

**Patient Name:** \_\_\_\_\_

Today's date: \_\_\_\_\_

First Middle Last

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

Number Street Apt number City State Zip

**Date of birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Gender:** ( ) F ( ) M **Ht:** \_\_\_\_\_ **Wt:** \_\_\_\_\_

**SSN:** \_\_\_\_\_ **Home phone:** \_\_\_\_\_ OK to leave message? Y N

**Employer:** \_\_\_\_\_ **Work phone:** \_\_\_\_\_ OK to leave message? Y N

**Referred by:** \_\_\_\_\_ **Cell phone:** \_\_\_\_\_ OK to leave message? Y N

**Email:** \_\_\_\_\_ OK to leave message? Y N

**Name of spouse/partner:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_

**Emergency contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**INSURANCE**

**Insurance company:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Subscriber Name:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_

**Subscriber's SSN:** \_\_\_\_\_

**Relationship to you:** ( ) Self ( ) Spouse ( ) Child ( ) Other

**ID number as shown on card:** \_\_\_\_\_ **Group number:** \_\_\_\_\_

**Employer of subscriber:** \_\_\_\_\_

**AUTO**

**Is this visit injury related?** ( ) Y ( ) N **Work related?** ( ) Y ( ) N **Auto accident?** ( ) Y ( ) N **State:** \_\_\_\_\_

**Insurance company:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Claim address:** \_\_\_\_\_

**Subscriber's name:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_

**Relationship to you:** ( ) self ( ) spouse ( ) dependent ( ) other

**ID / Claim # :** \_\_\_\_\_ **Policy #:** \_\_\_\_\_

**Claim adjuster's name:** \_\_\_\_\_ **Date of Injury:** \_\_\_\_\_

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.

I am financially responsible for all charges. I agree to pay for all charges not covered by my health insurance. If I fail to cancel an appointment at least 24-business-hours in advance, I agree to pay a fee of up to **\$150.00 (late cancel fee)**. I agree to **pay copay and coinsurance at time of service to avoid \$10 billing fee**. I agree to pay a **fee of \$35.00 for each returned check**. When I chose to consult with Dr. Yu, I agree to pay for phone or email consultation fee (ranges from \$30 to \$75).

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**HEALTH INFORMATION---confidential**

**Present Health Concerns** in order of importance.

**How Long?**

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

**Chronic health problems** you have had for years not listed above

**How long?**

**Still active?**

- 1) \_\_\_\_\_ Yes / No
- 2) \_\_\_\_\_ Yes / No
- 3) \_\_\_\_\_ Yes / No
- 4) \_\_\_\_\_ Yes / No

**Family history**

Father

Mother

Aunt/uncle

Grandparents

Siblings

Heart disease/cholesterol					
High blood pressure					
Stroke					
Obesity					
Cancer (type)					
Cancer (type)					
Cancer (type)					
Diabetes					
Thyroid disease					
Osteoporosis					
Early menopause					
Breast, uterine, ovarian disorder					
Mental illness					
Allergy, asthma, hay fever					
Blood disorder, anemia					
Arthritis, muscle pain					
Other					
Other					

**Surgeries, hospitalizations, major injuries, and serious illnesses:**

**Year**

**Outcome**

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

**Allergies:** Please list all **food, environmental,** and/or **drug** allergies.

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**Habits:**

Smoking: No / Yes \_\_\_ pack a day for \_\_\_ years      Recreational drug: \_\_\_\_\_

Alcohol: No / Yes \_\_\_ glasses of wine, beer, mixed drink, \_\_\_\_\_ per day / week/ month / year

Exercise: No / Yes Aerobic \_\_\_\_\_      Weight \_\_\_\_\_

Coffee: \_\_\_ cups /day Tea: \_\_\_ cups /day Cola/pop: \_\_\_ / day Aspirin/Tylenol/Analgesic: \_\_\_\_\_

**Stress level** (10 being highest): 1   2   3   4   5   6   7   8   9   10

**Digestion:**      Heart burn      Stomach upset      Bloating      Burping      Gas      Nausea

**Rate your meal** average per week (1 being poor, 5 being excellent/healthiest): 1   2   3   4   5

**Sweets / chocolate intake** average per week (1 being negligible, 5 being large amount): 1   2   3   4   5

**Medications: Prescription and Over-the-counter.** Please list medications that you are taking now.

Name of drugs/ medicine	Reason for taking	Doses: milligrams or # of capsules	How many times per day or week	How long have been taking ?

**Vitamins, herbs, and supplements** you are taking now

Name of herbs	Reason for taking	Doses	How many times per day or week	How long have been taking ?

**Review of Health:** please circle any of the following problems not mentioned before

**General:** recent weight gain / loss, fevers, night sweats, fatigue

**Skin:** itching, rash, infection, eczema, psoriasis, lumps, hair loss

**Eye/ear/nose/throat:** hearing, vision, dental problem, sinus infection, colds, swallowing problem, swollen glands, allergies, sore throat, Strep, pain, discharge, sensitive to pollen / dust / mold

**Head / Neck:** migraine, tension headache, dizzy, fainting

**Heart:** Chest pain, palpitations, high blood pressure, irregular heart beat, murmur, swollen legs

**Lung:** cough, shortness of breath, asthma, frequent bronchitis, pneumonia

**Digestive:** indigestion, food stays in stomach / slow emptying, bad breath, constipation, diarrhea, irritable bowel, mucus or blood in stool, hemorrhoid, heart burn / acid reflux, ulcer, lump in throat, bloating, gas, nausea, vomiting

**Liver / gall bladder:** hepatitis B or C, fatty liver, gall stone, gall bladder removed

**Genital / Urinary:** frequent or painful urination, burning, urgency, blood in urine, leakage / can't get to bathroom on time, kidney stone, bladder or kidney infection, sexually transmitted disease, Herpes

**Male:** BPH, prostate infection, difficult to maintain erection, use medication

**Female / reproductive:** PMS, \_\_\_ day cycle, period lasting \_\_\_ days, light / normal / heavy bleeding, spotting between cycle, irregular cycle, birth control pills / ring / Depo provera / \_\_\_\_\_, fibrocystic breasts, breast lump / cyst, fibroids, ovarian cyst, pregnancy \_\_\_ times, birth \_\_\_ times, termination \_\_\_ times, miscarriage \_\_\_ times

**Peri- or Post-menopause:** on HRT, hot flushes, sleep disturbance, mood swings, shorter cycle between periods, night sweats, spotting, bursitis / tendonitis, osteoporosis, osteopenia

**Hormones / endocrine:** hypothyroid, hyperthyroid, diabetes

**Joints / bone / muscles:** pain in neck, back, low back, shoulder, elbow, wrist/hand, hip, knee, ankle, or foot. Muscle pain all over

**Neurologic:** numbness, tingling, pain, loss of sensation, decreased / loss of arm or leg function

**Bleeding, bruising, anemia**

**Psychological:** feeling sad, crying, hopeless, insomnia, poor appetite, weight change, tired all the time, not interested in activities/ socializing, irritable, poor concentration, anger, lack of libido, anxiety, hard to swallow

**Major life changes:** marriage, divorce, move, job, death of \_\_\_\_\_

Anything else we should know about you? \_\_\_\_\_

## *Mutual Understanding, Informed Consent for Treatment, and Financial Policy Agreement*

**Confidentiality:** Information provided during the visit is confidential. No information will be released to others unless you direct us to do so or the law compels us to do so.

Dr. Yu practices naturopathic medicine on an outpatient preventive medical care basis. If you have a serious health problem that requires immediate attention, please call 911.

**Treatments with other practitioners** are not necessarily to be discontinued. It is your responsibility to inform Dr. Yu if you are being treated by other healthcare providers. It is your responsibility to disclose changes in your condition, symptoms, contact information, or treatments between visits.

**No guarantees:** Although your unique health status will be researched and treatment customized, no guarantees can be assured regarding the outcomes of treatment(s) or procedure(s). We invite you to ask any questions and actively take part in your health care.

**Physical examination, naturopathic treatment, and massage do involve physical contact, which may be uncomfortable for some persons.** If you are uncomfortable or unfamiliar with naturopathic treatments, please let Dr. Yu know so that we can assist you, explain it to you, and/or modify treatments.

**Potential risks:** while naturopathic treatments are remarkably safe, there may be potential risks associated with your care. Please be advised of the following risks and ask us any questions you may have: allergic reaction to herbs, supplements, other treatments, or supplies; post-treatment soreness and stiffness in skin, joints, muscles or other soft tissues; and other unforeseen possible injuries. No patient was injured during the procedures. We take every precaution to prevent injury. Please ask any questions or concerns you have before the start of the treatments.

**Notice to Pregnant Women:** please let Dr. Yu know if you know or suspect the pregnancy as some therapies can present a risk to the pregnancy.

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**Cancellation Policy:** If you cannot keep the appointment, **PLEASE CALL 24-HOURS IN ADVANCE at 425-644-6048. We do charge \$75 to \$150 for a missed appointment or cancellation less than 24-hour notice.**

**Phone and email consultation** fees range from \$30(up to 5 minutes on phone, 1 or 2 simple questions on email) to \$55(5-10 minutes) to \$75(up to 15 minutes). Dr. Yu does not bill insurance for phone/email consultation.

**Insurance:** You are responsible to know and inform us of your insurance eligibility and coverage. Some insurance do not cover naturopathic medical visits. It is your responsibility to verify if your insurance covers naturopathic medical visits. You are ultimately responsible for all charges regardless of insurance coverage.

**Financial Information:** Dr. Yu will bill your insurance if you request. Any remaining balance must be paid immediately. The unpaid balance after 15 days will accrue **\$5.00 or 1.5% (of the balance) finance charge per month, whichever is greater. Balance not paid in 120 days** will be turned over to **Collection**. We charge **\$35 for each returned check** (RCW 62A.3 515520). Copays and coinsurance are due at time of service to avoid \$10 billing fee. We charge **\$10 billing fee** for each bill or invoice to cover the administration expense.

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The information I provided on this registration forms is complete and accurate. I understand risks and my responsibilities. I will not hold physicians and staff at this clinic responsible for any errors or omissions I may have made in completing the registration forms.

I understand and accept the terms of the above described cancellation, phone consultation, insurance, and financial policies. I am individually responsible and agree to pay for all charges.

**Signature of patient or guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_