



Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Sex: _____ Other names that records may be kept under: _____

Email Address: _____

Home Ph: (____) _____ - _____ Work Ph: (____) _____ - _____ Cell Ph: (____) _____ - _____

May we leave confidential voice-mail messages for you at any of the above numbers? ___ No ___ Yes

Would you like to receive ___text and/ or ___email appointment reminders?

Employer/School (if student): _____

Mother's Name (minors only): _____ Father's Name (minors only): _____

Emergency Contact: _____ Relationship to Emergency Contact: _____

Emergency Contact's Phone #: (____) _____ - _____ ___Home ___Work ___Cell

Insurance: (please provide front desk staff with your current insurance card so we have a copy on file)

Primary insurance company: _____ Subscriber ID: _____

Subscriber's name (if different than patient): _____ **Subscriber's Date of Birth:** _____

Address: _____ City: _____ State: _____ Zip Code: _____

Current Marital Status (circle):

Single/never married, Married, Divorced, Separated/Divorced, Widowed, Domestic Partnership

How did you hear about us (circle):

Website, Workshop/ Event, Medical Referral, Friend/Family: _____, Insurance. Co.

Other: _____

Terms of Admission

Privacy Terms: We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so. Sound Holistic Health is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgment that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning that management of your healthcare information at our clinic, wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please call our office at (425)258-4633.

I hereby acknowledge that I have received a copy of Sound Holistic Health/Healthy Balance Natural Medicine's Notice of Privacy Practices. Should I refuse or fail to sign this form, I acknowledge that Healthy Balance Natural Medicine has made a good faith effort to obtain my acknowledgment.

Patient's Signature

Date

Guardian/Representative's Signature

Relationship to Patient

Date

DATE _____

PATIENT PROFILE

Last Name: _____ First Name: _____ MI: _____

Nickname: _____ Birth date: _____ Sex: _____

A note to our patients: Please complete this questionnaire as thoroughly as possible in order to aid your clinicians in their diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except when you have provided us with written authorization to do so. Thank you.

PRESENT HEALTH CONCERNS

Please list most important health concerns in their order of significance.	Details, painful or distressed areas:
1.	
2.	
3.	
4.	
5.	

What goals do you have for your visit at the clinic today? _____

Have you ever consulted a: Naturopathic physician, Acupuncturist, Nutritionist, Counselor

Do you have any questions about our clinic or the care that you've chosen today? _____

Please list prescription medications that you are currently taking, with dosages: None

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

List vitamins, minerals, herbs, homeopathics that you are currently taking, with dosages: None

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

Allergies: None

Severe or life-threatening allergies: _____

Food, Environmental, Drug allergies: _____

Personal Habits:

Do you follow any particular diet regimens or restrictions? Yes No

Diet Details: _____

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Alcohol (# / week) _____ Coffee / tea (# / week) _____ Soda (# / week) _____

Tobacco (# / day) _____ Drugs (for non medical purposes, # / week) _____

Water (# / day) _____

Do you exercise regularly? Yes No

What type? _____

How long? _____ How often? _____

Sleep (hours / night) _____ Bedtime: _____ Wake-up time: _____

of Times Waking Up: _____

Past History:

Primary Care Physician: _____

Specialists: _____

Hospitalizations & Dates: _____

Serious Illnesses and Injuries & Dates: _____

Date of last physical/annual exam _____ Date of last blood tests: _____

Social History:

Please circle those that apply: Single Married Significant other

Do you have any children? Yes No Please list their age(s) _____

Occupation: _____

Hobbies: _____

Personal and Family History:

Family: M, F, B, S, MGM, MGF, PGM, PGF

Alcoholism/Drug Addiction	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____	Headaches	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____
Allergies	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____	Heart Disease	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____
Alzheimer's / Dementia	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____	Hepatitis	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____
Anemia	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____	Herpes	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____
Anxiety	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____	High Blood Pressure	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____
Arthritis	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____	High Cholesterol	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____
Asthma	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____	Kidney Disease	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____
Autoimmune	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____	Lung Disease	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____
Cancer	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____	Mental Illness	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____
Depression	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____	Osteoporosis	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____
Diabetes	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____	Sexually transmitted infections	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____
Eczema	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____	Stroke	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____
Epilepsy	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____	Thyroid disease	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____
Gout	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____	Other	<input type="checkbox"/> Self, current <input type="checkbox"/> Self, past <input type="checkbox"/> Family:_____

Issues with:	Details	Issues with:	Details
Weight		Lungs / breathing	
Sleep		Digestion / bowel movements	
Headaches		Urination	
Mood		Muscles / joints / bones / spine	
Eyes / vision		Skin / hair / nails	
Ears / hearing		Nerves	
Nose / smelling		Reproductive	
Mouth / Gums / Jaw		Sexual	
Heart		Other	
Circulation			

*Please indicate the top 3 issues that you have above.



Insurance Coverage Checklist

SHHC can bill some insurance plans as a service to you. However, it is important for you to verify your benefits prior to your appointment. Please note that coverage is based on each patient's individual plan. If your insurance company does not pay for the services listed below, you will be responsible for the payment of all services rendered.

Below is a list of questions to ask your insurance company so you may determine potential out-of-pocket costs*

Date: _____ Time: _____ Insurance Rep. Name: _____ Reference #: _____

Please note that the doctors at our clinic sometimes co-manage patients so even if you think you might not necessarily use a particular service, it's good to know in case it is suggested to you.

*Providers may be listed as practicing at **Sound Holistic Health or Healthy Balance Natural Medicine.***

Dr. Kevin Shaw ND, LAc NPI # 1659570893; Dr. Leila Kuehner, ND NPI # 1417401928; Dr. Lara Thompson, ND NPI # 1104467778

Is Sound Holistic Health in-network on my specific plan? YES NO

If yes, what is my annual deductible, or coinsurance per member or family? _____

If no, does my plan have out-of-network (OON) benefits? YES NO

What is my OON annual deductible, or coinsurance per member or family? _____

What is my OON co-pay? _____

Does my plan cover telemedicine and telehealth? YES NO

Do I have Naturopathic Medicine coverage? YES NO

Is a referral needed? YES NO Does this service require prior authorization? YES NO

What is my visit limit? _____ What is my co-pay? _____

Which services or visit limits are grouped together: acupuncture, chiropractic, physical therapy, massage, naturopathic medicine

Do I have acupuncture coverage? (CPT codes 97810-97811, 97813-97814) YES NO

If yes, do I need a referral for this service? YES NO

Does this service or CPT codes require a prior authorization? YES NO

Do I have a co-pay? YES NO

If yes, how much? _____

What is my annual visit limit? _____

Do I have physical medicine coverage? (CPT codes 98925-98929) YES NO

If yes, do I need a referral for these services provided by a Naturopathic Doctor? YES NO

Do these services or CPT codes require a prior authorization? YES NO

What is my annual visit limit? _____

Do I have physical therapy coverage? (CPT codes 97140, 97112, 97014, 97032) YES NO

If yes, do I need a referral for these services provided by a Naturopathic Doctor? YES NO

Does this service or CPT codes require a prior authorization? YES NO

What is my annual visit limit? _____

Completing this form does not guarantee payment by your insurance.



Office Policies

At Sound Holistic Health we strive to maintain a positive provider-patient relationship. Outlining our policies allows for effective communication to ensure we meet that goal. Please read this carefully and do not hesitate to ask our staff any questions.

Cancellation and No Show Policy

If you are unable to keep your appointment, please call the clinic with at least 24 business hours notice before returning visits and 48 hours for first visits. This allows us time to offer the spot to another patient. A fee may be charged for late cancellations and missed appointments. Exceptions can be made for extenuating circumstances and emergencies.

Fragrance Free/Low Scent Policy

Sound Holistic Health Clinic is a fragrance free environment as many people are sensitive to synthetic fragrances. Please refrain from wearing perfumes, colognes, or highly scented body products.

Insurance

It is your responsibility to understand your insurance, flexible spending, and health benefit plan(s). If benefits are denied, you are responsible for payment in full. Coverage and benefits disputes should be addressed to your insurance company as they determine your coverage, co-payments, co-insurance, and deductibles. If our providers do not participate in your insurance plan, we may submit an out-of-network claim on your behalf. You may be responsible for the balance due depending on your out-of network coverage.

Financial Terms and Payment

All payments are due at the time of service, including copayments. You, or your guarantor, are responsible for all charges and services rendered whether covered by your insurance or not. Excessively overdue accounts may incur finance charges and will be forwarded to an outside collection agency. You will be responsible for any fees generated as a result of collection efforts. A guarantor, other than yourself, is not authorized to receive any of your medical information unless authorized by you in writing. If you are having difficulty paying your balance or affording services, please inquire at the front desk.

Labs

We strive to use the most accurate functional measures of health to best guide your health care decisions while working to keep the cost to the patient as low as possible. As such, we charge a phlebotomy handling and convenience fee to cover the cost of offering optimal lab services to you at our clinic. Other fees may apply for specialty labs or labs not covered by insurance.

I have read and understand the aforementioned policies.

Patient's Signature

Date

This section must be completed if someone other than the patient is financially responsible for the patient's account

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip Code: _____ Phone: () - _____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed above.

Guarantor's Signature

Date

NATUROPATHIC MEDICINE INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize the licensed naturopathic physicians at Healthy Balance Natural Medicine, PLLC (DBA Sound Holistic Health) or any of its licensed personnel to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

General Diagnostic and Minor Office Procedures Consistent with the Practice of Naturopathic Medicine (the use of venipuncture, health history taking, physical examination, radiography, examination of body orifices excluding endoscopy such as pap smears, laboratory medicine -urine and blood work, and obtaining samples of human tissues, but excluding incision or excision beyond that which is authorized as a minor office procedure, care and procedures of superficial lacerations, lesions, and abrasions, and the removal of foreign bodies located in superficial structures, not to include the eye; and the use of antiseptics and topical or local anesthetics in connection therewith, intramuscular, intravenous, subcutaneous, and intradermal injections of substances)

Herbs/Natural Medicines (prescribing of various therapeutic substances including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical creams, pastes, plasters washes; suppositories or other forms. Homeopathic remedies, highly dilute quantities of naturally occurring substance(s), may also be used.)

Counseling; Lifestyle Counseling; Dietary Advice and Therapeutic Nutrition (use of counseling, biofeedback, hypnosis or other methods in the scope of naturopathic medicine; foods, diet plans or nutritional supplements for treatment)

Exercise Prescriptions, Soft Tissue and Osseous Manipulation (use of exercise and movement, massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, manipulations of the extremities and spine including traction and craniosacral therapy)

Electromagnetic and Thermal Therapies (includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and infrared and ultraviolet therapies or hydrotherapies.)

Potential Risks and Consequences: Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre- existing symptoms.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Telemedicine: In some circumstances, you may be scheduled for a telemedicine visit. Telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when the patient is located at a different site than the provider; and hereby consent to Sound Holistic Health and its licensed personnel to providing naturopathic consultation to me via telemedicine. The laws that protect privacy and the confidentiality of medical information also apply to telemedicine. I understand that I will be responsible for any payments that apply to my telemedicine visit. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of any care at any time, without affecting my right to future care or treatment.

Potential Risks and Consequences: The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a physician at a distance. At first it may be difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to patient contact. Following the telemedicine consultation, your physician may recommend a visit to a hospital, specialist, or urgent care for further evaluation.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Healthy Balance Natural Medicine (DBA Sound Holistic Health) or any of its personnel. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee. I acknowledge that it is my responsibility to check my insurance coverage prior to visits. I may revoke my consent orally or in writing at any time by contacting Sound Holistic Health. As long as this consent is in force (has not been revoked) Sound Holistic Health and its licensed personnel may provide naturopathic services to me without the need for me to sign another consent form.

Patient's Name

Signature of Patient

Signature of Patient Representative or Guardian

Date

ACUPUNCTURE AND EAST ASIAN MEDICINE INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize the licensed acupuncturists of Healthy Balance Natural Medicine, PLLC (DBA Sound Holistic Health) or any of its licensed personnel to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Acupuncture: insertion of special sterilized needles through the skin into underlying tissues at specific points on the surface of the body.

Cupping: a technique to relieve symptoms in which cups made of glass or other materials are placed on the skin with a vacuum created by heat or other device.

Gua Sha: a rubbing on an area of the body with a blunt, round instrument.

Herbs: may be given in the form of pills, powders, tinctures, pastes, plasters, or other forms such as raw herbs to be cooked. Cooked herbs may be given to take internally or externally as a wash. Herbal formulas may include shell, mineral, and animal materials.

Moxa: indirect burning on an acupoint using stick, string, or ball moxa to relieve symptoms.

Tuina: an ancient massage used to treat a wide variety of common disharmonies.

Dietary Advice: based on traditional Chinese Medical Theory.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: discomfort, pain, infection, or blistering at the site of the procedure; temporary discoloration of the skin; nausea, loose bowel movements, abdominal cramping; and aggravation of symptoms existing prior to the acupuncture treatment.

Potential benefits: drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem and the strengthening of the constitution.

Notice to Pregnant Women: We do not use labor-stimulating acupuncture points unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment. All female patients must alert the intern or doctor if they know or suspect they are pregnant.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Healthy Balance Natural Medicine (DBA Sound Holistic Health) or any of its personnel. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law.

I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee. I acknowledge that it is my responsibility to check my insurance coverage prior to visits. I may revoke my consent orally or in writing at any time by contacting Sound Holistic Health. As long as this consent is in force (has not been revoked) Sound Holistic Health and its licensed personnel may provide naturopathic services to me without the need for me to sign another consent form.

Patient's Name

Signature of Patient

Signature of Patient Representative or Guardian

Date