

# *Serena McKenzie, ND*

Whole Life Medicine @ Balancing Health  
12900 NE 180<sup>th</sup> St, #100 Bothell, WA 98011  
P: 425.398.9355 F: 425.486.5913 Web: [www.DrSerena.com](http://www.DrSerena.com)

## NEW PATIENT INTRODUCTION PACKET

**WELCOME:** To Whole Life Medicine and the private practice of Dr. Serena McKenzie at Balancing Health. Our goal is for you to have an extraordinary health care experience in our office. This packet provides general information and is intended to answer any questions you may have. Please read and complete forms before your visit. We look forward to having you as a patient!

**WHAT IS A NATUROPATHIC PHYSICIAN?** Naturopathic physicians (N.D.'s) are general practitioners trained as specialists in natural medicine. They are educated in the conventional medical sciences, laboratory diagnostics, and holistic treatments. A naturopathic physician has a Doctor of Naturopathic Medicine (N.D.) degree from a four-year graduate level naturopathic medical university. In practice, naturopathic physicians perform physical examinations, laboratory testing, gynecological exams, nutritional and dietary assessments, X-ray and other diagnostic and screening tests. Naturopathic physicians treat using therapies from the sciences of clinical nutrition, herbal medicine, physical medicine, exercise medicine, and counseling. Naturopathic physicians may prescribe some medications in the event that is considered clinically necessary.

**WHO IS DR. MCKENZIE?** Dr. McKenzie is a graduate from Bastyr University, and completed a family medicine residency at the Bastyr Center for Natural Health. She is licensed as a Primary Care Provider in the State of Washington, and practices holistic, integrative medicine with focus on women's care and sexual health.

## BASIC PRINCIPLES OF INTEGRATIVE MEDICINE

- ❖ A partnership between patient & practitioner in the healing process.
- ❖ Appropriate use of conventional & alternative methods to facilitate the body's innate healing response.
- ❖ Consideration of all factors that influence health, wellness, disease, including mind, spirit, & community as well as body.
- ❖ A philosophy that neither rejects conventional medicine nor accepts alternative medicine uncritically.
- ❖ Recognition that good medicine should be based in good science, inquiry driven, and open to new paradigms.
- ❖ Use of natural, less invasive interventions whenever possible.
- ❖ The broader concepts of promotion of health & the prevention of illness as well as treatment of disease.
- ❖ Practitioners as models of health & healing, committed to the process of self-exploration & self-development.

**PATIENT RELATIONSHIP:** Dr. McKenzie and office staff are committed to having a relationship with you based on mutual understanding, trust, and communication. Please make any suggestions you feel are appropriate.

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## WELCOME!

"Health is the thing that makes you feel that now is the best time of the year." ~ Franklin Pierce Adams

### Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
SSN: \_\_\_\_\_ Gender:  Female  Male Date of Birth: \_\_\_\_\_  
Check appropriate box:  Partner  Single  Married  Divorced  Widowed  Separated  Partner  
Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Number easiest to contact you to leave messages: \_\_\_\_\_ Email address: \_\_\_\_\_  
HIPAA regulations require permission to leave detailed messages. Which number is best for this? \_\_\_\_\_  
Spouse/Partner or parent's name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Patient's or parent's employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
If patient is a student, name of school/college: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Person to contact in case of an emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

### Responsible Party

Name of person responsible for this account: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Driver's license #: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Financial Institution: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Is this person currently a patient at our office?  Yes  No

### Insurance Information

Insured's name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Insurance company & ID # AS SHOWN ON CARD: \_\_\_\_\_ Group #: \_\_\_\_\_  
Employer of Insured: \_\_\_\_\_ Phone: \_\_\_\_\_  
What is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_  
Do you have any additional insurance?  Yes  No

*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 business 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

\_\_\_\_\_  
Signature of patient or parent if minor

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

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## HEALTH HISTORY Confidential Information

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### GENERAL

Place of birth	Education
Relationship status	Occupation
Hobbies	Previous occupations
Exercise/recreation	Height
Weight                      Weight 1 year ago                      Maximum Weight	
Date of last Physical Exam	Date of last Eye exam
Date of last colonoscopy	Date of last Prostate /Gyn exam
Date of last full bloodwork	Date of last Bone Density testing
Date of last Mammogram	Date of last Dental Exam
Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred): <input type="checkbox"/> None	List all serious illnesses, operations, and other operations, and other hospitalizations you have experienced and indicate year these occurred: <input type="checkbox"/> None
_____	_____
_____	_____
_____	_____

**CHIEF COMPLAINTS:** Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICATION:** (Include everything you have taken or are taking: pills, tablets, liquids, ointments, suppositories, etc)

Antacids	Antibiotic/Antifungal	Antidepressants	Antidiabetic/Insulin
Aspirin/Tylenol	Chemotherapy	Cortisone	Anti-Inflammatories
Heart Medications	High Blood Pressure	Hormones	Laxatives
Lithium	Oral Contraceptives	Radiation	Recreational Drugs
Relaxants/Sleeping Pills	Thyroid	Ulcer Medication	Other

**VITAMINS, MINERALS, HERBS, DOSES:**


**ALLERGIES:**

Drugs:			
Foods:			
Environmental Sources:			
Other:			

**CIRCLE IF YOU:**

Diet often	Are under excessive stress	Are exposed to chemicals at work	Do not sleep well
Eating Disorder	Recreational Drugs	Spiritual Practice, please indicate →	

**DO YOU DRINK OR CONSUME:**

Alcohol	Candy	Carbonated beverages	Cheese
Cigarettes	Coffee	Meals at fast food restaurants	Fried foods
Luncheon meats	Margarine	Meat eater	Milk or Ice Cream

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Refined sugar	Saccharine or Aspartame	Chew tobacco	Butter
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**DIET:** *please list typical foods consumed on a regular basis*

Breakfast: \_\_\_\_\_  
 Lunch: \_\_\_\_\_  
 Dinner: \_\_\_\_\_  
 Snacks: \_\_\_\_\_  
 Fluids: \_\_\_\_\_  
 Alcohol: \_\_\_\_\_

**PAST MEDICAL HISTORY**

Measles	no	yes	Hives or Eczema	no	yes	chest x-ray	no	yes
Mumps	no	yes	Tuberculosis	no	yes	Infectious Mono	no	yes
Chickenpox	no	yes	Diabetes	no	yes	Rheumatic Fever	no	yes
Whooping Cough	no	yes	Cancer	no	yes	Mitral Valve Prolapse	no	yes
Scarlet Fever	no	yes	Polio	no	yes	Stroke	no	yes
Diphtheria	no	yes	Glaucoma	no	yes	Hepatitis	no	yes
Smallpox	no	yes	Hernia	no	yes	Thyroid Disease	no	yes
Blood Transfusions	no	yes	Kidney Disease	no	yes	AIDs or HIV+	no	yes
Heart Disease	no	yes	Bleeding tendency	no	yes	Anemia	no	yes
Venereal Disease (STD's)	no	yes	Any other disease (please list) _____					

**FAMILY HISTORY:**

	Who		Who
Alcohol or Drug Problem		HIV	
Allergies		Kidney Disease	
Anemia		Leukemia	
Ankylosing Spondilitis		Mental Illness	
Asthma		Migraine Headaches	
Autoimmune disorders		Multiple Sclerosis	
Cancer		Muscular Dystrophy	
Chronic Lung Disease		Obesity	
Diabetes		Osteoporosis	
Eczema		Psoriasis	
Epilepsy		Parkinson's disease	
Glaucoma		Rheumatoid Arthritis	
Gout		Stroke	
Heart Disease		Thyroid Disease	
Hepatitis		Tuberculosis	
High Blood Pressure		Ulcers	
High Cholesterol		Other	

Present age /or Age of death

If living, health (good, fair, poor)

If deceased, cause of death

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Siblings: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Spouse: \_\_\_\_\_

Children: \_\_\_\_\_

Please list any other information you think is important:

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## Patient Financial Agreement

### Visit Consultations and Fees:

- Most patients require a minimum of two office visits to establish a comprehensive treatment plan. Regular follow-up appointments are generally recommended.
- The first office consult which includes a comprehensive intake, review of medical records, physical exam, and initial treatment plan, generally lasts 60 minutes and ranges from \$200 - \$350.00 depending on the complexity of your circumstances.
- Follow up visits last 30 – 60 minutes and range from \$100 - \$200.00.
- If you are a new patient and require an annual gynecologic exam, this exam will typically take place on the second visit.
- Lab work and nutritional supplements are not included in these fees.

### Insurance Billing:

- Dr. McKenzie is credentialed by most major insurance plans. It is the patient's responsibility to check if Dr. McKenzie is covered by your specific insurance plan.
- Dr. McKenzie is licensed as a Primary Care Provider (PCP) in the State of Washington, with the exception of coverage under Regence Blue Shield by which she is credentialed as a Specialist. Most Regence plans allow for the patient to self refer to Dr. McKenzie for women's health issues (not requiring a referral from a PCP).

### Phone Consultation: \$50 minimum charge

- Telephone consults are on a cash basis only as insurance will not cover these services.
- Fees for telephone consults are \$50.00 for each 15 minutes.
- Brief phone calls are accepted at no charge. Messages are checked daily and will be returned within 48 hours.
- If there are any questions about this service, please ask at the time of the call.

### Cancellation Charge:

- We understand that circumstances occasionally arise changing your plans.
- No charge if cancelled with a minimum of 24 hour notice.
- There is a \$50 fee with less than 24 hour notice.
- Full fee will be charged if no notice is received.

### Payment:

- Payment for visit co-pays and/or medication and supplies is to be rendered at time of service and can be made by cash, check, money order, or credit card.
- There is a minimum billing fee of \$25.00 or 12% APR, whichever is greater, for account balances due beyond 30 days.
- There is a \$35 NSF fee on all returned checks.
- Patients will be held responsible for non-payment by their insurance company. Accounts unpaid by the insurance company greater than 90 days will be billed to the patient.
- Outstanding balances greater than 120 days will be turned over to a collection agency unless prior arrangements have been made in writing.

~ Dr. McKenzie is committed to providing quality care for the whole family. Your patronage is appreciated. ~

**IF I HAVE INSURANCE, I UNDERSTAND THAT I AM RESPONSIBLE TO READ MY MEDICAL BENEFIT BOOK AND UNDERSTAND IT. WHEN APPLICABLE, I AM RESPONSIBLE TO PAY A PERCENTAGE OF THE COST OF MY VISIT AT THE TIME OF TREATMENT. I AGREE THAT I AM FULLY RESPONSIBLE FOR THE TOTAL PAYMENT OF ALL PROCEDURES PERFORMED IN THIS OFFICE. THIS INCLUDES ANY TREATMENT THAT IS NOT A BENEFIT OF ANY MEDICAL INSURANCE THAT I MAY HAVE**

I, \_\_\_\_\_ agree to the above defined financial policies of Whole Life Medicine. In the 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.

I, the undersigned, have read, understand, and accept the information and conditions specified in this document.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date