

NATURAL HEALTH CLINIC
Laura A. Shelton, N.D.
Emily Sharpe, N.D.
1707 F St., Bellingham, WA 98225
(360) 734-1560

Welcome!

Whom may we thank for referring you? _____

Naturopathic physicians are primary health care providers emphasizing optimal health, as well as the natural treatment and prevention of disease.

The goal of your naturopathic physician is to help you enhance the quality of your health and life by working with various treatment modalities such as lifestyle counseling, clinical nutrition, botanical medicine, and homeopathy. Your physician will develop a therapeutic plan that is best suited to you and is most appropriate to your situation. Physicians may perform physical exams and order lab or other studies to gather the information needed to make diagnostic and treatment decisions. Your physician will make referrals to specialists if she believes it is in the best interest of your health.

Initial Free Consultations (15 minutes) are offered as an introduction to your doctor, and Naturopathy with focus on your particular health problem. This time is not intended for treatment. **If a free consultation is longer than 15 minutes, or culminates in treatment, you will be charged for an office call.**

Office visits will be charged based on the actual time spent with the Doctor, and according to allowable standard insurance rates.

Acute care If you have sudden onset symptoms of ear infection, mastitis, or urinary tract infection, please call for a 5 minute visit with one of our doctors. We will get you in as soon as possible; usually the same day you call.

Lab and pharmacy charges will vary depending on item(s) provided.

Telephone Care No charge for first 5 minutes. Phone calls that extend beyond 5 minutes will be charged based on office call rates, and cannot be billed to insurance.

House Calls can be arranged with your physician, but cannot be charged to insurance.

Payment is expected immediately following your visit unless other arrangements have been made with the office manager. If you need to cancel or reschedule your appointment, please give us 24 hours notice. This allows other patients the opportunity to fill your time slot. There will be a 35.00 fee charged for cancellations made with less than 24 hour notice.

Over please...

Insurance: Please provide office personnel with any insurance information prior to your visit. While many companies do cover naturopathy in whole or part, it is better for all parties for patients to understand coverage in advance. Depending on your coverage, we may ask that you pay for services at the time of the visit and be reimbursed directly by your insurance.

Please feel free to ask questions and offer comments about our services! It is our mission to provide quality health care in a comfortable, supportive environment. Thank you.

I have read this handout explaining fees and services.

Patient Printed Name

Patient signature

Date

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PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date _____ Name _____
Address _____ City _____ State _____ Zip _____
SSN _____ Male Female Birthdate _____
Relationship status: S, M, S/D, W Spouse/Partner name: _____
Home Phone _____ Work Phone _____ (OK to leave messages at these?)
Patient's or parent's employer _____
If patient is a student, name of school/college _____ City _____
Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Person responsible for this account _____ Relationship to patient _____
Address _____ Home phone _____
Employer _____ Work phone _____
Is this person currently a patient at our office? Yes No

INSURANCE INFORMATION

Name of insured _____ Relationship to patient _____
Birthdate _____ Social Security Number _____
If insurance provided through employer:
Name of employer _____ Work phone _____
Address of employer _____ City _____ State _____ Zip _____
Insurance company _____ Group # _____ Union or local # _____
Ins. Co. address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____
Do you have additional insurance? Yes No If yes, please complete the following:
Name of insured _____ Relationship to patient _____
Birthdate _____ Social Security Number _____
Name of employer _____ Work phone _____
Address of employer _____ City _____ State _____ Zip _____
Insurance company _____ Group # _____ Union or local # _____
Ins. Co. address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____
Signature of patient or parent if minor Date _____

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Laura Shelton, N.D., or Emily Sharpe, N.D.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information. This notice is posted for your review at all times in the Clinic waiting room. You may request a copy for your records if you wish.

By my signature below I acknowledge the availability of the Notice of Privacy Practices.

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of the patient

Relationship to patient

This form will be retained in your medical record.

NATURAL HEALTH CLINIC

CHILD HEALTH HISTORY

To help us meet all your healthcare needs, please fill out this form completely in ink. This is a confidential record of your child's health history.

Today's date: _____

Child's name (Last, First, MI): _____ Date of birth: _____ Age: _____
Parents' names (Last, First, MI): _____ Phone: _____
_____ Phone: _____

In what way is your child unhealthy? (If here for a well child exam, please state that): _____

What have you, the parent, already done to help your child be healthier? _____

FAMILY BACKGROUND:

Who does your child live with? _____
Are parents divorced? _____ If so, what type of arrangements (visitation, etc.) are made for the other parent? _____

FAMILY MEDICAL HISTORY:

Please mark relationship of anyone in your family that has had the following conditions: (M = mother, F = father, S = sister, B = brother, A = aunt, U = uncle, MM or FM = mother or father's mother, MF or FF = mother or father's father, MGM or FGM = mother or father's grandmother, MGF or FGF = mother or father's grandfather).

High blood pressure	_____	Tuberculosis	_____	Diabetes	_____
Bleeding tendency	_____	Heart disease	_____	Stroke	_____
Drug/alcohol problem	_____	Epilepsy	_____	Allergies	_____
Chronic lung disease	_____	Cancer	_____	Asthma	_____
Mental Illness	_____	Leukemia	_____	Obesity	_____
Migraine headaches	_____	Ulcer	_____	Depression	_____
Thyroid disease	_____	Gout	_____	Glaucoma	_____
High cholesterol	_____	Kidney disease	_____		

BIRTH HISTORY:

1. Did mother receive prenatal care? _____ Take prenatal vitamins? _____
2. State of mother's health during pregnancy _____
3. Did mother smoke cigarettes? _____ Drink alcohol? _____ Take drugs? _____
4. What type of birth? _____ How long was labor? _____
5. Carried to term? _____ If no, how premature? _____
6. Birth weight? _____ Apgar scores (if you remember) _____
7. Any complications of labor or delivery? _____

Over please.....

Child's name: _____

HEALTH HISTORY: How often does your child get:

Colds _____ Sore throats _____ Diarrhea _____ Earaches _____
Coughs _____ Constipation _____ Headaches _____ Tummy aches _____
Diaper rash _____ Others _____

Has your child been immunized? Update: DPT _____ Polio _____ HIB _____ Hep B _____ MMR _____

What medications has your child been on? (Include details: How often, how long, for what? _____

ENVIRONMENTAL HISTORY:

Do you have indoor pets? _____ If so, what types? _____
What type of dwelling do you live in? _____ How old? _____
Any remodeling recently? _____ Has your child been exposed to any chemicals or toxins? _____
Do you heat with a wood stove? _____ Does anyone in the family smoke cigarettes? _____

DIET:

1. What did your child eat and drink yesterday?
Breakfast: _____
Snack: _____
Lunch: _____
Snack: _____
Dinner: _____
Snack: _____

Is this typical? _____ If not, what is? _____

2. What foods does your child enjoy? _____
Dislike? _____

3. What supplements does your child take and how often? _____

STRESSES:

Has your child experienced many stresses in his/her life-time? _____ What? _____

SLEEP:

How much sleep does your child get? _____ From: _____ p.m., to _____ a.m.

Is there anything not covered by this questionnaire that you feel is important for a caring doctor of yours to know about? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the doctor's office of any changes in my child's medical status. I also authorize the healthcare staff to perform the necessary health care services my child may need.

X _____
Signature of patient's parent Date