



PATIENT REGISTRATION FORM

Today's Date _____

PATIENT INFORMATION

Name:	Date of Birth:	Age:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status:	
Address:	Phone (hm):	
City/State/Zip:	Phone (cell):	
Email:	May we leave messages at these numbers? <input type="checkbox"/> H <input type="checkbox"/> C	
Preferred method of communication:	<input type="checkbox"/> Email	<input type="checkbox"/> Home phone <input type="checkbox"/> Cell phone
Emergency Contact:	Phone:	
Their relationship to you:		
For Minors Only: Name of Mother:	Name of Father:	

HOW DID YOU HEAR ABOUT US?

- Family/Friend Insurance Physician Referral
 Internet: Specify _____ Other: _____

BILLING FORMATION

Is patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, Name of Person Responsible for Bill:		
Primary Insurance: (PLEASE GIVE YOUR CARD TO THE RECEPTIONIST)	*Address and Phone Number of Responsible Party (if different from above)		
Subscriber's Name	Employer:	Occupation:	Date of Birth:
Patient's Relationship to Subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child <input type="checkbox"/> Other:
Subscriber #:	Group #:		
Secondary Insurance:	Subscriber's Name	Employer:	Date of Birth:
Patient's Relationship to Subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child <input type="checkbox"/> Other:
Subscriber #:	Group #:		

By checking this box, I am verifying that the above is true to the best of my knowledge.

Date: _____



119 Cedar Ave, Snohomish, WA 98290

Phone: 360-863-3223 Fax: 888-875-1198

Consent for Treatment

I, the undersigned, hereby authorize the physicians listed above to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

General Diagnostic Procedures, which may include but is not limited to venipuncture, PAP smears, radiography, and blood and urine lab work, general physical exams, neurological and musculoskeletal assessments.

Lifestyle Counseling and Hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, immunization, psychological counseling, and balancing of work and social activities.

Dietary Advice and Therapeutic Nutrition: use of foods, diet plans or nutritional supplements for treatment – may include intramuscular vitamin injections.

Herbs/Medicines: prescribing various therapeutic substances including plants, minerals, animal materials, and some pharmaceuticals, and non-drug contraceptive devices. Substances may be given in the form of teas, pills, powders, tinctures – may contain alcohol; topical creams, pastes, plasters, washes, suppositories or other forms.

Soft Tissue and Osseous Manipulation: use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine, including traction.

Homeopathic Remedies: use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.

Minor office procedures: Dressing wounds, ear cleansing, care of superficial lacerations.

Electromagnetic and Thermal Therapies: The use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, infrared and ultraviolet therapies, and hydrotherapy.

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

Potential risks: Discomfort, pain, minor bruising, infection, blistering, loss of consciousness or deep tissue injury from, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements, soft tissue or bone injury from physical manipulations, temporary discoloration of the skin, temporary dizziness and lightheadedness, and aggravation of pre-existing symptoms.

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, 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.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

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 myself or my representative or if it is required or permitted by applicable law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last treatment. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of [her](#) ability.

Patient's Name (Print)

Guardian's Name (Print)

Patient's Signature

Guardian's Signature

Date

Relationship to Patient

Date



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Acknowledgement of Receipt:

Financial Policy

The following outlines our financial policy. Please review carefully and sign/date it.

- Payment is due at time of service. The provider may arrange this differently under certain circumstances. Acceptable forms of payment include cash, check, Visa, & MasterCard. Insurance is also accepted. Payment for services are paid to the appropriate billing provider (not CAIM).
- Patients who pay out of pocket for their visit will ONLY be given a 20% discount if they pay at time of service.
- Nutritional supplements must be paid for at the time of purchase, regardless of insurance.
- Please give us 24 hours' notice if you can't make your appointment. Failure to give 24 hours advance notice for appointment cancellations may result in a fee. Patients will now be billed **\$50.00 for appointments that are cancelled with less than 24 hours' notice.** Special circumstances may waive this fee. The front desk will now remind patients of this policy when they call for appointment reminder.
- Patients may be responsible for charges incurred by using the practitioner's pager, cell phone, or text service outside of normal business hours (Monday-Friday: 9am-6pm). This fee will be \$40 per page, cell phone call, or text. We encourage all patients to call the front desk with immediate concerns during normal business hours.
- Patients are responsible for all bank charges and fees resulting from a returned check.
- Accounts more than 60 days overdue will incur financing charges of 1% per month on any outstanding balance.
- There may be an associated form fee at physician's discretion of \$25. Forms include but aren't limited to letters of medical necessity.

Insurance: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance as a courtesy for which we are contracted providers, as long as you provide us with your current and correct information.

I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize my provider or my insurance company to release any information required to process my claims. I understand that payment is dependent on my eligibility at the time of service and ALL terms and conditions of my insurance plan. I also acknowledge that certain services may not be covered by my benefit plan, or deemed medically unnecessary, and agree to pay for any Non-Covered Service, such as phone or email consultations and outside labs. This authorization shall remain valid until revoked by me in writing.

Payment Issues: If financial problems arise, please contact our office ASAP. Installment or payment arrangements can be implemented. Balance will become due immediately if you break rules of the plan.

I have carefully read the Financial Policy. I understand and agree to the terms therein.

Signature of Patient or Responsible Party

Date

Print Patient Name

Date of Birth



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Acknowledgement of Receipt:

Notice of Privacy Practices:

- I have been offered a copy of the Notice of Privacy Practices for the Practitioner that I am seeing. For future reference, I may access a copy at the front desk or on the website.

Signature of Patient or Responsible Party

Date

Acknowledgement of Confidentiality:

- **Voicemail (please check one circle):**

I hereby give permission for Origins Natural Health to leave the following on my voicemail:

- Detailed medical information
- Limited medical information (please specify with your provider)
- Billing and appointment information

Signature of Patient or Guardian

Date

- **Email (please check one circle):**

I hereby give permission for Origins Natural Health to leave the following on my email:

- Detailed medical information
- Limited medical information (please specify with your provider)
- Billing and appointment information

Signature of Patient or Guardian

Date

Print Patient Name

Date of Birth



HEALTH HISTORY QUESTIONNAIRE *For Newborns*

All questions contained herein are strictly confidential and will become part of your child's medical record.

Form completed by and relation::		Date:		
Name: (Last, First, M.I.)		<input type="checkbox"/> M <input type="checkbox"/> F	DOB: Time:	
BIRTH HISTORY				
Prenatal history:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Gestational diabetes		
	<input type="checkbox"/> YES <input type="checkbox"/> NO	Group B Strep		
	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hypertension		
	<input type="checkbox"/> YES <input type="checkbox"/> NO	Smoking during pregnancy		
	<input type="checkbox"/> YES <input type="checkbox"/> NO	Alcohol or recreational drug use during pregnancy		
Birth History:	<input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean Section <input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum <input type="checkbox"/> Trauma? Timing: <input type="checkbox"/> On time <input type="checkbox"/> Before 37 weeks <input type="checkbox"/> After 42 weeks Birth site: _____ Birth Attendant: _____			
Illness:	Any newborn problems? <input type="checkbox"/> Jaundice <input type="checkbox"/> Hospitalization <input type="checkbox"/> Other, describe			
DIET AND ENVIRONMENT				
Feeding Plans:	Home Environment:			
<input type="checkbox"/> Breastmilk only	How many children in your home? _____			
<input type="checkbox"/> Formula	This child's birth order (3 rd of 4 kids...) _____			
<input type="checkbox"/> Mixed	What adults live with your child? _____			
	<input type="checkbox"/> YES <input type="checkbox"/> NO	Does your home have adequate heat, a telephone and enough food?		
	<input type="checkbox"/> YES <input type="checkbox"/> NO	Was your home built before 1950?		
	<input type="checkbox"/> YES <input type="checkbox"/> NO	Does your home have mold?		
	<input type="checkbox"/> YES <input type="checkbox"/> NO	Is your home safe?		
FAMILY HEALTH HISTORY				
Is your child adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Has any family member (or you) been diagnosed with:	YES	NO	Who? At what age?	Details
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>		
Severe allergies	<input type="checkbox"/>	<input type="checkbox"/>		
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>		
Stroke/Blood clots	<input type="checkbox"/>	<input type="checkbox"/>		
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>		
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>		

High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>		
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>		
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>		
Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>		
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>		
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>		
Colitis/Crohn's/Celiac	<input type="checkbox"/>	<input type="checkbox"/>		
Anemia	<input type="checkbox"/>	<input type="checkbox"/>		
Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		
Alcohol or drug problems	<input type="checkbox"/>	<input type="checkbox"/>		
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		
Mental illness/depression	<input type="checkbox"/>	<input type="checkbox"/>		
Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>		
Deafness	<input type="checkbox"/>	<input type="checkbox"/>		
Developmental disability	<input type="checkbox"/>	<input type="checkbox"/>		
Bed-wetting after age 10	<input type="checkbox"/>	<input type="checkbox"/>		
Other:	<input type="checkbox"/>	<input type="checkbox"/>		