LAKEWOOD NATURAL MEDICINE & CHIROPRACTIC

Welcome

About You

Name: _____

Date of Birth: _____/_____/_____ Age: _____

☐ Male ☐ Female ☐ Other: _____

Social Security #: _____-____-_____

Home Address: _____

City: _____ Zip: _____

Phone #: (_____) _____-_____ Cell / Home

Alt #: (_____) _____-_____ Cell / Home

Email: _____

Occupation: _____

Employer: _____

☐ Married ☐ Single ☐ Divorced

☐ Widowed ☐ Other: _____

Spouse Name: _____

Spouse Occupation: _____

No. of Children: _____

Primary Care Provider: _____

Phone #: (_____) _____-_____

Emergency Contact: ☐ Spouse ☐ Other: _____

Name: _____

Phone: (_____) _____-_____

Which account type applies for you?

☐ Personal Health Insurance

Insurance Company: _____

Insurance Phone #: (____) ____-_____

Member #: _____

Group #: _____

Name of Insured: _____

Relation to Patient: _____

Insured's Date of Birth: ____/_____/____

Insured's Employer: _____

☐ Cash Account

Payment is due in full at time of service

☐ VA Authorization

☐ L&I (Worker's Comp)

Please continue to next page

☐ Auto Insurance

Please continue to next page

How were you referred to our office?

☐ Friend or Family _____

☐ Google/Internet Search ☐ Social Media

☐ Advertisement ☐ Other: _____

How can we help you?

Areas of complaints: _____

_____

_____

Describe any accidents or injuries: _____

_____

_____

_____Date of injury: _____/_____/_____

Is the condition worsening? ☐ Yes ☐ No

☐ Constant ☐ Comes and goes

Have you had similar injuries in the past?

☐ No ☐ Yes Explain: _____

_____

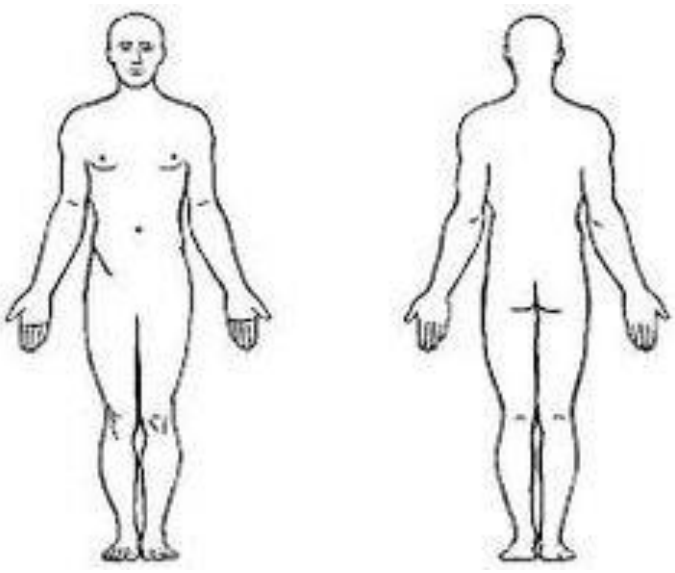
Have you been treated for this complaint before? ☐ No ☐ Yes

Has this complaint been treated by a

☐ Medical Doctor ☐ Chiropractor

☐ Naturopath ☐ Other: _____

Please mark with X's where you feel pain:



LAKEWOOD NATURAL MEDICINE & CHIROPRACTIC

Because you are the person ultimately responsible for your account and your health, we invite you to discuss with us any questions you may have regarding our services. The best health services are based in a friendly, mutual understanding between the patient and the provider.

Health History:

Have you ever been treated by a Chiropractor or Naturopath before? ☐ No ☐ Yes
Explain: _____

Check the following conditions you have had:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Headaches
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Back Pain
- ☐ Measles
- ☐ Migraines
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ T.B.I.
- ☐ Ulcer

List any medications you are currently taking:
_____ for _____
_____ for _____
_____ for _____

Do you smoke? ☐ No ☐ Yes _____
Do you drink alcohol? ☐ No ☐ Yes _____
Do you exercise? ☐ No ☐ Yes _____
Are you pregnant? ☐ No ☐ Yes ☐ Unsure
Last Spinal X-Rays: _____/_____/_____
Last Spinal Exam: _____/_____/_____
Last Physical: _____/_____/_____

Auto / Work Injuries

Have you had previous complaints in the now injured areas? ☐ No ☐ Yes Explain: _____
_____

Who did you report the accident to?

- ☐ Employer
- ☐ Insurance Company
- ☐ Police
- ☐ Claim Manager
- ☐ Other: _____

Before this injury, were you able to work on an equal basis with others of your age? ☐ No ☐ Yes
Explain: _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? ☐ No ☐ Yes Name: _____

Have you retained an attorney? ☐ No ☐ Yes
Name: _____
Phone number: _____

Insurance Company: _____
Claim #: _____

Auto injuries continued.

☐ Pedestrian ☐ Driver ☐ Passenger ☐ Back Seat
Number of People in vehicle: _____
Were you knocked unconscious? ☐ No ☐ Yes
Did the impact come from the:
☐ Front ☐ Rear ☐ Right ☐ Left
During the impact were you facing:
☐ Forward ☐ Right ☐ Left
Were you surprised by the impact? ☐ No ☐ Yes
Driver of your vehicle: _____

I authorize the staff to preform any necessary services needed during the diagnosis and thereafter. I also authorize the provider to release my information required to process insurance claims.

I understand the above information and guarantee this form was completed to the best of my knowledge, and I understand that it is my responsibility to inform this office of any changes in my medical status.

X_____ _____/_____/_____
Signature of Patient or Legal Guardian of Patient *Date*

Informed Consent

Thomas J Young ND, DC, PS

This form is designed to present benefits and risks of the therapies offered by this clinic and must be signed before treatment is rendered. Ask the doctor if you have questions or concerns regarding your consent to treat prior to signing this Informed Consent form. Treatments, procedures, and/or products used in your treatment may or may not be FDA approved. Treatments may include one or a combination of the following:

- Dietary and nutritional counseling.
- Nutritional and other supplementation, either orally, topically, or as an injection/IV therapy, such as: vitamins, minerals, enzymes, amino acids, essential fatty acids, homeopathic remedies, and others.
- Physical Medicine (manipulation), nutritional or other IV therapy, trigger point injection, mesotherapy, neural therapy, hormone replacement therapy, therapeutic massage therapy and more.

I am seeking medical health care services, including alternative medical therapies. I hereby request and consent to the performance of physical medicine (including, but no limited to, various modes of physical therapy and diagnostic testing/examination) or to the performance of naturopathic procedures (including, but not limited to, physical examination, diagnostic testing, and the use of natural substances such as vitamins, minerals, botanical medicines, and prescription drugs) on me (or on the patient named, for whom I am legally responsible) by the doctor(s) of this clinic.

I understand and am informed that results from treatment may vary and are not guaranteed. In addition, I understand that my compliance with diet recommendations, supplements, prescribed medications, prescribed exercises and lifestyle modifications will increase the effectiveness of my care and enhance or maintain the results.

I acknowledge that the scope of practice of a Naturopathic Physician has limitations including limited prescription privileges and limited hospital privileges. Consequently, a referral to a specialist or emergency room may be deemed necessary under certain circumstances and is in my best interest.

I understand that this medical practice may use diagnostic and treatment methods which are considered as mainstream medicine, but also some therapies that may be investigative, complementary, alternative, holistic, nutritional, and herbal oriented. Some of these methods have not been accepted by consensus, mainstream, or the FDA.

I understand that I am in no way obligated to purchase products or run labs that may be recommended. I am free to purchase these products from any source that I may choose.

I do not expect the doctor to be able to anticipate and explain all the risks and complications that could possibly happen during or because of treatment, and I wish to rely on the doctor's ability to exercise judgement during the course of the procedure based upon the facts known at that time.

I understand and am informed that in the practice of naturopathic medicine, spinal manipulation care, intravenous therapy, injection therapies, nutritional and other supplementation, hormone therapy, and any treatment this office administers or orders, there are some risks.

Continued on following page

Informed Consent

Thomas J Young ND, DC, PS

Some of the potential side effects to treatments and therapies are, but not limited to:

- Bruising/Local tenderness and swelling (with venipuncture, IM injections, mesotherapy, trigger point therapy)
- Allergy (with drugs, supplements, herb/drug interactions)
- Fainting (with drugs, supplements, herb/drug interactions)
- Infection (with venipuncture, injections, minor surgery and other)
- Scars (with venipuncture, injections, minor surgery and other)
- Fractures, Dislocations, Sprains, Disk Injuries (with manipulation and other)
- Strokes (with manipulation and other)
- Organ Puncture (injections, minor surgery, and other)

Patient Rights

- You have the right to be treated with courtesy, respect, and dignity.
- You have the right to know the process through which services are offered, including the general course of treatment.
- You have the right to full confidentiality. All transactions and records within this office are kept strictly confidential. Your records may be released to other parties only when requested in writing by you, or when required by law.
- You have access and may request copies of your information at any time.
- You have the right to know and understand the practitioner's assessments and recommendations. These will be given to you at each visit, including therapeutic goals, success of treatment, and proposed duration of treatment. If this is unclear, please ask.
- If a medication is prescribed, or any other specific treatment is recommended, you have the right to know what the medication or treatment is, why it is being prescribed, and what the expected outcome is, and general side effects which might be reasonably expected. Please ask your physician to explain prior to treatment.
- You have the right to access other community services, and also the right to select and change practitioners.
- You have the right to refuse service.
- You have the right to assert your rights as described within this document at any time without retaliation or fear of negative consequences.
- You as a patient have the right to full disclosure of fees.
- You have the right to know of any changes to services or charges.

I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatments and understand the risks and benefits involved.

X_____ _____/_____/_____

Signature of Patient or Legal Guardian of Patient *Date*

HIPAA Consent

Thomas J Young ND, DC, PS

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and provide you with a Notice of Privacy Practices. Our Notice provides information regarding how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. **You have a right to review our Notice before signing this consent, and you are advised to do so.**

By signing this form, you consent to our use and disclosure to third parties of your PHI for treatment, payment, and health care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Consent but later change your mind, you have the right to revoke this Consent by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The Patient understands that:

- This Clinic has a notice of Privacy Practices. The patient has received, and had the opportunity to review this Notice before signing this Consent. The Clinic encourages all patients to review the Notice of Privacy Practices.
- The Clinic reserves the right to modify the Notice of Privacy Practices in accordance to changes in the law or office practices. We will make all modifications available for review by patients.
- Protected health information may be disclosed or used for treatment, payment, or health care operations, and for certain marketing purposes.
- The Clinic or its business affiliates may use your PHI to contact you with educational and promotional items in the future via email, U.S. Mail, telephone, fax, and/or pre-recorded messages. We **WILL NOT** ever sell, or "SPAM" your personal contact information.
- The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures that require the patient's prior written consent will then cease.
- The Clinic may condition receipt of treatment upon the execution of this Consent.

I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatments and understand the risks and benefits involved.

X_____ _____/_____/_____

Signature of Patient or Legal Guardian of Patient *Date*

_____ _____

Print Name *Relationship to Patient*

X_____ _____/_____/_____

Signature of Witnessing Office Staff *Date*

_____ _____

Print Name *Refusal Reason*

Financial Agreement

Thomas J Young ND, DC, PS

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is **NOT A SUBSTITUTE FOR PAYMENT**. Some Companies pay fixed allowance for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

In order to control your outstanding balance, it is our policy to collect co-pays at time of service. All products must be paid for in full at time of service.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

X_____ _____/_____/_____

Signature of Patient or Legal Guardian of Patient *Date*

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee healthcare benefits coverage with the above captioned, and hereby assign and convey directly to Lakewood Natural Medicine and Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financial responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above name doctor and clinic to the full extent permissible under the law and under the applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action, or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

X_____ _____/_____/_____

Signature of Patient or Legal Guardian of Patient *Date*

Financial Policies

Thomas J Young ND, DC, PS

Payment is due in full at time of service. If insurance is to be billed, it must be one that the doctor is listed as a preferred provider.

First time patients with insurance must bring photo ID and your medical card, along with a co-payment if your policy requires you to pay one.

All co-pays are due at time of service or your appointment will be rescheduled. This is a contract between you and your insurance company, to which you agreed when signing with them. If you have no insurance, full payment is due at time of service.

Returned checks will be charged $30 to be paid in cash within 5 business days. We will not run them through a 2nd time. Check writing privileges will then be permanently suspended.

All products must be paid for in full at time of purchase.

For existing patients, we will verify your insurance again at the first visit of a new year to be sure we have the correct information. Please be sure to bring your new card for us to copy.

Any patient responsibility charges after insurance has paid will be due 2 weeks after we bill you. If a third notice becomes necessary and your account is not paid in full, your account will be sent to collections if we are unable to come to a mutual agreed upon payment plan. In the event your account is sent to collections, please understand we will have to terminate treatment permanently.

If you are being seen for a motor vehicle accident under PIP, and that becomes exhausted, please be aware your insurance company will then be billed. If you have no insurance coverage, payment will be due in full at time of service. If you have retained an attorney, all information must be provided prior to your next appointment so the office may verify your case and determine eligibility for either a signed letter of guarantee or for a lien to be filed on your claim.

If you have a Labor & Industries injury and wish to open a claim, we will be happy to assist you. If you have a closed claim you wish to reopen, we are happy to assist with that as well. You must provide your claim number as well as any other information regarding your claim. Please be aware that if your claim is denied, you will be responsible for all visits, in accordance to our previously detailed policies.

I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction.

X_____ _____/_____/_____

Signature of Patient or Legal Guardian of Patient *Date*