

WOODINVILLE WELLNESS CENTER @ Balancing Health

12900 NE 180<sup>th</sup> Street, Suite 100, Bothell, WA 98011

Phone: 425.398.9355 Fax: 425.486.5913

**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

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Pediatric/Adolescent Intake

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

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

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Phone (home): \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Parent's Email address: \_\_\_\_\_

Person to Notify in Case of Emergency Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

PLEASE LIST MOST IMPORTANT HEALTH CONCERNS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MEDICATIONS:

	Now	Past
Asprin	_____	_____
Tylenol	_____	_____
Antibiotics	_____	_____
Decongestants	_____	_____
Other _____	_____	_____

SUPPLEMENTS:

	Now	Past
Vitamins	_____	_____
Herbs	_____	_____
Minerals	_____	_____
Other	_____	_____

PLEASE LIST ANY KNOWN ALLERGIES:

MEDICATIONS: \_\_\_\_\_

FOOD: \_\_\_\_\_

ENVIRONMENT: \_\_\_\_\_

CHILDHOOD ILLNESSES:

<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Croup
<input type="checkbox"/> Measles	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Mumps	<input type="checkbox"/> Strep Throat	<input type="checkbox"/> Asthma	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Rubella	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Other _____	

IMMUNIZATIONS: (List types, dates given, and any adverse reactions)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HOSPITALIZATIONS/SURGERIES/ACCIDENTS/SERIOUS INJURIES: (Describe and give date)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WHAT IS YOUR INFANT'S/CHILD'S/ADOLESCENT'S DISPOSITION?

\_\_\_\_\_

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FAMILY HISTORY: (Identify all family members who have or have had any of the following)

Alcoholism Cancer High Blood Pressure
Allergies Diabetes Hypoglycemia
Anemia Eczema Mental Illness
Arthritis Epilepsy Obesity
Asthma Heart Disease Stroke
Birth Defects Hearing Loss Thyroid Disorder
Other

INFANT'S/CHILD'S/ADOLESCENT'S HEALTH HISTORY: (Please check all that apply)

Table with columns for NOW and PAST for various conditions: Acne, Asthma, Colic, Cradle Cap, Ear Infection, Fatigue, High Fever, Moodiness, Allergies, Bed Wetting, Constipation, Depression, Eczema, Headaches, Hyperactive, Sinusitis, Anemia, Birth Defects, Cough, Diarrhea, Epilepsy, Heart Murmur, Insomnia, Vomiting Spells.

PRENATAL/BIRTH HISTORY:

Mother's Health During Pregnancy with this Patient (check and describe)
Age Bleeding Nausea Illness Toxemia High Blood Pressure Trauma Medications Diabetes
Alcohol Consumption Drugs Smoking Other

Describe:
TERM: Full Premature Late Birth Weight
PLACE OF BIRTH: Hospital Home Birth Center Other

FEEDING HISTORY:

Breast Fed: Yes No If yes, how long? Formula: Yes No If yes, what type and for how long?
Age solid food introduction: What Foods?
Food Intolerances: Favorite Foods:
Diet Eaten Yesterday:

SOCIAL HISTORY:

Parents: Married Separated Divorced
Mother's Occupation Father's Occupation
Guardian: Relationship:
Others' Residing in the Home? Yes No Relationship:
Daycare: Yes No Where and how many hours/week:
Siblings: Name Age Health Problems
1.
2.
3.
4.

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

Dr. Kimberly Otis
Naturopathic Physician

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**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

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**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

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Naturopathic Physician