN TO A NATUROPATHIC PHYSICIAN BEFORE TODAY'S VISIT?** \_\_\_\_\_

**PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING, WITH DOSAGES:**

- 1) \_\_\_\_\_ 4) \_\_\_\_\_
- 2) \_\_\_\_\_ 5) \_\_\_\_\_
- 3) \_\_\_\_\_ 6) \_\_\_\_\_

**LIST VITAMINS, MINERALS, HERBS, HOMEOPATHIC REMEDIES PRESENTLY TAKING, WITH DOSAGES:**

- 1) \_\_\_\_\_ 4) \_\_\_\_\_
- 2) \_\_\_\_\_ 5) \_\_\_\_\_
- 3) \_\_\_\_\_ 6) \_\_\_\_\_

**PLEASE LIST ANY KNOWN ALLERGIES TO THE FOLLOWING:**

**DRUGS:** \_\_\_\_\_

**FOODS:** \_\_\_\_\_

**ENVIRONMENTAL (grasses, pollens, etc.):** \_\_\_\_\_

**PERSONAL HABITS:**

Do you smoke/use tobacco products? Yes No If yes, for how long and what/frequency? \_\_\_\_\_

Did you every smoke? Yes No If yes, for how long? \_\_\_\_\_

Please circle any of the following substances that you use regularly: coffee/tea/cola alcohol recreational drugs

Please indicate amount, and frequency of substance use: \_\_\_\_\_

How many glasses of water do you drink each day? \_\_\_\_\_

Do you follow any particular diet regimes? If yes describe: \_\_\_\_\_

**PAST MEDICAL HISTORY:**

Hospitalizations (Indicate reasons/date:) \_\_\_\_\_  
 Serious Illnesses and Injuries: \_\_\_\_\_  
 Date of last complete Physical Exam: \_\_\_\_\_ Date of last blood tests: \_\_\_\_\_

**WOMEN ONLY:**

Menstrual cycles regular? Yes No Length of Cycle: \_\_\_\_\_  
 Date of Last Menstrual Period: \_\_\_\_\_ Date of last Pap: \_\_\_\_\_ Results Were: Normal Abnormal Don't know  
 Number of Pregnancies: \_\_\_\_\_ Number of Births: \_\_\_\_\_  
 Have you ever used birth control pills? Yes No If yes, for how long? \_\_\_\_\_  
 Other forms of birth control: \_\_\_\_\_

**SOCIAL HISTORY:**

Please circle those that apply: Single Married Divorced Remarried Significant Other Widowed  
 Do you have children? Yes No If yes, how many? \_\_\_\_\_ Please list their names/ages/genders:  
 \_\_\_\_\_

**EXERCISE:**

Please indicate type and frequency of current exercise regime: \_\_\_\_\_

**OCCUPATIONAL:**

Circle if your work exposes you to: Stress Hazardous Substances Heavy Lifting  
 Other: \_\_\_\_\_

**FAMILY HISTORY:** Please check the "yes" box next to each condition that applies to you or one of your family members. Please note whether condition applied to family member in the past or currently by denoting a "P" for past or "C" for current. Indicate the relationship or the word "self" in the "RELATION" column when appropriate.

	YES	RELATION	COMMENTS		YES	RELATION	COMMENTS
Alcoholism				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Diabetes				Stroke			
Eczema				Tuberculosis			
Epilepsy				Other			

Please provide any additional information that you believe is relevant to your health and wellness: \_\_\_\_\_

I certify that the above information is correct to the best of my knowledge.

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

### Informed Consent for Treatment

I, the undersigned, voluntarily consent to receive healthcare from Dr. Kimberly Otis, independent contractor at Balancing Health. I understand that there are intrinsic differences between the care of Naturopathic physicians and medical doctors and it is my decision to pursue Naturopathic treatment for any medical condition that I have. I hereby authorize my Naturopathic physician to perform the following procedures as necessary to facilitate my diagnosis and treatment:

Common Diagnostic Procedures: e.g., venipuncture, laboratory

Minor Office Procedures: e.g., ear lavage, cleaning a wound

Medicinal Use of Nutrition: e.g., therapeutic nutrition, nutritional supplementation, intramuscular vitamin injections

Botanical Medicines: e.g., capsules, tablets, creams, tinctures

Homeopathic medicines

Lifestyle counseling; e.g., dietary therapy, wellness recommendations for sleep, exercise, stress reduction

Vaccination, Contraception, Pharmaceutical prescriptions

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

Potential Risks: allergic reactions to prescribed herbs and supplements, side effects of medications or vaccinations, aggravation of pre-existing symptoms, discomfort, pain, infection, injury from procedures, inconvenience of lifestyle changes. Notify Dr. Otis if you experience any symptoms which may be secondary to the above procedures.

Potential Benefits: restoration of health and the body's optimal functional capacity without the use of drugs or surgery, relief of pain and symptoms of disease and the prevention of disease progression.

I understand that as with all medical treatment, there is no guarantee that this treatment will offer a complete resolution to any or all conditions that I may have.

I understand that Woodinville Wellness Center will keep a record of the healthcare services provided to me. This record will be confidential; it will not be released to others unless so directed by my legal representative or myself or unless 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 seven years after the date of my last visit. I understand that any questions I have will be answered by my practitioner to the best of her ability.

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Signature of Client (or parent/guardian of minor)

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Date

Dr. Kimberly Otis  
Naturopathic Physician

## Patient Financial Agreement

### Office Visit Fees:

Fees are determined after the visit has taken place and depends on the complexity of the health concern, which procedures are performed, and the amount of time spent with the client. Here are some average costs for different types of visits:

- **First Office Call:** \$250-\$300 this is an extended visit
- **Return Office Call:** \$100.00 minimum charge
- **Acute Visit:** \$50-\$150
- **Discount:** 20% for payment at the time of service (for non-insured patients)
- **Supplements and labs are not included in these fees**

### Insurance Billing:

**Dr. Otis bills the insurance companies for which she is a contracted provider. It is the patient's responsibility to clarify the details of your health insurance coverage with your insurance company. Insurance does not cover the following fees:**

- Phone or email consultations: \$50.00 minimum charge

Phone or email consultations for established clients may be arranged under special circumstances when an office visit may not be deemed necessary or possible. This fee is charged for any phone consultation requiring 15 minutes or less and for email response where a single reply suffices for the concern. Phone consultations that extend beyond 15 minutes will incur a greater charge. Email consultations that require multiple communications will incur additional charges. This fee is not charged in the following cases: (1) When you are calling or emailing for clarification of on-going therapy or (2) when a doctor has asked you to call. Due to unexpected medical emergencies, a return call or email is sometimes delayed.

- Emergency pager: \$35.00

In cases of medical emergency a doctor is available 24 hours a day. To access this service call 425.398.WELL (9355) and follow the instructions.

- Cancellation and No Show Policy:

We require notification 24 hours in advance if you cannot keep your appointment. There is a \$50.00 fee for cancellations with less than 24 hours notice. If no advance notice is received, you will be charged the full fee for your scheduled appointment.

- Supplements:

All nutritional supplements must be paid for on receipt.

### Payment Policy:

- Full payment for co-pays, nutritional supplements and lab fees must be rendered at the time of service.
- We accept payment by cash, checks, VISA/MasterCard.
- Checks or credit card payments that are denied for lack of funds, will incur a fee of \$35.00.
- A minimum billing fee of \$25.00 or 15% APR, whichever is greater, is added to any unpaid balances over 30 days.
- Patient will be held responsible for non-payment by their insurance company. Accounts unpaid by the insurance company after 120 days will be billed to the patient.

I \_\_\_\_\_ agree to the financial policies of Woodinville Wellness Center. I give permission for the release of information requested by my insurance company to assist in processing my insurance claims. I agree to be responsible for payment of all services rendered on my behalf or my dependants. Insurance does not pay for any phone or email consultations, cancellation or no show fees, and nutritional supplements. In case of default of payment, I am responsible for full payment of the balance, interest accrued and any collection costs and legal fees incurred to collect on this account.

\_\_\_\_\_  
Patient/Guardian Name and Signature

\_\_\_\_\_  
Date

Dr. Kimberly Otis  
Naturopathic Physician